

## 1. JOB IDENTIFICATION

Job Title: Discharge Hub Team Lead

Responsible to: Clinical Service Manager

Department(s): Discharge Hub WGH

Directorate: Medicine

Operating Division: Lothian University Hospitals Division

Job Reference:

No of Job Holders: 1

Last Update: July 2020

## 2. JOB PURPOSE

To coordinate and manage the Hub functions, performing a key link between Acute care at WGH and the wide range of community services including down stream beds and Social Work Department.

Responsible on a day-to-day basis for delivering the key outcomes of the Hub in managing the flow of patients into the community. A pivotal role to assist, support and promote a seamless patient journey up to and including discharge, promoting a positive patient experience and achieving reduction in the inpatient Length of Stay (LOS) and numbers of Delayed Discharges.

Professional and managerial responsibility for the discharge hub service with overall responsibility for both clinical and staff governance issues. Responsible for the day-to-day deployment and coordination of staff within the Hub and will be expected to motivate staff to provide high standards of service.

## 3. DIMENSIONS

This role is to facilitate mainly delayed discharges in a safe and effective manner, by working collaboratively with other agencies. The post holder will be responsible for the effective and complex procedures to enhance the pathway for those patients affected by delays.

As Team Lead for the Discharge Hub, the post holder will be directly responsible for managing the most complex discharges, including "Moving On" discussions with patients and their families/carers.

Staffing Responsibility:

Management of **WTE 5.67** staff, incorporating nursing/therapy discharge facilitators and administrative staff.

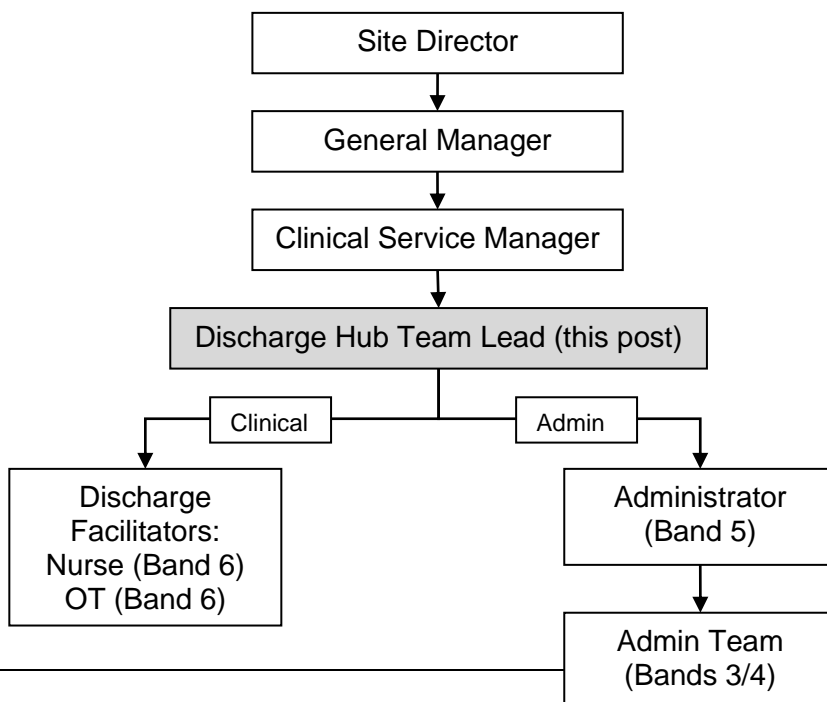
Financial Responsibility:

The post holder will have responsibility for the delegated annual budget of **£192,094** (delegated budget from the Clinical Service Manager) for staff pays, non pays and service supplies.

The post holder will be based in the Western General Hospital and will manage patients from the City of Edinburgh, the Lothian's and beyond. The post holder will be expected to work alongside the integrated joint boards.

The Lothian University Hospitals Division delivers services within the environment of a University Teaching hospital setting.

