COVID-19 Hospital Discharge Service Requirements (Wales)

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1. Executive Summary

1.1 This document sets out the Hospital Discharge Services Requirements for health, social care, third and independent sector partners in Wales, who must adhere to this guidance from 6th April 2020.

Much of the content will already be familiar as work has been ongoing to grow and embed the 'Every Day Counts; Home First' ethos and to implement the Discharge to Recover then Assess Pathways in Wales, illustrated as **Annexe A**.

The arrangements to manage discharge and hospital flow during the COVID-19 emergency period, require us to:

- expedite these service and practice developments at scale and pace; and
- pool the expertise and learning at local, regional and national levels.

1.2 For clarity, the discharge options and pathways referred to in this document are summarised below:

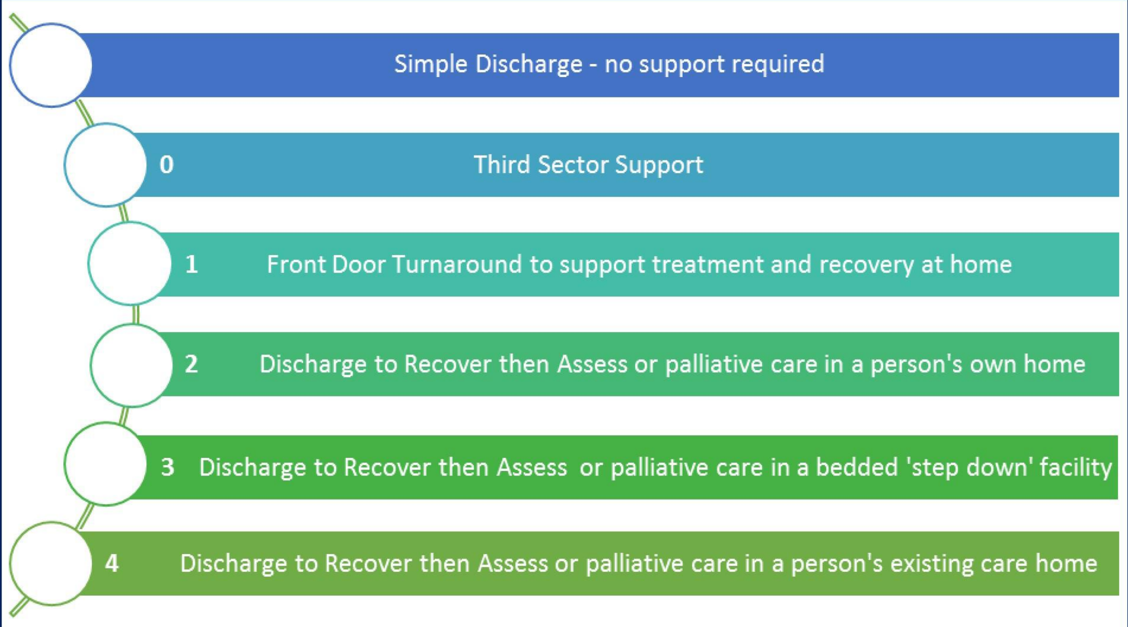


Figure 1: Discharge to Recover then Assess Model & options (Wales)

1.3 Unless required to be in hospital (see **Annex B**), patients must not remain in an NHS bed.

1.4 Based on these criteria, acute and community hospitals must discharge all patients as soon as they are clinically safe to do so. Transfer from the ward should happen within one hour of that decision being made to a designated discharge area. Discharge from hospital should happen as soon after that as possible, normally within 2 hours.

1.5 Acute and community hospitals must keep a list of all those suitable for discharge and report on the number of patients on the list who have left the hospital through the daily situation report.

1.6 Usual reporting procedures for Delayed Transfers of Care will be suspended during this period. Instead brief updates will be submitted to Welsh Government on a weekly basis, so that barriers to implementation can be understood and addressed. This data will not be used for performance management purposes.

1.7 Continuing NHS Health Care (CHC) assessments for individuals on the acute hospital discharge pathway and in community settings will not be required until the end of the COVID-19 emergency period.

1.8 The Welsh Government has commissioned a rapid analysis of the resources required to enable health and social care communities to fund the cost of new or extended out-of-hospital health and social care support packages referenced in this guidance. Further detail will be shared with Health Boards and Local Authorities imminently and this should not create a delay in implementing the guidance in the meantime.

1.9 The vast majority of patients will be able to be discharged without further support, other than that provided by their usual support mechanisms, such as family, friends and neighbours. Others will need some short-term practical help with tasks such as those provided by third sector discharge schemes (Option 0 in Figure 1). For those who will require ongoing support, the default will be immediate entry on to a Discharge to Recover then Assess Pathway (Options 1-4 in Figure 1).

1.10 The Discharge to Recover then Assess model can only be achieved through close partnership working. Local community co-ordination hubs will work together closely and on a daily basis:

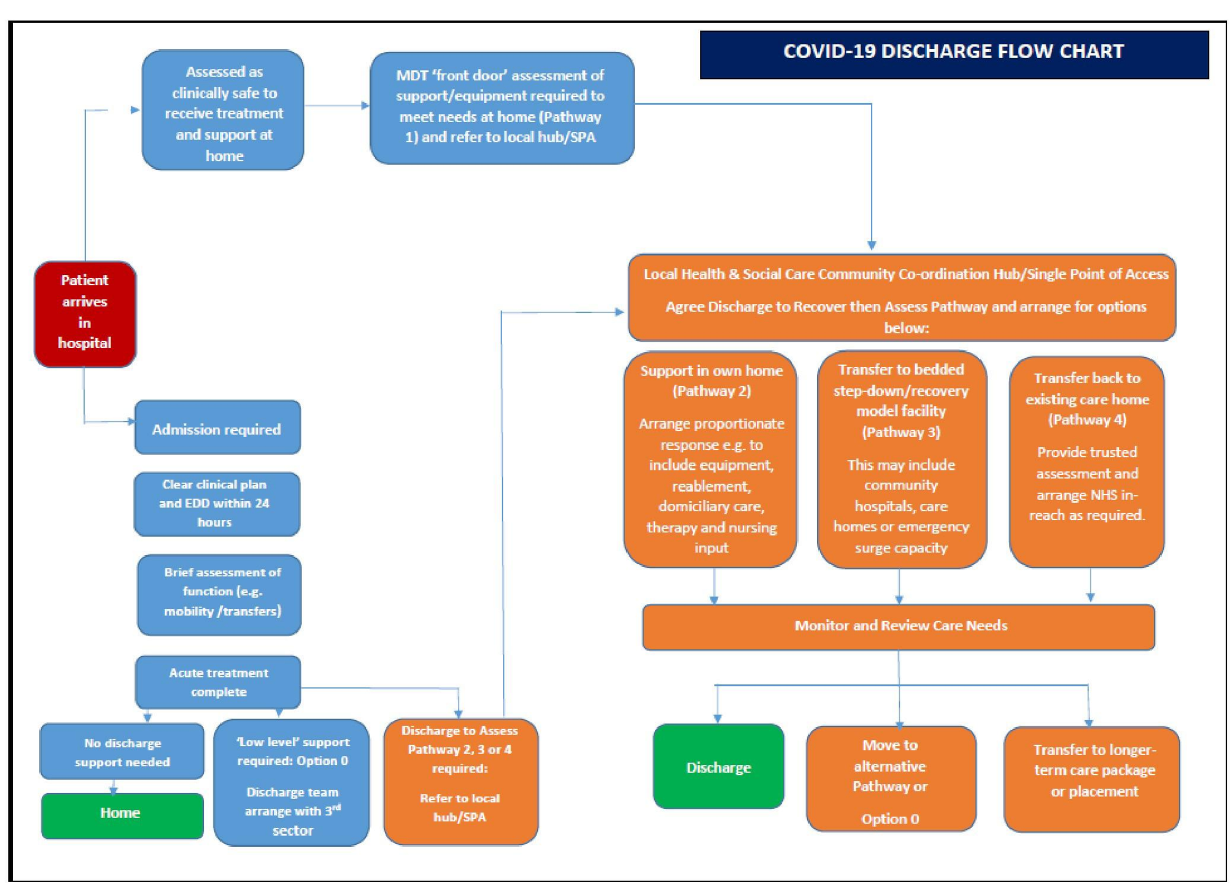
- Review available community capacity. To support this, key discharge leads will have access to the live Care & Support Capacity Tool from 6th April 2020;
- Minimise the risks associated with multiple contacts for patients, and actively seek to implement reciprocal arrangements for delegated tasks between health and social care staff. For example, subject to established guidelines and governance arrangements[1], simple nursing tasks that could be appropriately undertaken by domiciliary care staff and vice versa;
- Ensure there are robust tracking mechanisms so that care users do not get lost in the system at a time of very rapid response.

