Standard Operating Process (SOP) Guidance Document

COMMUNITY RECOVERY SERVICE, WARWICKSHIRE – PATHWAY 1

What have we done?

As of 24th April 2023, all patients leaving hospital to receive ongoing support in their own home, who may have a new or increased need, or a short-term recovery and rehabilitation need can be supported by the Community Recovery Service (CRS) which is part of the Discharge to Assess Pathway 1 offer in Warwickshire.

CRS is a hospital discharge service that operates an inclusive model of delivery. This means that all those referred to the pathway will be accepted unless it is deemed as not beneficial to their needs. Assessments will take place **at home not in hospital** in line with D2A ethos and National Discharge Policy.

This pathway replaces the previous pathways.

1. Home-Based Therapy/Restricted Mobility.
2. Stroke Early Supported Discharge.
3. Patients being supported to return home with a new or increased needs at discharge.

Patients entering the service are provided with the opportunity to access Therapy (if it is required) and will have up to 6 weeks free care.

The aim of the service is that it will commence within **24 hours** of the patient being referred to a Domiciliary Care Service to support their discharge. The Domiciliary Care Service will assess within the person's own home within **2 hours** of return to their home.

The Community Recovery Service is a pilot and therefore the criteria and process are subject to review and change during the pilot.

Criteria for the Community Recovery Service

Inclusion Criteria

- ✓ The patient must be over the age of 18 years, a resident in Warwickshire with a Warwickshire GP.
- ✓ The patient must consent to receive the service.
- ✓ The patient can be supported with either 4 single care calls or 4 double up calls a day. Needs over 28 hours of care can be supported if the referrer is confident that the patients' needs will reduce whilst on the pathway.
- ✓ All patients are assumed to have mental capacity to make decisions about their treatment within and following discharge from hospital. If there are doubts about the patient's mental capacity, a mental capacity assessment (MCA) must be completed.
- ✓ The patient must no longer meet criteria to reside in hospital.

- ✓ The patient is being discharged from an Acute or Community Hospital.
- ✓ The patient must have transport, essential equipment, medication, and any other medical requirement in place prior to discharge e.g., district nursing in place to enable their discharge to take place in a safe and timely way.
- ✓ The patient must need/want a care at home supported discharge to assist them to optimise their recovery and independence.
- ✓ The patient will not require overnight support with risks being managed between care calls.
- ✓ The patient will live at home, which should include an Extra Care Housing facility.
- ✓ If a patient referred for CRS already has a private package of home care and wishes to remain with their care provider, they can still be considered for CRS. However, CRS can only be delivered by the agreed CRS Domiciliary Care Providers and/or Therapy Services.

Exclusion Criteria

- ✓ Patients being discharged with the same level of care to their preadmission position who will need to follow the re-start process.
- ✓ Patients requiring a Supported Living package of support.
- ✓ Patients requiring care following a stay in a D2A short stay or Moving on Bed (MOB) are out of scope.

Domiciliary Care Provision

The Domiciliary Care Provision is provided by commissioned CRS domiciliary care providers and the sourcing of care provision will be through the Council's Domiciliary Care Referral Team (DCRT). This process is activated by the Discharge Information Form (DIF)

The CRS Domiciliary care provider is responsible for delivering care and support to the patient. The patient may have an allocated Health or Social Care Practitioner providing case management.

Referrals can be received **7 days per week, 365 days a year from 8am – 5pm.**

The Domiciliary care provider will undertake an assessment at the patient's home within 2 hours of their returning home.

Patients will need to be **home by 5pm** so that the assessment can take place no later than **7pm**.

These assessments can take place between **8am and finishing at 7pm**.

Care times are not prescribed, and the CRS provider agrees with the therapists and the patient, the call times and call duration. The CRS provider will ensure that any specific call times such as those to support time critical medication are established at the point of assessment with the individual. This information should also be highlighted on the referral form.

Referral Process

Referrals for the service can be submitted by any Discharge Team or Acute Therapist.

Referrals will be undertaken on a trusted basis.

The referrer

Prior to referral - Provide patients with the Warwickshire Community Recovery Service (CRS) leaflet and obtain consent for admission to the service, referral and sharing of information.

[If the patient **does not consent,** refer to the Hospital Social Care Team (HSCT) who will explain to the patient that they will have to exit on to a chargeable / long term pathway. There is no guarantee that the patient will be able to return to their previous care provider.]

- ✓ Determine if the referral is appropriate for CRS.
- ✓ Complete the DIF indicating Community Recovery Service and complete all the mandatory questions on the form.
- ✓ Only confirm if the patient requires either 4 single calls (14 hours) or 4 double calls a day (28 hours).
- ✓ Referrer identifies equipment required through the Integrated Community Equipment Service to enable patient to be discharged with package of care (POC), as part of the early discharge planning process.
- ✓ Referrer to identify if monitored Assistive Technology (AT) is required for discharge, if so, referrer to send DIF to the Hospital Social Care Team (HSCT) to progress and forward to CRS once AT equipment is in place.
- ✓ If the patient requires a lifeline ONLY, then the Discharge Team to arrange via the local council's lifeline service. i.e., District and Borough Councils as these do not need to go via Millbrook unless other AT equipment is required.