#### 4. ORGANISATIONAL POSITION



#### 5. ROLE OF DEPARTMENT

The role of the Discharge Hub WGH is to ensure the safe and effective pathway for those patients who have finished their medical intervention. The role of the hub is to work collaboratively with other social and healthcare professionals to maintain a steady and productive discharge profile within the wards at the Western General Hospital. The main role of the Discharge Hub is to eliminate delays and support an effective seamless pathway out of hospital for patients.

The management of health delays involves signposting and managing the referral process to

other hospital sites, including Hospital Based Continuing Complex Care (HBCCC) facilities.

The management of social delays involves directing referrals for Social Work and Homecare to facilitate safe appropriate discharge. This is for both the allocation of a Social Worker to cases and referrals for ongoing care (Homecare) and will also incorporate nursing home referrals and coordination of dates for discharge.

The Discharge Hub takes responsibility for monitoring the length of stay of patients over 14 days as well as focusing on the potential delays in a patient's journey where no clear plan is identified.

The Hub team works closely with all wards across the WGH as well as the Health and Social Care teams across Lothian. The Discharge Hub works with ward teams to improve their knowledge regarding delayed discharge and to act as a specialist resource for those teams.

## **6. KEY RESULT AREAS**

Act as lead practitioner for patients, using clinical judgement and reasoning skills to assess the patient. Coordinate their safe discharge back to their own home, care home or downstream hospital, thereby reducing the number of patients becoming delayed. This will include patients with multiple pathologies and complex clinical presentations.

Initiate and co-ordinate a multi-disciplinary assessment process and subsequent care and support packages to facilitate and sustain discharge to maintain an individual in their own home.

Use clinical judgement and reasoning skills to make daily decisions in conjunction with the multi-agency team relating to whether patients can be safely managed at home.

Work closely with the patient and their relatives/carers to ensure their full understanding of the planned discharge with or without support.

In partnership with other agencies, analyse, assess and monitor progress against agreed strategies and policies developed to support safe, effective and timely discharge and prevent and resolve delayed discharge. This is of particular importance in relation to pathways in place to support discharge and various criteria set across Lothian within the different locality-based initiatives such as the Home First Service embedded in the Edinburgh Health and Social Care Partnership.

Operate within the framework of all Lothian Joint Health and Social Care Policies and Protocols. Responsible for ensuring a high quality of data information is provided by the Discharge Hub to support planning and patient flow across the hospital, NHS Lothian and Integrated Joint Boards (IJBs). This includes but is not limited to delayed discharge statistics (by hospital ward, delay reason and locality), personalised discharge planning details, and real time reporting.

Support NHS Lothian's values of quality-, teamwork, care and compassion, dignity and respect, and openness, honesty and responsibility through the application of appropriate behaviours and attitudes.

Direct the development, implementation and monitoring of Discharge Hub staff induction,

recruitment, appraisal, matters of discipline and grievance and performance management.

-Participate in specific projects regarding future service development, developing and implementing identified changes to the routine and delivery of patient outcomes, such as the recent Home First Pilot which is being spread across the Hospital Sites.

Contribute to the promotion of Supported Discharge, Discharge to assess, Intermediate Care and Hospital to Home by participating in presentations and teaching of health care and social work staff.

Responsible for assessing risk when recommending patient pathways – for example the risk to patients staying in hospital when medically fit. Supporting staff and families that hospital is not a place of safety once well.

Responsible for the delegated Budget for the Discharge Hub including authorised signatory.

The service participates in Audits when required.

### **7a. EQUIPMENT AND MACHINERY**

The post holder may use various pieces of equipment including: -

- Personal Computer (including Intranet, email, Word, Excel, PowerPoint and database management)
- Mobile phone.

**Note:** New equipment may be introduced as the organisation and technology develops, however training will be provided.

### **7b. SYSTEMS**

Maintenance of patient records

Human Resource Administration system.