[1] https://heiw.nhs.wales/news/all-wales-delegation-guidelines/

1.11 The following sections detail what these changes mean for all health and care sectors with a role in hospital discharge and provide clarity on the actions organisations need to take straightaway. This information will be supplemented by specific action cards outlining how key roles should work differently during this period, which will be published separately and discussed as part of the national support for these changes (see Section 11).

1.12 There needs to be clear accountability and escalation mechanisms at each stage of the discharge to assess process in each locality (see **Annex G**).

Figure 2: Overview of COVID-19 Discharge Process



2. What do COVID-19 discharge arrangements mean for patients?

2.1 The Hospital Discharge Services Requirements set out in this document will already be familiar to health, social care, third and independent sector colleagues in Wales. Work has been ongoing to grow and embed the 'Every Day Counts; Home First' ethos and to implement the Discharge to Recover then Assess Pathways illustrated as **Annexe A**. 'What Good Looks Like' advisory papers have been developed in collaboration with the partner agencies and published[2].

2.2 The arrangements to manage discharge and hospital flow during the COVID-19 emergency period, require us to:

- expedite these service and practice developments at scale and pace; and
- pool the expertise and learning at local, regional and national levels.

Doing so will allow us to provide the best experience for those requiring urgent acute hospital care, whilst supporting recovery and minimising the risks for those who no longer need to be in an acute hospital bed.

2.3 The majority of patients will be able to be discharged without further support, other than that provided by their usual support mechanisms, such as family, friends and neighbours. Others will need some short-term practical help with tasks such as those provided by third sector discharge schemes. For those who will require ongoing support, the default will be immediate entry on to a Discharge to Recover then Assess Pathway. For clarity, the options referred to in this document are summarised in **Figure 1** below:

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[2] http://howis.wales.nhs.uk/sitesplus/407/page/36206

http://extranet.wales.nhs.uk/howis/sitesplus/407/page/36206

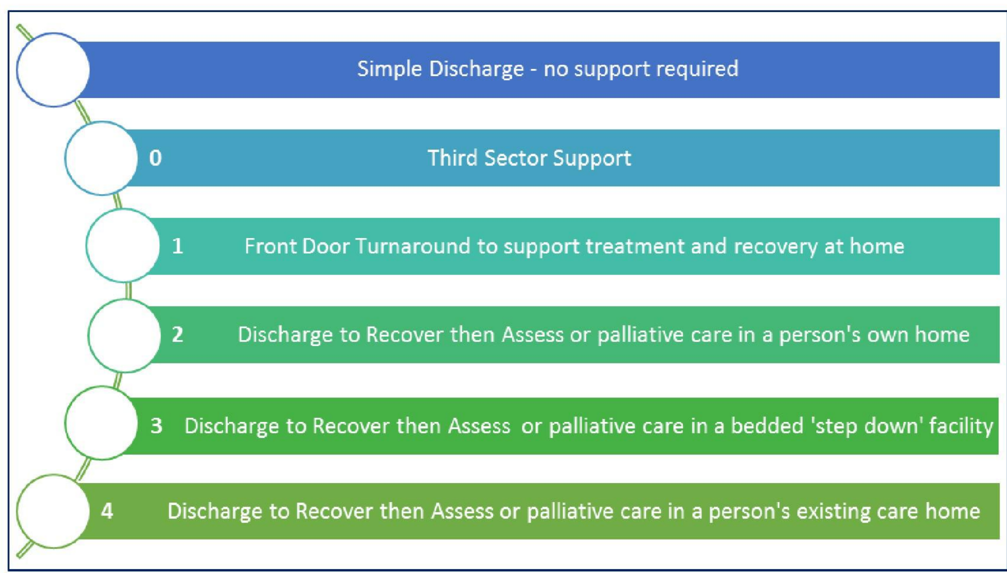

Figure 1: Discharge to Recover then Assess Model & options (Wales)

2.4 On the day a patient is to be discharged (following discussions with the patient, their family and any other professionals involved in their care, using leaflets B1/B2 in Annex C), within one hour the ward will arrange to escort the patient to the hospital discharge lounge, so their acute bed can be immediately used by someone being admitted who is acutely unwell.

2.5 Within two hours of arriving in the discharge lounge, transport home, any volunteer and voluntary sector support and immediate practical measures, such as shopping and the heating turning on, will be organised by the discharge co-ordinators for those who have no one else to do this.

2.6 Wherever possible, utilise trusted assessor protocols to ensure that arrangements are in place to meet the individual's immediate needs on discharge. Where trusted assessor protocols are not in place, a lead professional or multidisciplinary team, as is suitable for the level of care needs, will need to visit patients at home on the day of discharge or the day after to determine what support is needed in the home environment and rapidly arrange for that to be put in place. If care support is needed on the day of discharge from hospital, this will have been arranged prior to the patient leaving the hospital site, by a care coordinator.

2.7 For patients whose needs are too great to return to their own home, transfer will be arranged to a suitable 'step-down' bedded facility, which could be in a community hospital, care home or other emergency surge capacity.

2.8 During the COVID-19 pandemic, patients transferring to a new care home placement, will not be able to wait in hospital until their preferred choice of care home has a vacancy. This will mean a temporary stay in an alternative care home.

2.9 NHS and Local Authority partners will track and monitor all individuals in step-down bedded facilities and in care homes not of their first choice. The nominated care coordinators will follow up to ensure patients are able to transfer back to their own home, or move to their long-term care home, as soon as possible.

3. What are the actions for NHS Wales Health Boards?

'Why not home? Every hour counts'

Health Boards need to rapidly review their processes and assure themselves that their practices are fit for purpose, to deliver the discharge to recover then assess model.

3.1 **Ward level (acute and sub-acute hospitals):**

- A clinically-led review of all patients will be undertaken at an early morning board round. Any patient meeting the revised clinical criteria, i.e. whose acute treatment is completed, will be deemed suitable for discharge.

- A second, afternoon board round will agree any further patients not required to be in hospital and therefore able to be discharged.

- Social care colleagues, or appropriate representatives from the integrated discharge team, should be involved in the twice daily ward reviews. This will help with the early identification of any possible care and support, placement or housing issues with discharge and allow the MDT to undertake arrangements in good time. Virtual options should be employed wherever practicable.

- Ensure professional and clinical leadership between nursing, medicine and allied health professions for managing decisions and use prompts in the box below:

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Figure 3: Prompts for board rounds in acute hospital wards

- **Is acute treatment complete?**
- **Can this person's care now be provided in another setting?**
- **Does this person need to be on a Discharge to Recover then Assess Pathway? If so, which? *Think 'Home First'***
- **What is value added for this person remaining on an acute ward, balanced against the risks?**
- **Why not home? Why not today?**
- **If not today, when? (Expected date of discharge)**
- **What needs to happen next? (Actions for today)**

- All patients who are not required to be in hospital and are therefore suitable for discharge will be added to the discharge list and allocated to a discharge pathway. Discharge home today should be the default pathway.
- On decision of discharge, the patient and their family or carer, existing care providers and any formal supported housing workers should be informed and receive the relevant leaflet (see Annex C).
- Individuals and their families must be fully informed of the next steps.
- The co-ordinator will ensure that all practicalities are addressed, including availability of existing care provider, transport arrangements, medication, discharge communication etc.
- Transfer off the ward into a discharge lounge within one hour of decision to discharge.
- During the COVID-19 period, patients should be discharged with up to 28 days' supply of medication, depending on their individual circumstances.

- In limited circumstances, depending on the individual's prognosis (e.g. 24 hours or less), it may be appropriate for hospitals to issue a small amount of palliative care medicines at the point of discharge, to support end of life care in their place of choice. However hospitals **must not** routinely do so. Any further supplies required after this timeframe can be accessed via the usual mechanisms.

3.2 **Hospital Discharge teams:**

- Provide expert advice and support to the ward teams on the appropriate Discharge to Recover then Assess Pathways. Act as a key problem-solving contact between hospital and community teams
- Arrange dedicated staff to support and manage all patients on Pathway 0. This will include:
  - co-ordinating with transport providers
  - local voluntary sector and volunteering groups helping to ensure patients are supported (where needed) actively for the first 48 hours after discharge
  - 'settle in' support is provided where needed
- Provide effective discharge planning for people with no home to go to and ensure that no-one is discharged to the street. See Annex D for further details on homelessness.
- Where not already in place, train discharge staff (potentially those who no longer have to undertake CHC assessments) to operate 'Trusted Assessments' for patients in hospital from care homes, so they can return to their care home promptly, and support all care homes with these new discharge arrangements.

Figure 4: Suggestions to increase confidence for discharging

To create a safety net and increase confidence in discharging, consider:

- **Patient initiated follow-up.** Give patients direct number for the ward they are discharged from, to call back for advice. (Do not suggest going back to their GP or coming to A&E)
- **Telephone the following day** after discharge to check and offer reassurance/advice
- **Call them back** with results of investigations and any changes or updates to a patient's management plan. Ensure this information is also conveyed to the Discharge to Recover then Assess team/care provider, and GP
- **If required, bring them back under the same team/speciality**
- **Request Community Nursing** follow up for a specific clinical need
- **Request GP follow up** in some selected cases

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3.3 **Hospital clinical and managerial leadership team:**

- Create safe and comfortable discharge spaces for patients to be transferred to within one hour of decision to discharge, ensuring enough space for increased numbers of discharges.