  Equipment order is placed on Millflow and must include:

  a. Delivery Speed = Next Day (unless there is an urgent clinical need).
  b. Issue Type = Community Recovery Service.
  c. Pre-Delivery Checks = Prescriber completes these checks with patient/family and includes in the Millflow notes field.

- ✓ Referrer will ensure that where equipment is required to make a discharge safe, this is clearly marked on the referral form.
- ✓ Referrer ensures patient and ward are aware of care agency details and start date and time.
- ✓ Discharge delays within 24 hours of the agreed start date are arranged directly with the Provider. Provider then sends an email to adminchdt@warwickshire.gov.uk Once the email is received CRS Business Support will email Therapy to advise of the delay.
- ✓ **If the delay is over 24 hours a new referral will be required.** Referrer to contact the CRS Provider to inform of the delay. The Provider will then email CRS Business Support adminchdt@warwickshire.gov.uk who will then notify Therapy.
- ✓ Once the patient is ready for discharge, the DIF will need to be sent to crshealthreferrals@warwickshire.gov.uk.
- ✓ If delay to discharge is before DCRT have sourced the care, the referrer to contact adminchdt@warwickshire.gov.uk who will notify DCRT to cease sourcing and close down all workflows.

The Hospital Ward

- ✓ **Inform the CRS Care provider when the patient has left the hospital.**
- ✓ Update CRS Business Support at the daily Multi Agency Meetings (MDTs) where they discuss current CRS patients. CRS Business Support are informed in these meetings of any delays and will then update Mosaic. CRS Business Support then update Therapy and the ward updates the Provider.

The Councils CRS Business Support Team

- ✓ Receive the CRS referral via the DIF to crshealthreferrals@warwickshire.gov.uk
- ✓ Load a conversation record and create a CRS Pathway.
- ✓ Create a Provider Sourcing Form and send this to DCRT to source a CRS Provider.
- ✓ Email Therapy Team - swg-tr.pop_bracepathway@nhs.net confirming patient is on CRS pathway and ask them to screen.

The Community Therapy Teams

Are responsible for all CRS patients, excluding those that are discharged to CRS following the Hospital Social Care Team route.

- ✓ Therapy will accept inpatient Therapy assessments as a trusted assessment. Where an acute assessment has not taken place, Therapy will undertake a paper-based screening assessment either over the phone or face to face within the first 48 hours of the patient coming home. This process will determine priority for first visit (initial assessment).
- ✓ During screening, Therapy will forward appropriate referrals to the SWATT and Stroke teams. Stroke referrals will be forwarded to the Warwickshire Integrated Community Stroke Service (WICSS) where patients will be screened using the Stroke eligibility criteria.
- ✓ Patients who are not eligible for SWFT Therapy due to GP out of area, will be forwarded to CWPT ISPA for Therapy intervention.
- ✓ Referrals identified with an elective or trauma orthopaedic need requiring the South Warwickshire Accelerated Transfer Team (SWATT) will be screened using the SWATT team eligibility criteria
- ✓ Referrals identified with a Fractured Neck of Femur within GEH will be seen by GEH staff and will be identified upon receipt of the DIF.
- ✓ Therapy will respond to the referrals from CRS Business Support, advising whether the patient has been accepted by Therapy or not. **If patient screened as not requiring Therapy but later it appears they have Therapy needs, CRS providers will need to flag this by exception via the MDT.**
- ✓ A Therapy generic initial assessment will take place with the patient in their own home (first visit).
- ✓ Strengths based individualised SMART goals will be set.
- ✓ Patient goals, advice for carers and changes to mobility of functional ability will be shared directly with Providers via email, as per the local 'Email Policy'. Therapy will undertake a specialist assessment as required e.g., Physiotherapy or Occupational Therapy.
- ✓ Therapy will undertake joint visits with the CRS providers if indicated and upon request.
- ✓ Therapy outcome measures are utilised throughout.
- ✓ Multi-disciplinary team (MDT) meetings will take place once per week, per place to discuss patients progress and exits.
- ✓ CRS providers will be able to contact the Therapy team for advice via swg-tr.pop_bracepathway@nhs.net
- ✓ Any patient requiring Therapy post 6 weeks will be considered for onward referral to alternate Therapy services.

- ✓ Where Therapy is involved, they will be responsible for the patient exit – see 'Exit Routes'. If someone declines CRS once home, including those not wanting to change Domiciliary Care provider, they are closed to CRS but will still be able to access Therapy via routine services if there would be a benefit to the individual and they agree to this.