DATIX Intranet – Manage Incident Reporting

Internet and Intranet – Personal and Business

City of Edinburgh Council system (Swift)

**Note:** New systems may be introduced as the organisation and technology develops, however training will be provided.

## **8. ASSIGNMENT AND REVIEW OF WORK**

Works within occupational, national and local policies and guidelines.

Will have a Professional Personal Development Plan including an assessment of clinical competence which will be reviewed annually by the responsible line manager.

Professional nursing advice may be provided by the Chief Nurse/Advanced Nurse Practitioners.

The post is self directed, organising own workload in relation to specialist caseload to meet the demands of the service.

The clinical workload is generated through various referral protocols of multidisciplinary teams in line with legislation and performance indicators set by the Scottish Government Health and Social Care Department.

## **9. DECISIONS AND JUDGEMENTS**

Make clinical and professional autonomous decisions on a daily basis, including provision of advice to the multidisciplinary teams for example, on Home First principles around patient care provision not to be prescribed by the acute services only that the patient is medically fit. Responsible for supporting multidisciplinary teams across various clinical areas to maintain patient flow across the system, including educating the teams on Locality services available and the assessment of care needs for discharge being the responsibility of the Health and Social Care Partnerships across Lothian.

To undertake critical analysis and decision making on a daily basis providing advice to a range of professions across all directorates once the patient no longer requires an acute hospital bed, whilst embedding Home First Principles. Supporting the navigation of access of services across a complex community framework.

Use advanced skills in clinical reasoning to inform decisions regarding patient flow, ensuring appropriate and timely transfer and discharge of patients. Responsible for personally managing the most complex discharges including "Moving On" and realistic conversations with family re the home first process.

Recognise staff performance issues and appraise accordingly.

Support the daily, monthly and yearly data in relation to number of Delayed Discharges by Locality and needs based for example await Nursing Home, Package of Care. This Data is used system wide and is fed into daily safety huddles on the site. It is essential information to support pressure areas and trigger points for escalation across the whole system.

## **10. MOST CHALLENGING/DIFFICULT PARTS OF THE JOB**

Lead, motivate and inspire the multidisciplinary teams to ensure effective collaborative working is achieved.

Direct the provision of the highest standards of service in the allocated resources.

Managing provision of service within a finite envelope. Creating an environment to enable implementation of change including engaging and motivating staff to embrace and implement

change and overcoming resistance.

Balancing demands of both NHS Lothian and Health and Social Care Partnerships on a daily basis, leading a Lothian Wide team to deliver an integrated model within a developing integrated Hub within an acute care setting.

Requires a high level of negotiation skills and the ability to create a working relationship various professions and seniority levels.

## **11. COMMUNICATIONS AND RELATIONSHIPS**

Communicate with the patient, relatives and carers on the discharge process.

Responsible for liaising within the Health and Social Care Partnerships and also with external agencies to ensure effective joint working within the Health and Social Care system.

Key staff in which the post holder will interact with include Hospital Management / Medical / Nurses / Therapists / Social Work / Finance / Procurement / Support Services / Health and Safety and Risk Management.

Communicate verbally and in writing to members of the multidisciplinary team of various levels of seniority. Post holder needs to be able to communicate highly sensitive/ complex information about the whole service to senior managers / agencies, patient, carers and families on a daily basis.

Other relevant lines of communication will encompass the following internal and external groups to

### Internal Communication

- Site Director- Appraisal of number of Delayed Discharges by Locality daily on the Site
- General Manager- As above and escalation re any issues adding risk to capacity and Demand / patient flow and safety on the site.
- Clinical Service Manager- As above
- Assistant Service Manager- Regular Sit Rep re accuracy of situation to be confirmed.
- Associate Nurse Director- Daily update on Site Position in relation to Delayed Discharges and effect on patient safety and flow across the site.
- Clinical Director / Associate Medical Director- Daily sit rep re position and education to all clinical staff to support identification on TRAK of patients medically fit for discharge.
- Senior Charge Nurses- As above and encourage escalation of patients in wrong place.
- Nursing Staff- As above
- AHPs / Therapy Staff- As above and escalation to the Discharge Hub daily in relation to any barriers to discharging of patients to any locality.
- Administration and Clerical staff- Within and out with the hub in relation to accurate collation of data