- Maintain timely and high quality transfer of information to General Practice and other relevant health and care professional on all patients discharged.

- Senior clinical staff to be available to support ward and discharge staff with appropriate risk-taking and clinical advice arrangements.

- Where applicable to the patient, COVID-19 test results are included in documentation that accompanies the person on discharge. If results are not ready in time for discharge, ensure that they are forwarded in a timely manner to the patient, GP and any care or support Providers.

- Ensure all patients identified as being in the last days or weeks of their life are rapidly transferred to the care of community palliative care teams who will be responsible for co-ordinating and facilitating rapid discharge to home (which may be a care home) or a hospice. Community palliative care teams should have arrangements in place to provide advice, training and support to family / carers and care & support Providers.

- Follow the guidance on Continuing NHS Healthcare in line with the detail set out in Annex F.

- Free up staff resource from Continuing NHS Healthcare assessment processes to support the discharge to assess activities.

3.4 **Community Health Services**

Where not already in place, community healthcare teams are expected to update their processes and ways of working to deliver the discharge to assess model. Community health services will take overall responsibility for ensuring the effective delivery of the Discharge to Recover then Assess Pathways.

As part of this they should:

- Identify an Executive Lead to oversee the implementation and delivery of the discharge to assess model in the acute hospitals in their area. The model should operate at least 8am-8pm 7 days a week.

- Release staff from their current roles to co-ordinate and manage the discharge arrangements for all patients on Discharge to Recover then Assess Pathways. This will include patients being discharged from acute and community hospitals, and other bedded step-down facilities (in care homes or emergency surge capacity).

- Have an easily accessible single point of contact which will always accept assessments from staff in the hospital and source the care requested, in conjunction with local authorities.

- Provide a named point of contact to receive and respond to care provider queries.

- Deliver enhanced occupational therapy and physiotherapy 7 days a week to reduce the length of time a patient needs to remain in a step-down bed, subject to clinical prioritisation during the COVID-19 emergency period.

- Use multi-disciplinary teams on the day they are home from hospital, to assess and arrange packages of support for patients on Pathways 1 and 2.

- Ensure provision of equipment to support discharge.

- Ensure patients on Discharge to Recover then Assess Pathways 1 to 4 are tracked and followed up to assess for long term needs at the end of the period of recovery.

- Maintain the flow of patients from community beds including reablement and rehabilitation packages in home settings, to allow the next sets of patients to be discharged from acute care.

3.5 For patients identified as being in the last days or weeks of their life, community teams will work with specialist Palliative Care teams to co-ordinate and facilitate rapid discharge to home or hospice. This supersedes the current fast track end of life process.

4 What are the actions for Councils and Adult Social Care services?

As part of implementing the discharge to assess model, local authorities are expected to:

- Identify an Executive Lead for the leadership and delivery of the Discharge to Assess model.
- Agree a single point of contact arrangement for each health board, to approach when coordinating the discharge of all patients.
- Flexibly deploy social work, social care and occupational therapy staff across hospital and community settings to support patients on the Discharge to Recover then Assess pathways.
- Safeguarding investigations should continue to take place in a hospital setting, wherever necessary.
- Suspend the need for funding panels for hospital discharge during the COVID-19 incident, with additional funding available to local authorities to cover any increased costs during this period.
- Support real time communication between the hospital and the single point of contact, not just by email.
- Provide capacity to contribute to the review of care provision during the Discharge to Recover then Assess intervention.
- Ensure there is 7-day working for community health and social care teams.

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5. What are the joint actions for Local Health & Social Care Partners?

5.1 **Close partnership working will be key to the delivery of these COVID-19 Hospital Discharge Requirements. Health and Social Care partners must:**

- Work together and pool staffing to ensure the best use of resources and prioritisation in relation to patients being discharged, respecting appropriate local commissioning routes.

- On a daily basis review capacity across the system, pooling information from hospital sites, community teams and the national Care and Support Capacity Tool, to which discharge teams will have access from April 2020.

- In order to minimise the risks associated with multiple contacts for patients, actively seek to implement reciprocal arrangements for delegated tasks between health and social care staff. For example simple nursing tasks that could be appropriately undertaken by domiciliary care staff and vice versa.

- Ensure there are robust tracking mechanisms so that care users do not get lost in the system at a time of very rapid response. Monitor all individuals in step-down bedded facilities and in care homes not of their first choice. The nominated care coordinators will follow up to ensure patients are able to transfer back to their own home, or move to their long-term care home, as soon as possible.

- Coordinate work with local and national voluntary sector organisations to provide services and support to people requiring support around discharge from hospital and subsequent recovery.

- Work together to expand the capacity in domiciliary care, care homes and reablement services in the local area.

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5.2 **Equipment and assistive technology:**

Nominated lead co-ordinators for each local Joint Equipment Store will need to ensure that there is access to sufficient equipment to support discharge of people with reablement or rehabilitation needs at home:

- Local equipment services (across the NHS and local government) have a sufficiency of supply of the more common items of equipment used to support people with reablement or rehabilitation or longer-term care needs.
- Access to such equipment can be quickly (same day where needed) and easily facilitated seven days a week (utilising mutual aid with neighbouring areas or redeployment of community-based staff if required). This may include the purchase of additional equipment and the recycling, cleaning and reuse of equipment.
- Providers are prepared for rapid implication of increased volumes of rehabilitation equipment, including same day delivery requests.
- Use the cross border guidance to reduce unnecessary steps in provision routes and apply 'trusted assessor' status to partners (See Annex G)
- Ensure capacity to assess and make available equipment that can be used to reduce the need for two carers to provide care to individuals, or reduce call frequency releasing workforce capacity.
- A simple approval process should be initiated for more complex patients requiring hospital beds, pressure relieving equipment and hoists. This should be through discussion and verbal approval to order. Current senior clinician approval process and equipment prescription matrices will be stood down.
- Regular review and tracking of issued equipment to reduce over prescription of equipment. The responsibility for review of equipment once a patient is discharged will sit with the receiving care organisation.

- Where available, consider using photographs supplied by family/carers/community staff including District Nurses as an alternative to completing access and risk assessment visits for more complex patients. If a visit is required, this will need to be arranged within 4 hours of decision to discharge.

- Discharge tracking information is used to ensure regular restocking of buffer/satellite stores to maintain supply.

- There is a comprehensive range of assistive technology items that can support people to live safely and independently at home with next day access to support if required. This goes significantly beyond falls pendants.

- Stock includes gas, carbon monoxide, smoke alarms including devices that supports people who are blind and/or deaf, and temperature detectors. Movement detectors, bed/chair occupancy detectors and flood detectors. Work with other agencies, such as the fire service, wherever this is possible locally.

- There are enuresis sensors, epilepsy sensors and medication dispensers covering a 28-day period. Equipment can be made available at low-cost and can be simple to fit without hardwiring.

6. What are the actions for the Voluntary Sector?

Many systems already work with the voluntary sector to facilitate swift and safe discharges. Welsh Government will continue to fund the Emergency Department Wellbeing and Home Safe service delivered by British Red Cross, and the Hospital to Healthier Home service delivered by Care and Repair, to facilitate discharge from Welsh district general hospitals. These services remain available to Health Boards during the pandemic and throughout 2020/21, and both organisations have agreed to be flexible to the needs of Health Boards where appropriate, including through the enhancement of services if desirable/required.

6.1 **The sector should:**

- Mobilise quickly and focus on safety and positive experiences for patients on the discharge pathways, enabling patients to feel supported at home. They can also help reticent patients feel much more comfortable about being discharged.

- Provide a range of practical support to facilitate rapid discharge, including transport home and equipment such as key safes.

- Support discharged patients with home settling services to maintain wellbeing in the community (e.g. safety checks and essential food shopping).

- Provide ongoing community-based support to support emotional wellbeing, such as wellbeing daily phone calls and companionship.

- Engage with NHS providers (particularly discharge teams) to provide solutions to operational discharge challenges, freeing-up clinical staff for other activities – focusing on the patients on pathway 0.

- Utilise embedded local voluntary organisations in discharge pathways and enhance with input from large voluntary organisations.

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- Coordinate support between voluntary organisations and existing volunteers within NHS providers.

- In advance of discharge be at the patient's home to accept equipment.

6.2 NHS volunteers to support hospital discharge

In addition to the support being offered by the voluntary sector as part of the response to COVID-19, hospitals should consider how to deploy their NHS volunteers to volunteering roles that can most reduce pressure on services. Many hospitals utilise volunteers to assist people in getting ready to go home from hospital, ensuring they have everything they need and that everything is in place at their place of residence. They can greatly speed up the discharge process and also reduce the likelihood of readmission by ensuring that the person has the right support and resources in place at home. Volunteers can also provide advice and signposting to community support services and increase patients' confidence about leaving hospital and going home.