CRS Business Support actions post screening

If patient has Therapy needs:

Therapy email crshealthreferrals@warwickshire.gov.uk to inform of the exit plan when the patient is ready to exit (maximum 6 weeks):

- ✓ if no further intervention needed CRS Admin will close the package on Mosaic.
- ✓ If further needs identified, current conversation will be closed, and a new conversation record will be assigned to CHDT where the patient will have a Care Act Assessment.
- ✓ CRS Business Support will send the letter to the patient confirming CRS pathway has been transferred to CHDT team.
- ✓ Once Care Act Assessment has been undertaken CHDT will send Package Information Alert to Business Support CRS Intake List and ask them to end the CRS Package and CHDT will send a Provider Sourcing Form (PSF) to DCRT to source new provider for long term package.
- ✓ Once long-term package sourced, and Initial Review completed, CDHT will send CRS Admin task request from De-allocation or Closure workflow asking them to send out letter with supporting documentation.

If patient does not have Therapy needs:

- ✓ CRS Business Support will put an end date of Therapy intervention and create next actions on CRS Pathway form for Conversation Record to CHDT for Care Act Assessment.
- ✓ CHDT will then send Package Information Alert to Business Support CRS Intake List and ask them to end the CRS Package and CHDT will send a PSF to DCRT to source new provider for long term package of care and CRS Business Support will complete Pathway form and close it down.
- ✓ Once long term POC sourced and Initial Review completed CDHT will send CRS Admin task request from De-allocation or Closure workflow asking them to send out letter with supporting documentation.
- ✓ CRS Business Support will process West Midlands Ambulance Service (WMAS) Self Neglect Referrals in the as is process FOR HSCT to progress.
- ✓ CRS Business Support will create CRS Pathway and send PSF to DCRT and email Therapy Team - swg-tr.pop_bracepathway@nhs.net confirming patient is on CRS pathway.

For patients requiring intervention by Hospital Social Care Team (HSCT) before discharge (e.g. Safeguarding or Self Neglect)

- ✓ All patients who are referred to the HSCT for an intervention will be case managed by the HSCT, referrals to be sent to hsctreferrals@warwickshire.gov.uk
- ✓ HSCT Business Support will set up a HSCT pathway form, network, and conversation record.
- ✓ Once the patient is safe and ready for discharge, the HSCT practitioner to send a conversation clipboard request to CRS Business Support to create the CRS pathway form and generate the PSF.
- ✓ CRS Business Support will send the PSF to DCRT and an email to Therapy to screen for Therapy intervention.
- ✓ HSCT will remain as case holder regardless of Therapy outcome.

If a HSCT patient has Therapy needs

- ✓ If no further Social Care intervention is needed CRS Business Support will forward an email to HSCT allocated worker who will complete open workflows and send Information Alert to HSCT Business Support to end the package.
- ✓ If further needs are identified CRS Business Support update the CRS pathway form.
- ✓ CRS Business Support will also update the HSCT Pathway Form and forward the Therapy email onto the allocated worker in the HSCT.
- ✓ The allocated worker will complete the Care Act Assessment and send the Provider Sourcing Form to DCRT to source a new provider.
- ✓ Once DCRT have sourced a new provider, they will load the package and send paperwork to the new provider and send an information alert to the hospital allocations list to inform them of new provider and start date.
- ✓ HSCT allocated worker to send a package information alert to the HSCT Business Support to end the CRS package and close the CRS pathway.
- ✓ HSCT to follow process for allocation and closure.

If HSCT patient does not have Therapy needs

- ✓ The HSCT will remain the case holder.
- ✓ HSCT Business Support will add the date of the email which confirmed no Therapy needs identified into the CRS pathway form.
- ✓ If no further Social Care intervention is needed CRS Business Support will forward an email to HSCT allocated worker who will complete all open workflows and send an Information Alert to HSCT Admin to end the package.
- ✓ If further needs are identified CRS Business Support will update the CRS pathway form and forward to the email to the allocated worker. The allocated worker will then complete Care Act Assessment and send the Provider Sourcing Form to DCRT to source a new provider.
- ✓ Once DCRT have sourced a new provider, they will load the package and send paperwork to the new provider and send an information alert to the hospital allocations list to inform them of new provider and start date.
- ✓ HSCT allocated worker to send a package information alert to the HSCT Business Support to end the CRS package and close the CRS pathway.
- ✓ HSCT to follow process for de-allocation and closure.

If patient has Therapy needs and WAS NOT referred to CRS via the HSCT

- ✓ If no further Social Care intervention is needed, CRS Admin will close the package on Mosaic.
- ✓ If further needs identified, CRS pathway form will be updated, and a new conversation record assigned to CHDT to carry out Care Act Assessment.
- ✓ Once Care Act Assessment has been carried out CHDT will send package information alert to Business Support CRS Intake List and ask them to end the CRS Package and CHDT will send a PSF to DCRT to source new provider for long term package.
- ✓ Once long-term package sourced, and Initial Review completed, CDHT will send CRS Admin task request from De-allocation or Closure workflow asking them to send out letter with supporting documentation.

