Appendix 2

Overview of the Onward Care Team

The team is made up of social workers and social care workers who work closely and collaboratively with the acute trust wards and staff to provide advice and guidance around discharge planning. They work with patients, relatives, carers, and professionals to consider discharge options and early discharge planning. The team is responsible for confirming the discharge plans for patients with ongoing care and support needs who are within the Worcester Acute Hospitals (Alexandra Hospital and Worcester Royal Hospital). Where a patient has complex care and support needs the team is responsible for ensuring appropriate discharge planning is complete. This includes liaising with appropriate professionals and teams to ensure pathways can meet the needs of individuals, where it is confirmed, existing pathways cannot meet the required needs for the individual, appropriate discharge options are arranged outside of the standard commissioned pathways.

The Onward Care Team:

- Arrange discharge for individuals with complex care and support needs which cannot be supported by existing commissioned pathways.
- Work collaboratively with wards to provide appropriate advice and guidance around discharge planning including those patients who have Out of Area Local Authority or Health services and are currently inpatients in Worcester Acute Hospitals.
- Update Worcestershire Patient Tracker with discharge planning, ensuring notes are up to date and codes correct.
- Confirm discharge plan (pathway) for the patient, ensuring compliance with pathway criteria and that patient wishes have been considered. Ensuring the discharge to assess model with HomeFirst approach is at the forefront of discharge planning.
- Participate in early discharge planning with patients, relatives, and ward staff to ensure discharge plans are clear at the point a patient becomes medically optimised for discharge. This is contingent on early referrals by ward staff.
- Ensure appropriate professionals have been involved and where pathways have confirmed they are unable to safely meet the individual need, that alternative options are arranged.
- Participate and lead the daily Triage Hub meetings.
- Complete Safe to Transfer forms for patients who are Fast Track CHC eligible.
- Participate in Discharge Cells, MDTs, and conference calls to support discharge planning.