Job Description

Function:	Onward Care Discharge Facilitator
Position:	Discharge Facilitator
Job holder:	Erica Lunt
Date (in job since):	14/11/2022
Immediate manager (N+1 Job title and name):	Erica Lunt – Service Operations Manager
Position location:	Stoke Mandeville Hospital Aylesbury/ Amersham Hospital, Amersham

1. Purpose of the Job

To support timely discharge of hospital inpatients that are clinically fit for discharge, meet agreed criteria, and to put in place non-clinical support that will help reduce the chances of the discharged inpatients (clients) having future unplanned readmissions.
Liaise with the hospital Discharge Facilitator/ Team and or ward staff to identify clients that meet inclusion criteria.
To meet with prospective clients and their carers to explain the service, obtain consent, develop, and mobilise their home care plan.
To provide feedback to the Service Operations Manager on this role, client engagement, and any additional information that may help inform the future development of the service.

Main assignments

1. **General responsibilities:**
   - 1.1. Responsible for delivery of the non-clinical care pathway over 12 weeks and until the client is discharged (the service does not include support with activities of daily living).
   - 1.2. Ensure excellent client and stakeholder interfaces to promote the quality and effectiveness of the service.
   - 1.3. In person and telephone base support
   - 1.4. Rapid response to hospital discharge team, executing assessment/care planning within 24-48 hours of contact.

2. **For patients pre discharge from hospital:**
   - 2.1. Liaison with nominated hospital services discharge co-ordinator to discuss clients for inclusion.
   - 2.2. Demonstrate a clear understanding of inclusion and exclusion criteria and work constructively with hospital discharge team members to select appropriate patients for the service.
   - 2.3. Consent the client to be part of the service.
   - 2.4. Write a post discharge electronic care plan and agree it with Onward Care Service Operations Manager and/ or Clinical Lead and Discharge Coordinator
   - 2.5. Conduct a home review for the client in conjunction with the agreed discharge plan and OT/ therapy assessment to see what pre-discharge activities have been requested to support the clients discharge from hospital. e.g., stair rail added/ wheelchair ramp/ house deep clean.
   - 2.6. Liaise with local service providers (NHS, local authority, community, falls service, voluntary sector) to mobilise local services to support the client.
   - 2.7. Identify any gaps/ delays in local service provision of required activities/ services and outsource. With the support of local social prescriber if available
   - 2.8. Agree with the client/ carer which non-clinical home monitoring technology, for instance humidity detectors/ mobility detectors, will be installed and put those devices in place (may be done post discharge)

3. **Post discharge**
   - 3.1. Call or visit the client on day of discharge to assess how they are coping now back at home.
   - 3.2. Provide non-clinical advice to the client or their carer where possible in line with their post discharge care plans, for example to help them remember to take their medicines, provide advice on nutrition and adequate hydration, and signpost to local existing services where necessary.
   - 3.3. Review the results from the non-clinical monitoring at a fixed point each day to identify early if the client's activities of daily living (sleeping, step count, kitchen activity) are changing. If so, follow agreed escalation protocols.
   - 3.4. Talk to the client/ their carer to understand what is most important to them and what they would like to be able to do in 3 months' time.
   - 3.5. Provide non-clinical coaching and liaise with local services to support this.
   - 3.6. Provide access to Sodexo concierge service in order to source providers for support services the client may require e.g., dog walking, home repairs, weekly shopping), if not covered above
   - 3.7. Review progress towards these aims at 6 and 12 weeks.
   - 3.8. Respond to any calls from the client or their carer and give non-clinical advice where appropriate.
   - 3.9. Call the client at the end of the 12 weeks to make sure they are clear who is providing them with what care going forward (from their local care providers)
   - 3.10. Provide a summarised close off report to hospital provider discharge co-ordinator, and any other parties agreed with the NHS Contracting Organisation - transmitted securely and compliant with relevant IG.

4. **Audit and Compliance**
   - 4.1. Accurate note taking and ability to explain tasks done and time taken.
   - 4.2. To support Quality Assurance (QA) with departmental audits
   - 4.3. To support QA with detailed care pathway audit
   - 4.4. To support QA with random spot checks and audits as required to support business needs.

5. **Points to note:**
   - 5.1. Clinical responsibility transfers from the hospital to the community upon discharge as usual. Sodexo does not take clinical responsibility for the clients.
   - 5.2. The services delivered are assessed as being outside the remit of CQC regulated activities, therefore CQC registration is not required.

5.3. The role is to deliver non-clinical services with the aim of supporting the health and wellbeing of the client. No activities classed as 'Personal Care' by the CQC are to be undertaken, for instance any physical support to the patient or support with activities of daily living (a full list will be included as part of training)

6. Location

6.1. The role holder will need to live in the Buckinghamshire area. You will be based at Stoke Mandeville and Amersham Hospitals, with some home working and will need to visit clients in their homes.

7. Hours

7.1. The service will run from 0900 – 1700 Monday to Friday.

3. Context and main issues

- Liaise with the hospital Discharge Facilitator/ Team and ward staff to develop trusted relationships in order to identify clients that meet inclusion criteria.
- To meet with prospective clients and their carers and develop trusted relationships to explain the service, obtain consent, develop, and mobilise their home care plan.
- To provide feedback to the Service Operations Manager on this role, client engagement, and any additional information that may help inform the future development of the service.

4. Accountabilities

- Delivery against the identified Key Performance Indicators
  - NHS client engagement
  - User engagement
- Accurate and succinct note taking into client care plan.
- Accurate and succinct development and transcription of care plans
- Rapid escalation of any concerns
- Rapid communication of any NHS client or service user complaints.

5. Dimensions

- Up to nine staff members
- Up to sixty clients

7. Organisational Chart

Received:

Date:

Date:

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Job holder

_____

Immediate Manager