If patient does not have Therapy needs and WAS NOT referred to CRS via the HSCT

- ✓ CRS Business Support will put an end date of Therapy intervention into the CRS pathway form.

- ✓ The case holder remains as the provider until week 4/5 when the provider will email adminchdt@warwickshire.gov.uk to inform them of exit plan.
- ✓ If no further Social Care intervention is needed CRS Admin will close the package on Mosaic.
- ✓ If further needs identified, CRS pathway form will be updated, and a new conversation record assigned to CHDT to carry out Care Act Assessment.
- ✓ Once Care Act Assessment has been carried out CHDT will send package information alert to Business Support CRS Intake List and ask them to end the CRS Package and CHDT will send a PSF to DCRT to source new provider for long term package.
- ✓ Once long-term package sourced, and Initial Review completed, CDHT will send CRS Admin task request from De-allocation or Closure workflow asking them to send out letter with supporting documentation.

The Domiciliary Care Referral Team (DCRT)

- ✓ Confirm receipt and acceptance of the PSF and begin securing CRS Domiciliary Care services.
- ✓ Check to see if Patient already has private care and wishes to stay with the existing provider as this will need to be considered. (Note: The trusted assessment will need to consider if the patient's current level of care allows for the benefits of added calls through a CRS package of care, alongside their private care arrangements. e.g., where the patient has a package of care for one morning care call and would benefit from four calls short term to recover to their previous level of care, the CRS could be used for the additional three care calls on the CRS service).
- ✓ Identify a CRS Domiciliary Care provider.
- ✓ Confirm the start date and send the DIF to the provider as a trusted assessment and where relevant - refer to training information on complex braces for unstable fractures.
- ✓ Where the referral identifies there is an equipment need, DCRT will ensure that the package starts the next working day with the tea call.
- ✓ Contact referrer via information alert (HSCT) or email (for the referrer) and confirm provider details and start date/time.

Hospital referrer contacts to confirm POC start time.

- UHCW: IntegratedDischargeTeam@uhcw.nhs.uk and dischargeteamstcross@uhcw.nhs.uk
- GEH: discharge.liaison@geh.nhs.uk
- SWFT: dischargeplanning@swft.nhs.uk (SWFT Integrated Discharge Team) and acuteoccupationaltherapy@swft.nhs.uk (SWFT OT Therapy team)

- ✓ Re-assign purchase services step to CRS pathway intake list for CRS Business Support to load package and notify Therapy.
- ✓ Respond quickly to any requests for information from either WCC's Contract Management and Quality Assurance Team or SWFT's Patient Experience Team to enable them to investigate any complaints received.
- ✓ Manage the pre purchased block hours and will make any adjustments to available hours in line with CRS provider feedback.
- ✓ Send to adminchdt@warwickshire.gov.uk who will update the patient's hours in line with any changes on Mosaic.

Once CRS service is confirmed

The Discharge Team or inpatient Occupational Therapy Team (The Referrer)

- ✓ Confirm discharge date with the patient and arrange transport if required.
- ✓ Confirm the review process with the patient in terms of what may happen at the end of the service.

The Ward

- ✓ Ensures TTO's are in place.
- ✓ Arrange transport if required.
- ✓ **Inform the CRS provider when the patient has left the hospital.**
- ✓ Restarts – If the patient has been in hospital for under 72hrs, ward to contact CRS Business Support via telephone on 01926 414000 and ask for a CRS restart. CRS Business Support will notify Therapy of the restart and confirm with the provider. CRS Business Support will go back to the ward and confirm discharge date.

Millbrook Equipment Service

- ✓ Deliver in scope equipment as per the order placed on Millflow and recorded under the CRS Issue Type to the patient by 4pm the following day, unless there is an urgent clinical need for a same day delivery, in which case the referrer will have needed to make this clear at point of equipment prescription.
- ✓ DCRT will ensure these POC are started from tea call of the following day onwards.

Full Millbrook process is attached at the end of this document as Appendix 1.

CRS Domiciliary Care Provider

On receipt of CRS referral

- ✓ Ensure that relevant details are on referral form.
- ✓ Ensure that assessing and/or care staff are available at the patients home within 2 hours of their planned return home.
- ✓ Ensure that the care plan includes milestones towards Therapy goals in line with Therapy assessment.
- ✓ Notify DCRT and Admin CHDT, if the patient is not at home at the expected time, this will be recorded as a delayed start.
- ✓ If patient has a CTLSO Brace or Miami J Collar with thoracic extension, undertake a visit to the patient at Hospital prior to discharge (if required) to observe removal/placement of Brace.
- ✓ Undertake an initial assessment with the patient.
- ✓ Provide support in line with the trusted assessment, and provider risk assessment.
- ✓ Complete daily records of support being undertaken, including progress towards Therapy goals which can be shared with Therapists or others to support MDT conversations.
- ✓ Is expected to adjust the number of care hours delivered to the person in line with their needs.
- ✓ Report any changes in hours to Admin CHDT and leannestafford@warwickshire.gov.uk and scottmacdonald@warwickshire.gov.uk.
- ✓ If patient is ready to exit CRS and Therapy is the case holder, email swg-tr.pop_bracepathway@nhs.net to discuss and agree exit. Therapy to notify CRS Business Support via crstherapy@warwickshire.gov.uk

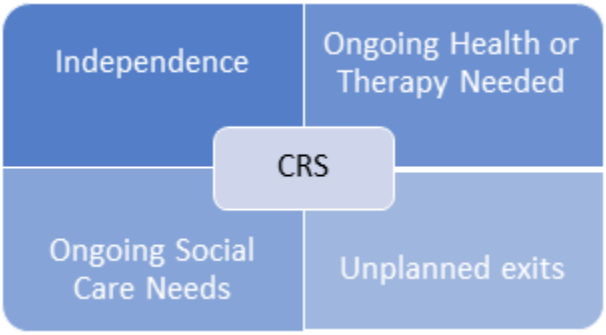
- ✓ If advised a patient is no longer ready to come home and the Provider has accepted them with an agreed start date, the Provider can agree an up to 24-hour delay to the start date with the referring hospital. The Provider must email adminchdt@warwickshire.gov.uk to amend the start date.
- ✓ If the patient is not ready for discharge after 24 hours, CRS Business Support will be notified at the daily Multi Agency Meeting, they will then cancel the package on Mosaic, send a cancellation order to the Provider and send an email to Therapy.
- ✓ If the patient is readmitted into hospital whilst on the pathway, their CRS package can be paused and restarted for up to 72 hrs. Provider must notify CRS Business Support immediately of the readmission into hospital. CRS Business Support will notify Therapy.
- ✓ If the Patient is still in hospital after 72hrs, the Provider sends another email to CRS Business Support adminchdt@warwickshire.gov.uk to notify them of the end date of the CRS package. CRS Business Support to inform Therapy.

Service Delivery

- ✓ The short-term service is to support a patient to stay at home and utilises a recovery and rehabilitation philosophy to instil confidence and safety.
- ✓ Feedback on this support can be requested by Therapists or Social Care practitioners. This information should be shared via this email address swg-tr.pop_bracepathway@nhs.net marking the emails CRS and the relevant place area e.g., CRS South Warwickshire.
- ✓ Any issues highlighted that could be resolved to minimise risk to the patient and enable their independence should be explored and expedited.
- ✓ If a concern or a complaint is received about the Domiciliary Care provision, this should be responded to informally by the Domiciliary Care provider. The Contract Monitoring Team can be contacted for assistance if required contractmonitoringteam@warwickshire.go.uk
- ✓ If the patient is readmitted to hospital whilst on the pathway, their CRS package can be paused and restarted for up to 72 hours. Provider will notify CRS Business Support immediately of the readmission into hospital. CRS Business Support to notify Therapy.
- ✓ Restarts – If the patient has been in hospital for under 72hrs, the hospital ward to contact CRS Business Support via telephone on 01926 414000 and ask for a CRS restart. CRS Business Support will notify Therapy of the restart and confirm with the provider. CRS Business support will go back to the ward and confirm discharge date.
- ✓ If the Patient is still in hospital after 72hrs, the Provider sends another email to CRS Business Support adminchdt@warwickshire.gov.uk to notify them of the end date of the CRS package. CRS Business Support to inform Therapy and referring ward or team.
- ✓ The patient will need to be re-referred to the appropriate pathway when they are ready for discharge.
- ✓ Should a patient require Respite Care whilst on the CRS pathway, the package will be suspended with the current CRS provider for a maximum of 14 days. The package of care can be restarted at any point during the 14 days. The number of days remaining on the CRS pathway for that patient will continue to decrease. For clarity, if a patient goes into Respite at the start of week 2 of the pathway and stays in Respite for 14 days, then they will restart at home on week 4 of the CRS pathway.

CRS Exit Routes

There are 4 exit routes (more than 1 exit route can apply per patient) from the Community Recovery Service.



Who is responsible?

- ✓ If **Therapy** are involved, they will be responsible for coordinating the patients exit as the key coordinator.
- ✓ The **CRS Domiciliary Care provider** will take the key coordinator role for patients with no Therapy input and will be supported at MDT.
- ✓ **CHDT** coordinate exits requiring long-term packages of care once a patient's referral has been accepted by this team for a Care Act Assessment. CHDT will screen and refer on to other Social Care Support teams if requiring a specialist team.
- ✓ **HSCT** are responsible for patients with a HSCT allocated worker and coordinate once the patient exits CRS if a Care Act Assessment is required.
- ✓ Exit plans will be discussed and confirmed at the weekly MDT meetings.
- ✓ The patient can exit the pathway at any point within the 6-week period.

Independence

- ✓ The patient can manage activities of daily living and so the package of care ends within the 6 weeks.
- ✓ End date to be discussed with patient.
- ✓ Key coordinator for patient to notify CRS Business Support by email with an end date.
- ✓ CRS Business Support will close the package on Mosaic.

Ongoing Health or Therapy Need

- ✓ Key coordinator will refer for ongoing health or Therapy needs when planning patients exit.
- ✓ Therapy will complete an onward referral to alternate Therapy services.
- ✓ Other health needs will be referred via the patients GP or ISPA as appropriate.

Ongoing Social care needs identified

- ✓ If there is a social care need identified, the coordinator for the patient makes a referral for a Care Act Assessment. This will need to be made no later than end of week 4. A referral can occur earlier if no further potential to reduce care is identified.

- If the coordinator is **Therapy,** they will complete an email advising of ongoing social care need to CRS Business Support at week 4 emailing crstherapy@warwickshire.gov.uk to request Care Act Assessment. The email subject will be highlighted as a 'CRS Exit referral' and will provide a brief patient summary and detailed care calls and requirements.
- If the Key coordinator is the **Domiciliary Care Provider**, they will complete an email advising of ongoing social care need to CRS Business Support at week 4 emailing adminchdt@warwickshire.gov.uk to confirm long term package of care is required.

- ✓ CRS will continue until week 6 **or** when the Care Act Assessment has taken place.
- ✓ For patients whose hospital discharge was arranged by the **HSCT**, this team will undertake the Care Act Assessment and exit the patient.
- ✓ For patients not allocated to the HSCT, they will be referred to **CHDT** for the CRS exits.
- ✓ If a Care Act Assessment is not possible within 6 weeks, the patient will be moved to an interim package of care (an Immediate Service), potentially resourced with a new provider, and coded as 'D2A (IS)'.
- ✓ **DCRT** will inform the CRS Provider of the end date and time and advise the patient of any change in provider.
- ✓ **CRS Business Support** will complete a CRS Conversation Record and send to CHDT to have a conversation with the patient about the Council's charging policy, financial assessment and allocate for a Care Act Assessment and send a PSF to source the ongoing care.
- ✓ Once new provider is sourced **DCRT** will notify the patient and CRS provider of any agreed end dates and the new care provider details and will update CHDT and CRS Business Support to load new package.

Unplanned CRS Exits

- ✓ At times, a patient may need to leave the service if there is a readmission to hospital or a need for immediate long-term care. These are unplanned changes and patients will be supported to exit CRS by their Key coordinator.
  [Discharge issues occurring in the first 24 hours of the patients return home should be directed to the referrer in the first instance]

Patients who become 'End of Life' whilst on the CRS pathway

- ✓ Patients' health identified as rapidly deteriorating, suspected to be end of life, standard escalation procedure for health deterioration remains e.g. (as appropriate) GP, district nursing, specialist palliative care service, UCR or 999/111 if emergency.
- ✓ Key coordinator to refer to GP and District Nurses for review of patient and to consider if for FastTrack.
- ✓ Key coordinator must request on referral that if a FastTrack end of life referral form is completed it must please state that the patient is currently being seen by the Community Recovery Service; specifying the name of the current Provider and how many care calls are being provided.
- ✓ Once the ICB receive the FastTrack end of life request they may liaise with current provider to determine if they have capacity to continue with care under fast-track funding.
- ✓ Once the ICB have agreed a start date for the FastTrack end of life package of care (sourced with either current or new provider) the ICB inform CRS Business Support of the arranged start date, via email to chcfasttrackbst@warwickshire.gov.uk
- ✓ CRS Business Support will then inform Therapy and the current care Provider, as well as updating Mosaic.
- ✓ Case will be closed to CRS.
- ✓ It is envisaged this process will be completed within the maximum 6 weeks of the CRS pathway and is subject review.

Social Care and Support Duty for CRS Patient.

- ✓ If an appearance of need for social care support is identified for the patient and/or their carer the CRS key coordinator (Therapy or CRS Domiciliary Care Provider) must contact the Customer Service Centre Supporting People (CSCSP) team on **01926410410** to make a referral for social care and support for the patient and/or their carer.
- ✓ The CSCSP team have an established resource directory and experienced staff including Operational Team Leaders and Social Work Team Leaders who can provide information, advice and signposting to the referrer and will divert referrals away from social care services where possible and appropriate to do so. For example, if there are mental health related concerns, a referral will be directed to MH services via the CSCSP team. If the referral is for Carer support of assessment, the referral is directed to the Carers Trust.

- ✓ If the CSCSP team are not able to resolve the social care related matter, they will create a conversation record in Mosaic with the referral details and direct the referral to any allocated worker in Social Care or, if no allocated worker, will direct the referral into the CHDT Team for the CHDT Team Leader to consider next steps and progress the case.
- ✓ If the referral is regarding adult abuse, or risk of abuse, the case is directed from CSCSP team to the SAST (Adult Safeguarding Team). This is (BAU) no change to process.
- ✓ If there is a new Self Neglect concern these will be directed to the relevant SCS team. This is (BAU) no change to process.
- ✓ If a Care Act assessment is required, the CHDT worker will contact the referrer and patient/or their representative (this also applies to cases that may be transferred into other SCS teams).
- ✓ The CHDT worker will explain the Care Act assessment processes, advise of the financial assessment and charges for social care and support and make any FABA (financial assessment) referral.
- ✓ The CHDT Team Leader will progress the Care Act Assessment in the CHDT or, will direct into the relevant SCS Team if more appropriate for another service to undertake the assessment.
- ✓ Any services that are provided following the Care Act assessment are subject to social care charges even when the CRS is ongoing (examples might be assistive technology or respite etc).
- ✓ If Social Care Support or a Care Act Assessment is declined the case will be closed in SCS.
- ✓ The CRS will continue pending any exit being directed to the CHDT or HSCT.

Invoicing

- ✓ Care Hours provided will be invoiced in the usual way as all CRS patients will be on Mosaic and coded against CRS which is a nil-charge code.
- ✓ Residual hours on the pre purchased hours that have not been used for care will invoice as a single invoice.
- ✓ These block hours will have to be invoiced in line with payment periods (4 weekly).
- ✓ The payable block hours will be total block minus paid care hours for the period.
- ✓ Providers must continue to accept packages in their Place area to maximise use of their block hours. Refusal to accept a care package when there is clearly capacity within the block may result in the residual block amount above delivered care hours being refused for payment.

Example CRS provider for 500 hours with 17 patients all at 28 hours a week:
To be processed through Mosaic. 17 care invoices x 28 hours a week at £22 per hour for a 4-weekly period. Total care invoices for period = 28 hours x 4 weeks = 112 hours 112 hours x 17 patients/invoices = 1,904 payable care hours 1,904 hours x £22 per hour = £41,888 1 x block invoice of 500hours x 4 weeks = 2000 hours 2000 x £22 per hour = £44,000 £44,000 block - £41,888 paid care hours = £2,112 for the 4-weekly block invoice

Quality Assurance and Complaints

Quality assurance will be completed by:

- ✓ SWFT's Out of Hospital Division for the Therapy provision including monthly quality assurance meetings, led by Clinical and Quality Lead; and
- ✓ WCC's Contract Management and Quality Assurance Team for Domiciliary Care.

All information shared with WCC's Contract Management and Quality Assurance Team will be viewed by the Quality Assurance Officer who will review and consider what, if any actions need to be taken and they will act accordingly.

All care provision is monitored on an escalation framework and where concerns increase or escalate these will be reported to Warwickshire's Service Escalation Panel who will monitor and agree actions to mitigate risks and issues.

Complaints and concerns:

There is an expectation that where possible the person raising an issue or concern should try to resolve this at a local level before escalating.

General concerns.

- ✓ Concerns relating to care delivery will be recorded and monitored by the WCC's Contract Management and Quality Assurance Team and should be sent to; **contractmonitoringteam@warwickshire.go.uk**
- ✓ Concerns related to Therapy should be sent to; Patient Advice and Liaison Service at SWFT **pals@swft.nhs.uk 01926 600054**

Formal complaints

- ✓ If a Complaint is about the Therapy offer this should be directed to the Patient Experience Team at SWFT **PatientExperience@swft.nhs.uk** which will then manage the complaints process.
- ✓ If the complaint relates to the Domiciliary Care provision or social care provision this needs to go to the Customer Relations Team. https://www.warwickshire.gov.uk/complaints
- ✓ Formal complaints will be responded to the Customer Relations Team will record and log details of the complaint on the Council's complaints system. This will automatically notify WCC's Contract Monitoring Team in the Contract Management and Quality Assurance Team.
- ✓ Where a complaint is about both Therapy, care or social care, a joint response to the complaint would be co-ordinated, this will be considered on a case-by-case basis depending on nature of complaint where agreement will be made between organisation as to who leads response to the complaint.
- ✓ Learning from complaints and concerns will be continuously used to inform improvements to the process and pathway. This will be picked up as part of assurance e.g., volume of complaints. Concerns may be flagged at the MDT meetings between organisations to ensure a shared learning approach and to help make recommendations for improvements to the pathway.
- ✓ Any issues related to quality of CRS providers will be shared at MDT as appropriate.

Note: If Safeguarding concerns are raised, and whilst patients are in CRS, they may not have an allocated social worker, a referral will need to go straight to the Safeguarding Team via WCC's Customer Service Centre, Supporting People Team as normal who will then refer to the correct team for an assessment.

Governance and Oversight of this process guide:

- ✓ This process guide has been developed and agreed by WCC and SWFT with support from the System Operational Discharge colleagues.
- ✓ This document is correct as of September 2023 and will continue to be reviewed and updated as the pilot progresses.

Appendix 1 Millbrook processes

Millbrook Healthcare Equipment Ordering Process

The following process and flowchart outlines the process for prescribers to follow when ordering equipment through the Community Recovery Service.

- The process reflects the existing 'business as usual' process with some enhancements introduced to support the CRS.
- The enhancements will ensure equipment can be delivered in advance of the patient being discharged.

Service Operating Times

Please note the current service operating times for Millbrook Healthcare are outlined below.

- Support for the Community Recovery Service will be aligned to Dom Care Referral Team (DCRT) and Therapy/Prescribing Teams.
- There is an out of hours service available where urgent delivery of equipment is required.

Service Area	Operating Days	Operating Hours
Customer Service Centre	7 days per week	8.00am – 5.00pm
Driver Technicians	Monday – Friday Saturday – Sunday	8.00am – 7.00pm 8.00am – 6.00pm
Out of Hours Oncall Service – Out of Hours and Bank Holidays	7 days per week	24 hours/day
Out of Hours Oncall Service – Emergency Repairs only	7 days per week	5.00pm – 8.00am

Service Contact Details

Contact Method	Contact Details
Service Telephone Number	**0333 321 8986**
Service Email Address	**warwickshirecontactus@Millbrookhealthcare.co.uk**
Out of Hours & Bank Holiday Telephone Number	**0333 321 8986**
Out of Hours Emergency Repair Telephone Number	**0333 321 8986**

Prescriber identifies equipment required as part of the early discharge planning process.

Order is placed on Millflow and must include:

- Delivery Speed – **Next Day** (unless there is an urgent clinical need)
- Issue Type – **Community Recovery Service**
- Pre-Delivery Checks – Prescriber completes pre-delivery checks (see Appendix 1) with patient/family and includes in Millflow notes field
- Prescriber contact information

The cut-off time for placing CRS orders only, to be delivered the next day is 5pm.

If an order for equipment is placed after 5pm, the equipment will be processed the next day and delivered the following day.

When making a referral to DCRT to source a package of dom care, prescriber to highlight that equipment is attached.

This will ensure that the package starts on the following day, with the tea call.

Millbrook will process order as usual and ensure equipment is delivered the following day, by 4pm, before the patient returns home.

Prescribers must adhere to the following to ensure equipment can be delivered according to the CRS timelines and minimise any delay in the provision of equipment.

Issue Type – **Community Recovery Service**	➢ Prescribers must select the 'Community Recovery Service' activity type for all orders placed through the CRS process. ➢ Any orders placed using any other issue type may not be delivered within CRS timelines.
Delivery Speed – **Next Day**	➢ As standard practice, Prescribers must use the Next Day delivery speed for all orders placed through the CRS process. ➢ There may be a small number of exceptions to this for which Same Day activity speed is necessary.
Expected Date of Discharge	➢ Prescribers are requested to include the EDD in the notes field on the equipment order to alert Millbrook Customer Services Team.
Pre-Delivery Checks **(see Appendix 2A)**	➢ For the purposes of CRS, prescribers are required to complete the pre-delivery check questionnaire with patient to facilitate faster delivery. ➢ Prescribers should record this information within the notes field of the order on Millflow e.g., 'checks complete, dog in house'. **NOTE: Millbrook will complete pre-delivery checks with patient/family if not included within the order however this may cause some delay to the equipment delivery if no contact can be made.**
Referral to DCRT	➢ Please ensure that the referral to DCRT clearly specifies that there is an attached equipment order placed. ➢ DCRT will then arrange the provider to start on the tea call of the following day.
Raisers – **Langhams**	➢ For the purposes of the CRS process all orders for raisers will only use Langham raisers as default.
Out of Scope of CRS	➢ The following elements/activities are not included as part of the CRS equipment process. ➢ Any orders placed against CRS for these may be queried with the prescriber and/or be delayed. ○ Minor Adaptations ○ Special Equipment Orders ○ Lifeline and monitored Assistive Technology

Appendix 2A - Equipment Pre-Delivery Check Questionnaire

Please note this questionnaire can be completed and copied/pasted into the Millflow notes field for ease.

Confirm the delivery address for the equipment:	
Name of person who will be receiving the order:	
Confirm the contact details:	
Are there dogs present in the home? *If yes, please secure in a different room.*	Yes/No
Does the patient or anyone in the home have COVID?	Yes/No
Is there a Key Safe? *If yes, record code into confidential notes.*	Yes/No
Is the property accessible for the delivery van? ➢ *Is there suitable parking?* ➢ *Is there a gravel drive?*	Yes/No
Is the room ready for the equipment to be delivered? *If no, this needs to be cleared before delivery can be made.*	Yes/No
Where is the room located? ➢ *Is it on the ground floor?* ➢ *Are there steps?* ➢ *Is there a stairlift/lift that could be used?*	
Does the room have suitable plug sockets (if needed)	Yes/No