The volunteering portal https://volunteering-wales.net/vk/volunteers/index.htm and County Voluntary Councils can also provide alternative opportunities to offer or search for volunteering support.

https://gov.wales/volunteering-during-coronavirus-pandemic

7. What are the actions for Care Providers?

Note: This chapter focuses on the discharge process.

Further advice on the care of patients being discharged to care homes or with domiciliary care support is being developed and will be published on the website detailed in Section 11.

7.1 **Care Home providers:**

- Maintain capacity and identify vacancies that can be used for hospital discharge purposes.

- Registered Managers are requested to use the Care & Support Capacity Tool App provided by DEWIS to make vacancy information available to NHS and social care colleagues in real time. (See Annex F)

- Providers of Care Homes, in partnership with their local Community Health teams, should consider how best to support residents' health needs, in their familiar environment, wherever possible.

- Where Trusted Assessor relationships and arrangements are not already in place, rapidly work with the discharge team to implement these rules and processes (See Section 11 for links to further information).

7.2 Domiciliary care providers:

- Work closely with health and adult social care contract leads to maximise existing capacity, and identify additional capacity if required, to support hospital discharge.

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Patient Transport:

- Non-Emergency Patient Transport Services (NEPTS) are a critical resource in moving non-emergency patients from one care setting to a more appropriate setting on another site. Demand for NEPTS will increase through this period, and services will need to be more responsive. In Wales all non-emergency transport is co-ordinated through the Welsh Ambulance Service.

- Welsh Ambulance Services NHS Trust NEPTS, independent and voluntary sector providers, will be expected to provide support to enable the transfer of patients as part of the discharge process and to support transfers and discharge as a priority in order to maintain flow and maximise patient safety.

- Additional guidance on how NEPTS will be enabled to deliver through this incident.

- Organisations should consider mechanisms to inform WAST as escalation and additional capacity is utilised. This may involve alternative transport options and could include:
    - Local Authority owned or contracted vehicles
    - Volunteer cars
    - Voluntary sector resources
    - Taxi services

8. Monitoring and increasing rehabilitation capacity

8.1 After the first phase of discharging existing patients who do not meet the criteria for being in an acute hospital, it will be essential to maintain this approach in any rehabilitation and step down facilities and broader care-at-home services. This will avoid creating blockages in the community facilities/services and stop the next sets of patients being discharged from acute care.

8.2 **Pathways 1, 2 and 3: Step-down bedded facilities**

- All patients on these Pathways should have a clear recovery plan, with access to the therapeutic/reablement support required to deliver it.
- It is essential that they are tracked and assessed after this period of recovery. Longer-term care packages or placement must be made available at the right time to ensure that the pathways are not blocked for future patients needing discharge from hospital.

8.3 **Community Hospitals**

It is vital that discharges from community hospitals are increased and delays eradicated with the same approach and action taken in acute settings. This includes a daily review using similar prompts:

Figure 5: Prompts for board rounds in community hospital wards

- **Has this person recovered to the point that their care now be provided in another setting? *Think 'Home First'***
- **What is value added for this person remaining on a community hospital ward, balanced against the risks?**
- **Why not home? Why not today?**
- **If not today, when? (Expected date of discharge)**
- **What needs to happen next? (Actions for today)**

8.4 Short-term placement for people who require 24-hour supervision and care

- For people who need a 24-hour care setting, it is essential they are assigned a care co-ordinator (social worker, allied healthcare professional, discharge team nurse or CHC nurse) who will review their care and support needs regularly using the same questions as for community hospitals.

- Discharge should be arranged as soon as possible to their own home and packages of support made available.

8.5 Short term rehabilitation/reablement-at-home review

- Community Teams must review the needs of all people on their caseloads daily.

- The team will identify all people who have been on caseloads for an extended period and the reasons why.

- These cases are discussed using the following questions:
  - What is our current aim of support?
  - Have we met this? If not, what is going to change to enable us to meet this aim?
  - Are we best placed to support this need? Is there an alternative e.g. third sector support or remote self-managed rehabilitation programme?
  - Can we safely discharge this person?
  - Actions from the discussion are recorded and actions followed up daily.

9. Finance support

The Welsh Government has commissioned a rapid analysis of the resources required to enable health and social care communities to fund the cost of new or extended out-of-hospital health and social care support packages referenced in this guidance.

Further detail will be shared with Health Boards and Local Authorities imminently and this should not create a delay in implementing the guidance in the meantime.

10. Reporting

10.1 Current performance standards on DTOC monthly reported delays will be suspended from 1st April 2020.

10.2 Usual reporting procedures for Delayed Transfers of Care will be suspended during this period. Instead, in addition to the daily situation report outlined below, brief updates will be submitted to Welsh Government on a weekly basis, so that barriers to implementation can be understood and addressed. This data will not be used for performance management purposes.

The template and submission guidance will be circulated separately.

10.3 Health Boards will be required to report the following during the COVID-19 incident:

- Bed occupancy in hospitals
- Number of patients on daily discharge list
- Number and percentage of patients successfully discharged from discharge list
- Bed availability in community settings

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11. Additional resources and support

11.1 It is acknowledged that practical implementation of this guidance will raise further questions and generate significant learning. In order to support implementation, Welsh Government and partner agencies will work together to provide regular updates and opportunity for dialogue, including Webinars, national calls and additional guidance where required.

Details will be circulated to the interested parties as the arrangements are made and in response to the issues arising.

11.2 The outputs from the calls will be widely disseminated and will include a Frequently Asked Questions repository.

Supporting guidance

All guidance issued on Covid-19 issued by Welsh Government to health and social care professionals is available at: https://gov.wales/health-professionals-coronavirus

https://www.adss.cymru/en/blog/post/covid19-commissioners

https://www.adss.cymru/en/category/coronavirus-covid-19

https://improvement.nhs.uk/documents/849/ECIP_RIG_Trusted_assessors_March2017.pdf
https://www.adass.org.uk/media/6030/developing-trusted-assessment-schemes_essential-elements-280717.pdf

Annex A:

The Discharge to Recover then Assess Model (Wales)

D2RA Pathway 1: Front Door Turnaround	D2RA Pathway 2: Home First!	D2RA Pathway 3: IC bed	D2RA Pathway 4: Existing Care Home
Is this person fit to admit?	Why not home? Why not today?	Are we providing the right conditions to maximise recovery & independence	Providing the least disruptive path & maximising recovery
Comprehensive assessment at the hospital front door Assess, treat and support at home	In-patient treatment is complete Default pathway for anyone who may need new or increased support at home, or a care home placement	Should only be considered if Pathways 1 & 2 are not appropriate for this individual i.e. they have high dependency and overnight needs that can't be met with short-term night sitting.	Same as Pathway 2 , with special considerations for delivering support within an individual's existing care home placement Assessment for new placement must follow Pathway 2 or 3

Process for implementing the Discharge to Recover then Assess Model

Stage 1: Decision to discharge

- Clinically-led review of all patients at an early morning board round. Any patient meeting the revised clinical criteria will be deemed suitable for discharge.
- At least twice daily review of all patients in acute beds (daily in community hospital and other 'step down' beds) to agree who is not required to be in hospital, and will therefore be discharged
- Senior clinical staff should be available to support staff with positive risk taking and clinical advice.
- All patients who are not required to be in hospital and are therefore suitable for discharge will be added to the discharge list and allocated to a discharge pathway
- Discharge to the patient's own home (Pathways 1, 2 and 4) should be the default
- The discharge list will be managed by the health board, in collaboration with social care partners.

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Stage 2: Making the discharge arrangements

- On decision of discharge, the patient and their family or carer, and any formal supported housing workers, should be informed and receive the relevant leaflet (Annex C)

- Health, social care and housing staff need to work collaboratively to ensure that patients are discharged on time.

- Hospital discharge teams will lead on arranging discharges for those requiring support from third sector discharge schemes.

- The local community teams will lead on co-ordinating arrangements for patients discharged on any of the Discharge to Recover then Assess Pathways, including the allocation of the care co-ordinator as the key point of contact for patients and their families/carers.

- The care co-ordiantor will be responsible for:

    - Keeping individuals and their families fully informed of the next steps
    - Arranging patient transport home, where needed
    - Ensuring settling-in support is provided where needed.

- All patients must be transferred to an allocated discharge area/lounge within one hour of decision to discharge.

- Where applicable to the patient, COVID-19 test results are included in documentation that accompanies the person on discharge. Where results are not yet available a nominated professional e.g. discharge co-ordinator, must be clearly tasked with forwarding as soon as possible.

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Stage 3: Post-hospital Recovery and Assessment

- Co-ordinated home assessments between health and social care, including equipment and reablement support, will take place ideally on the day of discharge, using a trusted assessor approach.

- The care co-ordinator will make the arrangements to ensure that the services and equipment are in place to meet the individual's immediate care needs and to review and assess for ongoing care if required.

- The local community service hub/single point of access will act as the point of interagency collaboration to ensure that the staff and infrastructure are in place to support such arrangements. To minimise the risks associated with multiple contacts for patients, this should include consideration reciprocal arrangements for delegated tasks between health and social care staff.

- The hub will draw on all available local resources, including voluntary, community and social care staff no longer undertaking assessment in acute hospitals.

Important considerations for all pathways:

- Duties under the Mental Capacity Act 2005 still apply during this period. If a person is suspected to lack the relevant mental capacity to make the decisions about their ongoing care and treatment, a capacity assessment should be carried out before decision about their discharge is made. Where the person is assessed to lack the relevant mental capacity and a decision needs to be made then there must be a best interest decision made for their ongoing care in line with the usual processes.

- If the proposed arrangements amount to a deprivation of liberty, Deprivation of Liberty Safeguards in care homes arrangements and orders from the Court of Protection for community arrangements still apply but should not delay discharge

Further guidance is currently under development and update information will be provided.

Key contacts for accessing support include:

- **The C.A.L.L. Helpline**
  A dedicated mental health helpline for Wales, it can provide you with confidential listening and emotional support, and help you contact support that may be available in your local area. Call 0800 132 737 or text 'help' to 81066.

- **Mind Cymru Infoline**
  For information on types of mental health problems, where to get help, medication, alternative treatments and advocacy. Call 0300 123 3393, email info@mind.org.uk or text 86463.

- **Samaritans Cymru**
  Offering a safe place for you to talk any time you like, in your own way – about whatever's getting to you. Call for free on 116 123 or email jo@samaritans.org

- **MEIC**
  Support for children and young people up to 25 years old open 8am to midnight, 7 days a week. You can contact them for free by phone 080880 23456, text and instant messaging on their website

- For patients identified as being in the last days or weeks of their life, community teams will work with specialist Palliative Care teams to co-ordinate and facilitate rapid discharge to home or hospice.

Annex B: Maintaining good decision making in acute settings

Every patient on every general ward should be reviewed on a twice daily board round to determine the following. If the answer to each question is ‘no’, active consideration for discharge to a less acute setting must be made.

- Requiring ITU or HDU care
- Requiring oxygen therapy/ NIV
- Requiring intravenous fluids
- NEWS2 > 3 (clinical judgement required in patients with AF &/or chronic respiratory disease)
- Diminished level of consciousness where recovery realistic
- Acute functional impairment in excess of home/community care provision
- Last hours of life
- Requiring intravenous medication > b.d. (including analgesia)
- Undergone lower limb surgery within 48hrs
- Undergone thorax-abdominal/pelvic surgery with 72 hrs
- Within 24hrs of an invasive procedure (with attendant risk of acute life threatening deterioration)

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Clinical exceptions will occur but must be warranted and justified. Recording the rationale will assist meaningful, time efficient review.

Review/challenge questions for the clinical team:

- Is the patient medically optimised? – (Don't use 'medically fit' or 'back to baseline').
- What management can be continued as ambulatory - e.g. heart failure treatment?
- What management can be continued outside the hospital with community / district nurses? E.g. IV antibiotics?
- Patients with low NEWS (0-4) scores – can they be discharged with suitable follow up?
    - If not scoring 3 on any one parameter e.g. – pulse rate greater than 130
    - If their oxygen needs can be met in a step-down facility
    - Stable and not needing frequent observations every 4 hours or less
    - Not needing any medical / nursing care after 8pm
        - Patients waiting for results – can they come back, or can they be phoned through?
        - Repeat bloods – can they done after discharge in an alternative setting?
        - Patients waiting for investigations – can they go home and come back as out patients with the same waiting as inpatients?

Criteria- led discharge:

- Can a nurse or allied health care professional discharge without a further review if criteria are well written out?
- Can a junior doctor discharge without a further review if criteria are clearly documented?
- How can we contact the consultant directly if criteria are only slightly out of range and require clarification?

Annex C: Patient discharge choice leaflets

It is recognised that issues of patient choice and engagement can often be significant barriers to hospital discharge where there are ongoing social care needs after discharge (particularly if moving to a residential or nursing home). During the COVID-19 response there will be suspension of choice protocols for this particular issue. The following leaflets have been produced to support the communication of this message.

- Leaflet A – to be shared and explained to all patients on admission to hospital
- Leaflet B – to be shared and explained to all patients prior to discharge, this is split into leaflets:
    - Leaflet B1 for patients who are being discharged to their usual place of residence
    - Leaflet B2 for patients moving on to further non-acute bedded care

Patient discharge choice Leaflet A – on admission to hospital

Hospital discharge information

It is important that our hospitals are ready to look after people who contract coronavirus (COVID-19) and need hospital care. Due to these pressures, once you no longer need care in hospital, as decided by the health team looking after you, you will be discharged. You will not have a choice over your discharge, but it is always our priority to discharge people to a safe and appropriate place.

In most cases this will be to your home. You might need some extra support, for example with your care needs or shopping.

If you require more complex out of hospital care, this could be in another bed in the community, for example a residential nursing home.

Your needs and discharge arrangements will be discussed with you.

What is Coronavirus?

COVID-19 is a new illness that can affect the lungs and airways. It is caused by a virus called coronavirus.

There is currently no specific treatment and some people who contract the illness will need to be admitted to hospital.

You can find out more about coronavirus and the best ways to stop it spreading by visiting www.nhs.co.uk/coronavirus

Patient discharge choice Leaflet B1 – for patients who are being discharged to their usual place of residence

Your hospital discharge: going home

This leaflet explains why you are being discharged from hospital an what you might expect after your discharge.

Why am I being discharged from hospital?

You are being discharged from hospital as your health team have agreed that you are now able to return home.

Why can't I stay in hospital?

The health system is busy helping patients affected by coronavirus (COVID-19). This is a new illness that can affect the lungs and airways and some people who contract the illness will need to be admitted to hospital. It is important that our hospitals are ready to look after those people who need this hospital care.

Because of this, you will not have a choice over your discharge. You will not be able to remain in hospital if you choose not to accept the care that is being offered to you.

What can I expect?

It is our priority to ensure that you are discharged safely from hospital and to the most appropriate available place.

Your health team will discuss discharge and transport arrangements with you (and a family member, friend or carer if you wish). If you require care and support when you get home, this will be arranged.

Any care provided will be free of charge for a period of time to support your recovery. After this time you may be required to contribute to the cost of your care.

Who can I contact?

After you have been discharged, if you have any concerns or need to speak to someone about your care you can contact <insert locally agreed details e.g. team name & contact number)

To find out more about coronavirus (COVID-19) and find out how to avoid catching or spreading it, visit www.nhs.uk/coronavirus

Patient discharge choice Leaflet B2 – for patients moving on to further non-acute bedded care

Your hospital discharge: another place of care

This leaflet explains why you are being discharged from hospital an what you might expect after your discharge.

Why am I being discharged from hospital?

You are being discharged from hospital as your health team have agreed that you are now able to continue your recovery in another care setting.

Why can't I stay in hospital?

The health system is busy helping patients affected by coronavirus (COVID-19). This is a new illness that can affect the lungs and airways and some people who contract the illness will need to be admitted to hospital. It is important that our hospitals are ready to look after those people who need this hospital care.

Because of this, you will not have a choice over your discharge. You will not be able to remain in hospital if you choose not to accept the care that is being offered to you.

It is our priority to ensure that you are discharged safely from hospital and to the most appropriate available place.

What can I expect?

Your discharge and transport arrangements will be discussed with you (and a family member, friend or carer if you wish) and you will be discharged with the care and support you need, to a bed in the community.

The care provided will be free of charge for a period of time to support your recovery. After this time you may be required to contribute to the cost of your care.

It is possible that you may be moved more than once after your discharge. This is because we will be trying to find the best place for your long-term care. Your health team are here to answer any questions you might have.

Who can I contact?

After you have been discharged, if you have any concerns or need to speak to someone about your care you can contact (insert locally agreed details e.g. team name & contact number)

To find out more about coronavirus (COVID-19) and find out how to avoid catching or spreading it, visit www.nhs.uk/coronavirus

Annex D: Homelessness

- The requirements of the homeless and people living on the streets, also need to be reflected in any local framework to support the Government's COVID-19 emergency.
- Practices that have been developed in systems to support homeless persons need to be maintained and enhanced to reflect the need to support the needs of those who are without a home and living on the street. It is already known that this group has a high level of mortality, and support needs including mental ill-health and substance misuse which may present a barrier to self-isolation.
- Health Boards have a statutory duty to refer people who are homeless or at risk of homelessness to a local housing authority. This statutory duty remains.

Welsh Government has issued separate 'Guidance for local authorities: support rough sleepers – COVID-19 outbreak'. https://gov.wales/coronavirus-covid-19-local-authority-support-for-rough-sleepers

Annex E: Care & Support Capacity Tool

As part of current discharge planning there is an imperative to understand bed occupancy and vacancies in the community.

The Care and Support Capacity Tool has been developed by Data Cymru, in partnership with Welsh Government and Care Inspectorate Wales.

- This is web-based tool providing the opportunity to easily track bed capacity and vacancies to support system wide bed and discharge planning. The Tool will go live on 26th March 2020.

- The Tool covers all care homes for adults in Wales, including care homes for people with residential, nursing, mental health and learning disability needs. There is an intent to extend the Tool's function to include domiciliary care provision in future, but this is not currently available.

- This is not intended to replace current information systems already being used in some localities to track bed / room vacancies, <u>but to run in parallel</u>

- Providers are requested to use the Dewis website to provide updated information (in as close to real time as possible) on:

  - Number of bed vacancies
  - Current status i.e. Open / Closed to Admissions

- In the first instance, nominated discharge leads for each health board area will be given access to the Care and Support Capacity Tool Dashboard.

For further information about the Tool please email CareandSupportCapacityTool@gov.wales

Annex F: Continuing NHS Healthcare and COVID-19 Planning

Continuing NHS Healthcare (CHC) as referred to throughout this document relates to individuals aged 18 or over.

CHC assessments for individuals on the Discharge to Recover then Assess pathways and in community settings, will not be required until the end of the COVID-19 emergency period.

The Continuing NHS Healthcare, the National Framework for Implementation in Wales 2020 (Proposed) Framework was due to be published April 2020 but, in response to the current situation, the timetable for publication is being revised.

However, Section 4 of the proposed Framework, which sets out the assessments for eligibility for CHC during Pandemic and Other Emergency Situations will be implemented with immediate effect, as detailed below:

Pandemic and Other Emergency Situations

- There is an appreciation that completing a full CHC assessment in hospital during a declared emergency, such as pandemic influenza, would be problematic. As CHC is an assessment of long-term needs, decisions on CHC eligibility should not take priority in these situations. The priority instead should be the safety of the patient, and ensuring they receive the care they need.
- In these situations, Local Health Boards (LHBs) should be able to choose not to undertake a CHC assessment until after the emergency period. The intention of this is not to withdraw a duty of care over the patient. In most cases, the LHB will retain responsibility for organising, funding and providing care for them. This may happen in various ways and does not mean a continued presence in hospital; it may mean discharge to a care or nursing home with appropriate support or discharge to their own home with appropriate support. In some cases this will mean a situation not too dissimilar to finding someone eligible for CHC and arranging a care package for them.

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- There is nothing which would prevent LA and NHS teams from working together to discharge to home, as necessary. During the pandemic response, or in guidance beforehand, local teams should be required to utilise their 'discharge to assess arrangements' to ease pressure on hospital beds if possible. This will be particularly relevant if a person does not wish to have their care provided by the NHS because they wish to retain direct payments. In such cases, the health board and local authority should work co-productively with the person to ensure they continue to have voice and control over their care. The health board and local authority should consider alternative arrangements such as joint packages of care or pooled funds to meet the person's needs in the most appropriate way. However, this should not delay discharge from hospital.
-
- Individuals can still make requests for a review of an eligibility decision (i.e. Local Resolution and Independent Review) however the time frame for a response will be relaxed.

- There is an expectation that LHBs will take a proportionate view to undertaking three- and twelve-month reviews to ensure that the individual's care package is meeting their needs and to ensure that any concerns raised are addressed as appropriate.

- During the COVID-19 emergency period, LHBs will not be held to account on the CHC Assurance Standards nor timeframes for dealing with CHC individual requests for reviews of eligibility decisions.

- These measures set out for NHS CHC are only in place for the duration of the COVID-19 emergency period.

- Local systems need to ensure that they have a method of monitoring actions taken during the COVID-19 emergency measures, for example using the NHS CHC Checklist, so that individuals are assessed correctly once business as usual resumes.

Implications for Adopting the COVID-19 Emergency Measures for Continuing NHS Healthcare

- If CHC full assessments of eligibility are deferred, a backlog will be created which will have future workload implications for NHS and Local Authority staff. The same will apply to individual requests for a review of an eligibility decisions (i.e. Local Resolution and Independent Review).

- A handling plan will need to be developed to enable the system to 'normalise' following the COVID-19 emergency period. For example, completing the CHC checklist prior to transfer, for patients who appear likely to need full assessment for eligibility.

- There may be a financial impact upon Health Boards funding under discharge to assess arrangements as part of the hospital discharge pathway for longer periods than usual. The rapid analysis referenced in Section 9 will include this consideration.

- Where social care has been provided free at the point of delivery for the emergency period, the expectations of individuals in receipt of funded care packages that may not continue to be funded after the COVID-19 emergency period, this will need to be managed, as some individuals will need to return to usual funding arrangements, which will mean they may have to contribute or fully fund their care.

- Although NHS CHC is effectively a 'funding stream', the clinicians involved in NHS CHC assessment and review are required to assess the specific needs of highly vulnerable individuals and to commission the relevant care. Therefore, it is still important to ensure that care packages are commissioned that meet the needs of these individuals.

Annex G: Community Equipment Cross Border Guidelines

Community Equipment Services:
Cross Border Guidelines (Wales)

This Guideline is owned and endorsed by the All Wales Occupational Therapy Advisory Forum (OTAF)

Guideline endorsed by OTAF: 15/11/18

Review date: 15/11/20

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Introduction

The purpose of this guideline is to clarify and ensure transparent processes for the equity of access to community equipment for all citizens, those assessing needs and recommending equipment and the Community Equipment provider. It describes which community equipment partnership and service should provide and thereby fund equipment for individuals. The funding arrangements within the partnership are a matter for the partnership.

The guidance attempts to help all parties by avoiding time wasting trying to establish who should provide equipment.

The guidance should be used as the basis of negotiation with between individual Health Boards and those Local authorities outside of it's' borders that the health board identifies as frequently needing to repatriate patients to. Or in the case of looked after children or adults with additional learning needs reside outside of its borders or where there is joint residency across borders.

The guidance applies to equipment provided by the local community equipment service partnerships. Where they provide equipment for continuing care the protocol applies. N.B. Continuing care equipment may lie outside the pooled budget but funded by the Local health Board and managed by the community equipment service. It may be included within the pooled budget and managed by the community equipment service.

Where continuing care equipment and/or paediatric equipment lie outside the pooled budget and the community equipment service the LHB has to make its own arrangements for the supply and maintenance of community equipment. It is strongly recommended that continuing care equipment and paediatric equipment is brought within the remit of the community equipment service to ensure its professional management. Estimates can be used to include funding for this equipment within the pooled budget.

The guidance does not cover wheelchairs or any other equipment provided via WHSSC.

Key Principles

1. The safety and well-being of individuals is paramount.
2. Community equipment should promote the independence of the individual.
3. Community equipment services should be person centred in that they offer a flexible response to need, based on each local authorities priorities and performance targets.
4. Users have expertise about the challenges they face on a daily basis and must be involved in the assessment and choice of equipment.
5. Equipment provision is underpinned by timely and clear clinical decision making

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Intended Outcomes

- To clarify an assessment process and responsibility for equipment provision
- To avoid delayed hospital discharges – and promote patient flow
- To prevent hospital admissions
- To enable staff to identify the correct equipment store to order equipment from.
- To avoid confusion to individuals and relatives
- To take into account of equipment costs on service provision

Operational arrangements to support principles.

1. Community Equipment Services will operate on Local Authority geographical boundaries and not registration of individuals with GPs. It should be relatively simple to establish the individual's county of residence and the county to whom he/she pays council tax. The community equipment partnership will fund equipment for residents living within the Local Authority or local authorities contained within the partnership.

2. Where the individual is being discharged to the home of a relative outside of his / her normal Local Authority of residence the local community service of the relatives' authority should provide the essential equipment required. This makes sense in the short term and if the arrangement turns out to be long term it becomes the user's ordinary residence. If the individual transfers to a different authority then the expectation is that the individual will contact the current and future Local Authority to ensure equipment suitability.

3. Ordering of equipment by a therapist who is not employed by the residing authority for adults or children will be undertaken by Trusted Prescribers who are staff employed by the discharging Health or Local Authority. It is the responsibility of each Health Board and Local Authority to nominate these posts and ensure they are updated as the post-holders change.

   What is a Trusted Prescriber?

   A Trusted Prescribers will be a registered member of staff employed by the discharging Health or Local Authority, who has the clinical knowledge and skills to undertake assessments and or sanction the equipment required. They will be fully aware of their accountability ensuring that equipment ordered is in accordance with the locality areas eligibility criteria for equipment – please refer to appendix 1 and 2 (to be completed locally). Therefore, trusted prescribers will be in situ where there is no joint equipment store agreement with the discharging organisation and receiving organisation/ locality.

   There is a requirement for the post holder to be updated by the equipment store they are a Trusted Prescriber for; to be updated of any changes in equipment or training needs (mechanisms to undertake this will need to be agreed locally when negotiating the agreement of a Trusted Prescriber).

4. For children and young people with special needs in special schools or children's homes or in foster care the funding of Community Equipment will be the responsibility of the local community equipment partnership encompassing the Local Authority funding the placement. This will avoid any authority being unfairly penalised due to the location of special facilities within its borders. The delivering authority will recharge the authority funding the placement.

5. Where equipment is required at two locations within the same Local Authority and community equipment partnership area for child with special needs; it is recommended that where a child is residing with both carers/parents equipment will be provide at both properties if the equipment is not transportable or transferable into different environments.

6. Where carers/parents have joint residency and share carer responsibility but where one of the carers has moved to a Local Authority outside the community equipment partnership area, the Local Authority of residence for this parent will be required to fund the equipment. It would be impractical for a Local Authority in South West Wales to assess, supply and maintain equipment in the home of the parent who has moved to North Wales. In these cases the carers

are both entitled to receive a service from their Local Authority and local health board. Please see appendix 3 for protocol on looked after children placed out of area.

7. For children and young people who are looked after, the authority who provide the looked after status is responsible to provide for all residences. The assessment for the equipment can be difficult where distances are involved, therefore the Trusted Prescribers for that area should assess and provide recommendations for the equipment required to the authority responsible for the looked after status. The ordering of the equipment should be made where the child is living for ease of delivery and cross charge and maintenance will need to be agreed and set up back to the looked after authority. It is essential that equipment needs are identified prior to the start of the placement to ensure smooth transitions. The Social Worker will be key in this liaison and collaboration. Repatriated equipment can either be purchased at reduced cost by the local equipment store or the originating authority can make individual local arrangements to have this transported to their own stores.

8. For children and young people from travelling families due to their limited time they can be in one area, assessment and delivery of equipment at each location takes too long. Therefore equipment should be provided from the authority they are residing to meet need and then this equipment should be provided to the family to take with them. The therapist in the area moved to should check the equipment for growth. When the child outgrows the equipment or needs change the authority they reside in at the time should re-assess and provide. Due to the mobile nature of this population, the duty of care and adequate information should be passed onto the parent/ carer regarding maintenance of equipment and contact numbers if required. It is not the intent of this guidance to identify how each authority will account for this "loss" on their stock.

9. Where the person moves from one Local Authority area to another every effort should be made to enable them to take any transferable equipment (i.e. not fixed) with them to avoid delays (this assumes the equipment is suitable for use in the new environment). The community equipment service in the new Local Authority should purchase the equipment at an appropriate rate of discount.

   It is not the intent of this guideline to address costs of equipment with regards to what discount should be applied to specific equipment; this should be negotiated locally via discussion between the store managers. The new Local Authority will assess the needs for any additional equipment or adaptations to support the individual in their new home.

   There is an expectation that individuals or their carers will inform the Local Authority of any relocation, contact details are to be provide on issuing of equipment.

10. Any individual within a given Local Authority in Wales will be eligible for equipment from the same Local Authority Community Equipment Service provider. For example any individual residing in Ceredigion and being discharged from a hospital in Carmarthen would have the equipment provided by the Ceredigion Community Equipment Service regardless if it is a social care or health care need. All deliveries will be in accordance with the local Authorities priorities and performance indicators.

11. Responsibility for the safe transfer of care from hospital remains with the NHS hospital. Hospital staff have the responsibility to communicate with primary and community NHS services and the local Social Services department with regard to the transfer of care of individual individuals. Hospital staff must do everything possible to engage the appropriate therapist or nurse in process of safe discharge at the earliest opportunity. This will help the local community equipment service to respond more quickly to facilitate discharge. The local community equipment service will ensure the safe fitting of equipment. In complex cases, for example, the hospital therapy staff and ward staff will be expected to liaise with the local receiving Occupational Therapist (OT). Complex cases may require a joint visit where possible to the home or hospital by both the discharging OT and local receiving OT. It is not the intent of this guidance to negotiate an all Wales key performance indicator for each authority and this remains a local target for each area.

12. Note any discharge protocols or new service developments must be discussed with the local Community Equipment Service provider in areas where the hospital regularly discharges individuals to. Any change in service delivery (e.g. the establishment of additional intermediate care services) must address the implications in terms of any changed demands on Community Equipment Services. This should ensure that service planning includes community equipment services in all service change, not simply when there may be additional demand, but recognises when there may be a reduced or very different demand.

13. Where the equipment provider has concerns about the appropriateness of the equipment (e.g. did not fit home environment) they will refer back to source of referral. The source of the referral should be provided with feedback if the equipment is not appropriate because may inform practice and raise training issues regarding prescription of equipment by different staff groupings.

14. For hospital discharge, where time scales allow the Trusted Prescriber will order the equipment via the protocol. However to support patient flow and where time scales are imminent, small pieces of equipment will be provided by the therapist from the satellite stores within the hospital. It is noted that at present there is no robust mechanism in place to recuperate the costs of using satellite stores equipment for out of area patients. It is not the intent of this guidance to address this issue, any associated costs and charging around this would this would need to be addressed local decisions by each equipment stores partnership board.

15. The local Community Equipment Service will monitor all referrals from Trusted Prescribers including individuals making referrals, equipment requested, and cost of equipment and date of delivery and/or installation. This will feature as part of a quarterly report to partnership board. Trusted Prescribers will need to be set up on the equipment stores IT system. The partnership board can then address any concerns with the hospital directly. This may include concerns about the referral, equipment prescribed or the eligibility criteria.

16. The Community Equipment Service will deliver and fit the equipment. The initial prescriber of the equipment should demonstrate the equipment where possible before hospital discharge. The initial prescriber should ensure that individuals know how to use equipment safely. Any concerns should be followed up with the appropriate local clinician. The local clinician or Trusted Prescriber may demonstrate the use of the equipment to the carer or other service providers when required. Service providers (e.g. Home Care Services, residential care services) including social services and the independent sector maintain responsibility to undertake their own risk assessment when using the equipment.

17. Trusted Prescribers will be Occupational Therapists at Band 7 or above (in exceptional circumstances e.g. Velindre this may need to be delegated to another registered but suitably skilled Occupational Therapist) or Local Authority nominated senior staff, working within identified teams who regularly need to request equipment for service user's resident outside of the Health Board or Local Authority area. They will be responsible for placing orders for colleagues within Health Board / Local Authority to ensure adherence to the agreed Trusted Prescriber and Community Equipment Services: Cross Border Protocol.

18. Responsibility for assessing and prescribing equipment lies with the discharging Health Board. It is the Occupational Therapist's responsibility within the discharging Health Board to ensure that the equipment requested from any local equipment service is equivalent to that identified on assessment and meets the individual's needs. (refer to appendix 2)

19. As equipment specification may vary across Joint Equipment Services Trusted Prescribers will need to specify equipment delivery details including height and location for equipment based on measurement not on equipment settings.

20. It is the responsibility of the Trusted Prescriber to ensure that the equipment is in situ prior to discharge using the established processes and delivery arrangements of each area.

21. Training will be provided for Trusted Prescribers by each partnership which reflects the training provided to local users.

22. Orders will be processed via the partnership's electronic ordering systems, e.g. CEquip however where this is not available or possible Trusted Prescribers will revert to using email on a standard request form sent to the Joint

Equipment Store. It is the responsibility of each health board and Local authority to check the security and GDPR guidance of its organisation (appendix 3 locally agreed forms).

23. Trusted Prescribers will be able to order equipment in line with locally agreed equipment for discharge lists and / or set budget limits. (See appendix 2).

24. Where equipment is identified as essential for discharge outside of this list Trusted Prescribers will be required to the seek authorisation from the relevant budget holder (See appendix 2).

25. Where it is applicable Trusted Prescribers will be required to order against criteria specifying long or short term loan.

26. Any concerns should be followed up with the appropriate Trusted Prescriber and / or prescribing clinician. Should the equipment be found to be unsuitable at the time of fitting the Joint Equipment Service will make contact with the Trusted Prescriber.

Governance

27. A record will be held of all those posts designated as Trusted Prescribers. This will be shared with each joint equipment service and budget holders. This list will be reviewed annually by all Occupational Therapy Leads to ensure that staff in these posts are updated on local processes and any equipment changes.

28. This protocol and the access to service user data will be agreed following the GDPR and information governance arrangements for each partnership.

29. All Trusted Prescribers will be expected to have completed mandatory training within their employing organisation in relation to information governance and IT security.

30. Equipment stores will inform Trusted Prescribers of any equipment changes and/or training requirements.

31. Trusted Prescribers will check that the OT has ensured patients and/ or carers are able to install and use the equipment correctly (e.g. raised toilet seat). The discharging OT will also ensure that any required follow up in the use of the equipment or installation of more specialist equipment e.g. hoist is in situ as part of robust discharge arrangements.

Monitoring Arrangements

32. Health Boards and Local Authorities are expected to provide quarterly reports on prescribing patterns of Trusted Prescribers through their established reporting mechanisms. Where patterns of prescribing are unexplained and diverge from local agreements this will be reviewed and discussed with Occupational Therapy Leads.

33. This guidance will be reviewed by Joint Equipment Service partnerships and the Occupational Therapy Leads should referral patterns change in line with major service developments or changes in patient flow.

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Appendix 1 - Cross Border equipment essential for discharge from Local Authorities (required long term over 12 weeks) and Health Boards (for short term use under 12 weeks) in Wales

	Blaenau Gwent	Bridgend	Caerphilly	Cardiff	Carmarth -enshire	Caer- digion	Conwy	Denbigh- shire	Flint- shire	Gwynedd
Raised Toilet seat										
W.C. frame and seat.										
Toilet surrounds/frames –fixed / free standing										
Chemical W.C. (complete) and stand										
Commode - (static/mobile)										
Chair raisers										
Bed raising equipment.										
Bed stick										
Bed levers										
Turn discs										
Standing Turntables										
Handling belts										
Home patient helpers (over bed pull handles)										
Transfer board										
Portable ramps										
Glide Sheets										
Trolley										
Perching stool										
Walking frame Caddy										
Hoist										
Sling										
Polycarbonate Flooring										

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Cross Border equipment essential for **discharge from** Local **Authorities (required** long **term over 12 weeks) and** Health **Boards (for short term use under 12 weeks) in** Wales

Raised Toilet seat	Vale of Glamorgan	Wrexham	Abertawe Bro Morganwg UHB	Aneurin Bevan LHB	Betsi Cadwaladr UHB	Cardiff & Vale UHB	Cwm Taf UHB	Hywel Dda LHB	Powys Teaching HB
Raised Toilet seat									
W.C. frame and seat.									
Toilet surrounds/frames –fixed or free standing									
Chemical W.C. (complete) and stand									
Commode - (static/mobile)									
Chair raisers									
Bed raising equipment.									
Bed stick									
Bed levers									
Turn discs									
Standing Turntables									
Handling belts									
Home patient helpers (over bed pull handles)									
Transfer board									
Portable ramps									
Glide Sheets									
Trolley									
Perching stool									
Walking frame Caddy									
Hoist									
Sling									
Polycarbonate Flooring									

Paediatric Equipment

	Blaenau Gwent	Bridgend	Caerphilly	Cardiff	Carmarth-enshire	Caer-digion	Conwy	Denbigh-shire	Flint-shire	Gwynedd
Specialist Seating										
Children's Bathing										
Children's toileting										
Children's changing tables										
Children's sleep systems										
Children's beds										
Hoist										
Slings										
Glide Sheets										
Polycarbonate Flooring										

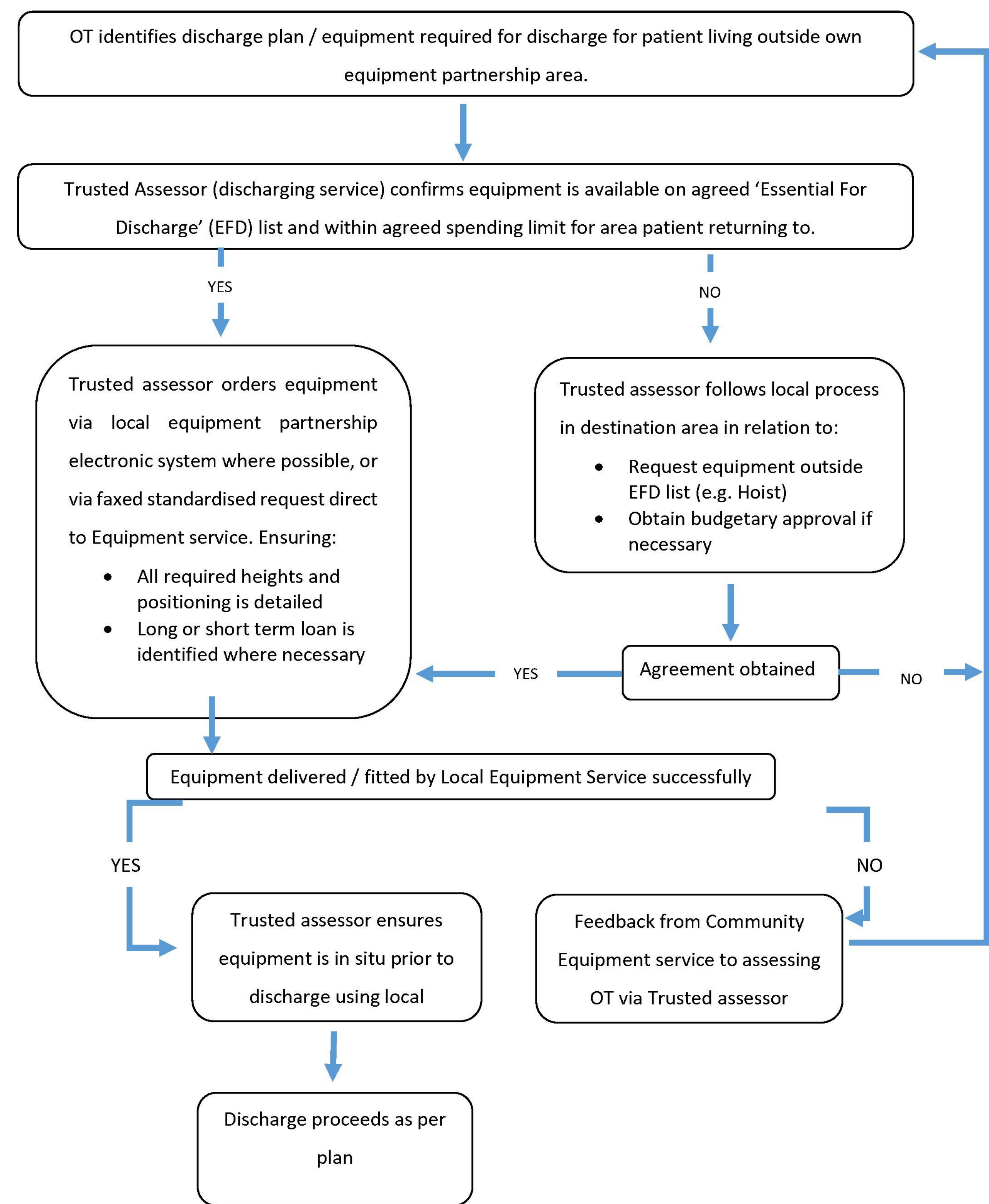
	Isle of Anglesey	Merthyr Tydfil	Monmouth shire	Neath Port Talbot	Newport	Pembrok eshire	Powys	Rhondda Cynon Taf	Swansea	Torfaen
Specialist Seating										
Children's Bathing										
Children's toileting										
Children's changing tables										
Children's sleep systems										
Children's beds										
Hoist										
Slings										
Glide Sheets										
Polycarbonate Flooring										

Paediatric Equipment

	Vale of Glamorgan	Wrexham	Abertawe Bro Morganwg UHB	Aneurin Bevan LHB	Betsi Cadwaladr UHB	Cardiff & Vale UHB	Cwm Taf UHB	Hywel Dda LHB	Powys Teaching HB	
Specialist Seating										
Children's Bathing										
Children's toileting										
Children's changing tables										
Children's sleep systems										
Children's beds										
Hoist										
Slings										
Glide Sheets										
Polycarbonate Flooring										

Appendix 2

Flow chart of action for Trusted Prescriber for hospital discharge



Annex H: Overview of decision making and escalation

Overview of Discharge Decision Making & Escalation to ensure hospital and community beds are freed up

Key Steps	Decision Points & Responsibilities	Route of Escalation
Morning Ward Round	Medical decision to discharge discharge pathway confirmed (Lead: Senior Dr in ward)	Executive Director in Acute
Waiting in discharge area in hospital	Case manager agreed (Lead: Local coordinator in acute)	Executive Director in Acute
	Discharge activities agreed incl. transport and medication (Lead: Single coordinator in acute)	
Patient leaves hospital or community bed	Transport to home / bedded setting (Lead: Single coordinator in acute)	Executive Director in Acute (for acute issues) and Director of Community Services (for community health issues)

Overview of Discharge Decision Making & Escalation to ensure assessment and support is provided

Key Steps	Decision Points & Responsibilities	Route of Escalation	
Assessment at home	Trusted assessor visit for those on pathway 1– acute or community health care professional (Lead: Single coordinator in acute)	Executive Director in Acute (for acute issues), Executive Director of Community Services (for community health issues) and Director of Adult Social Services (for social care issues)	Gold Command EPRR Team
Care provided as needed	At home support provided as needed by health and/or social care (Lead: Single coordinator in acute)	Executive Director of Community Services (for community health issues) and Executive Director of Adult Social Services (for social care issues)	Gold Command EPRR Team
Review post short term support	Ongoing short term support as needed by health and/or social care or discharge from all support (Lead: Single coordinator in acute)	Executive Director of Community Services (for community health issues) and Executive Director of Adult Social Services (for social care issues)	Gold Command EPRR Team