- Medical Staff- As above with Clinical Director and Associate Medical Director for medical staff on the shop floor. Education of realistic conversation required around Home First for patients and relatives.
- Capacity and Site Management: Daily in relation to the impact of adequate capacity to support demand and in relation to discharges moving off the site and impact to any specialty areas discharge position.
- Multi Disciplinary Leads- As above
- Finance– In relation to real time information collation and impact on finance pressure due to increased Length of stay
- Procurement- In relation to general management requirements
- Support Services- As above
- Human Resource- As above
- Health and Safety- As above
- Risk Management. Updating of risk register for the site in relation to Delayed Discharge Numbers and ability to support service provision on the site if capacity is impacted on e.g. Elective scheduling.

#### External Communication

- Integrated Joint Boards- Daily feed back to Localities in relation to patients fit for discharge for all localities across Lothian.
- Other NHS Lothian staff– Single Point of Contact for advice on complex discharge planning and services available within each Health and Social Care Partnership locality
- Voluntary Agencies: As above
- Scottish Ambulance Service; Planning ahead with the service and ward staff acting on planned discharge dates for complex patients.
- Community Health Practitioners: Single Point of Contact for patient need assessment data.
- Discharge co-ordinators- Across all acute and community sites re patient allocation and movement
- Social Work: Single Point of Contact regarding complex patients in relation to referral and processing patients needs for discharge
- Liaising with partnerships and external agencies to ensure effective joint working within the Health and Social Care System. This includes working with Locality Hubs and Integrated Joint Boards.
- Patients: As above
- Carers: As above
- General Public:
- Educational institutes and staff organisations.

## **12. PHYSICAL, MENTAL, EMOTIONAL AND ENVIRONMENTAL DEMANDS OF THE JOB**

### **Physical Skills:**

- Standard Keyboard Skills.
- Clinical skills in relation to patient care required on occasions, for example manual handling in assistance to mobilise.

**Physical Demands:**

- Extended standing, walking or sitting depending on demands of shift.

**Mental Demands:**

- Frequent interruptions whilst dealing with constant changes to workload demand and prioritisation.
- Maintenance of precise and accurate records and report writing.
- Frequent interruptions from patients / relatives / team members.
- Concentration required when participating in lengthy meetings, developing accurate reports and analysis of data
- Communication difficulties (multidisciplinary, multicultural, deaf, blind)

**Emotional Demands:**

- Communicating with distressed/anxious/worried patients/relatives.
- Communicating complex issues with the multidisciplinary teams.
- Motivating and supporting junior staff / colleagues in the work environment.

**Working Conditions:**

- Potential exposure to verbal and physical aggression from patients and relatives or other visitors on a weekly basis
- Requirement to travel to meetings offsite on a weekly basis.

**13. KNOWLEDGE, TRAINING AND EXPERIENCE REQUIRED TO DO THE JOB**

Registered Clinician e.g. RGN, AHP

Degree in relevant subject: Nursing/ Allied Health Professional

Evidence of management, education and training e.g. completion of Leading Better Care Modules, Institute of Leadership and Management (ILM).

Knowledge of discharge planning processes and Locality provision of services across Lothian

Knowledge of Scottish Government Definitions and coding of Delayed Discharges for data Analysis

Effective communication and interpersonal skills

Time management and organisational skills

Experience of staff and financial management

Evidence of management, education and training

IT skills and reporting skills.

TRAK SKILLS

#### **14. JOB DESCRIPTION AGREEMENT**

A separate job description will need to be signed off by each jobholder to whom the job description applies.

Job Holder's Signature:

Date:

Head of Department Signature:

Date: