Worcestershire Acute Hospitals NHS Trust

Standard Operating Procedures

General Medical SLT Caseload Inpatient Referral Process

Written by:	SLT Leadership Team, Sarah Empson (SLT General Medical Inpatient Team Lead)
Approved by:	Therapy Clinical Governance Meeting
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Reviewed by:	
Speech and Language Therapy Leadership Team - approved	02/03/2022
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Date:	Author(s):	Changes:
01/11/2021	Morag Inglis	Initial draft
20/01/2022	Sarah Empson	Full document for SLT leadership feedback
09/02/2022	Sarah Empson	Updated document for SLT Team feedback
10/03/2022	Sarah Empson	Changes from SLT Team meeting: document approved.

Aim and scope of Standard Operating Procedure

1.0 Introduction

Speech and Language Therapy (SLT) is a small team who work across a number of inpatient specialties across both Worcestershire Royal and Alexandra Hospitals. We have decided to process map current practice in order to develop a shared, efficient system of managing SLT General Medical inpatient referrals whilst avoiding delay and duplication. In sharing a new process, staff across the hospitals will be able to support the other's function at times of additional demand. SLT Stroke and Head and Neck Cancer referrals are managed differently (please refer to the SOPs for these caseloads for details).

2.0 Purpose of Guidance

- Streamline process for efficiency and best practice, across both acute hospital sites.
- Decreased variation in practice and avoiding confusion arising from this.
- Starting with this general medical inpatient SLT caseload SOP which will later be adjusted and updated to include the stroke inpatient SLT caseload.
- Does not include head and neck cancer SLT inpatients.
- To help induct new starters, bank workers, qualified and support workers.

- To facilitate/ train independence in Band 6 and above.
- To ensure that referrals are managed in a timely and efficient way.
- To help develop targets for processing inpatient referrals and systems to monitor these.

Target Staff Categories

3.0 SLT support workers and clinical staff involved in inpatient processes.

Key amendments to this Standard Operating Procedure

Date	Amendment	Approved by:
March 2022	New document approved	Therapy Clinical Governance Meeting
5th June 2025	Document extended for 6 months to allow time to fully review.	Andrea Milton

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4.0 Process of caseload prioritisation/triage and caseload allocation

CASELOAD PRIORITISATION:

Ideally 2 therapists will be responsible for General Medical morning prioritisation at WRH. The Alexandra General Medical caseload can be prioritised by one SLT, or if not staffed this can be managed remotely via WRH. Those prioritising the caseload will usually work 8-4 to allow caseload allocation as soon as possible and allow time for movement between sites if needed for cover. On Bank Holidays, staff cover may be reduced and may cover more than one caseload, but a brief prioritisation will still occur and there may still be contact between sites to agree whether a change in site is needed to optimise cover and capacity.

4.1 Local standards/remit:

See APPENDIX 1 for details of local standards/remit related to caseload prioritisation/triage and caseload allocation.

4.2 Check for new referrals or reprioritisation/escalation information (see 5.0 for details)

- Phone messages
- ICE referrals
- Generic email

4.3 Supporting information and history for new referrals:

Staff should attempt to gain the information necessary to know the reason for referral, urgency and any risk. This should be included in the ICE referral if completed correctly. Get additional background information for any patients you are seeing, if needed, via phone call/email with community SLT, CLIP, PACS (CLIP will identify if patient has had input from relevant specialisms e.g. ENT, gastro, neuro, and it may be patient has had investigations e.g. barium swallow, OGD, videofluoroscopy. Please do not assume the referral has all relevant information – checking background and knowing the patient is the responsibility of the assessing clinician. Continuity of care should help optimise the time spent on this essential aspect of care.

See APPENDIX 2 for more detail.

4.4 Check patient location for discharge planning (to inform the urgency of tasks arising) and to improve efficiency of caseload allocation:

See APPENDIX 3 for details.

4.5 Establish relative urgency and priority for patients/tasks:

The SLT Department operates an escalation system which adjusts SLT processes and standards according to the level of demand and cover/capacity/workload in the department. The level of escalation (green, yellow, amber, or red) is set in response to changes in demand and capacity/cover by agreement by Band 7/8 SLTs, and changes to practice are described. This document will be included in APPENDIX 4, below.

- SLTs should be mindful of the current SLT escalation level and implications for urgency/priority when organising the caseload.

- If when checking messages, there are absences, SLTs should consider whether this means escalation level may need to change, and discuss this with a Band 7/8 SLT if they feel this is the case.

See APPENDIX 4 for details.

4.6 Caseload allocation to therapists/support-workers:

The caseload and tasks for the day should be assigned to therapists/support-workers as soon as possible and before 9:00 to allow staff to optimise time management and reduce delays for patients.

A guide to allocating the caseload and tasks can be seen in APPENDIX 5.

This includes: how many any what kind of patients staff members would be expected to see; how to prioritise direct clinical care (DCC - direct clinical contact, indirect clinical contact of different kinds), and professional supporting activities (PSA), consider other relevant factors (eg: students); and the process for prioritisation.

5.0 Receipt of referrals

5.1 Telephone referrals are not accepted unless there is no other option or it would cause an unacceptable delay to request ICE referral.

The phone will be checked first where possible as staff absence messages may change cover and affect capacity and this should be taken into account as soon as possible.

See APPENDIX 5 for more detail about telephone referrals.

5.2 Internal referrals will be via ICE wherever possible.

ICE REFERRALS:

All inpatient referrals should now be received via ICE, exceptions are referrals from ED (Emergency Department aka Accident and Emergency/A&E)/EAC (Emergency Ambulatory Care) and ASU (Acute Stroke Unit).
Head and Neck SLT have a separate system for referrals and are not using ICE.
If referral received via phone contact the ward and request ICE referral.
Write front sheet/print ICE referral.
Accept, or reject referral. Be mindful that wards usually do not check the system after referring, consider calling the ward if rejecting or querying a referral to ensure the ward are aware, ensure this is documented (on front sheet and via email if appropriate).
Add patient to spreadsheet and CLIP worklist.
The ICE referral process for ward staff/SLTs is described in the IT Training intranet page for the Trust, in the ICE section, via the links to the ICE Referrals User Guide and ICE Referral e-Learning package.

5.3 Group/generic SLT email account SPEECHLANGUAGETHERAPY (WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST) wah-tr.SpeechLanguageTherapy@nhs.net is monitored daily for referrals from the community SLT department or other out-of-trust inpatient referrals.

GENERIC EMAIL:

Check and action relevant **inpatient or general** emails from WRH base.

The SLT Support Worker will be checking and actioning the generic email during the day. Please ensure the emails are checked when the Support Worker is not in work.

Leave emails relating to voice, head and neck or dysphagia outpatients as 'unread' so the appointed therapist is aware these have not yet been actioned.

Email should be checked 3 times a day: morning, lunchtime, afternoon. Additional checks as able.

Move actioned emails to relevant archive folder.

Where an email has not been actioned, please ensure its status remains is 'unread' so that the need to action it is obvious to the next therapist accessing the generic email box.

6.0 Documentation/organisation: use of spreadsheet and worklist.

6.1 CLIP WORKLIST:

Used to check the location of patients, which aids the prioritisation process.

Add/remove patients as appropriate.

Check patient location against front sheet – update any changes on front sheet/spreadsheet.

Patient may show as having a location which is in the community – hover cursor over the bed icon to check, don't assume that only patients with no location showing have left hospital.

Check location of monitor for discharge patients/patients awaiting letters – if patient has been discharged from acute hospital check Oasis for discharge date and location. Update front sheet/spreadsheet. Transfer front sheet to 'Letters' file for letter to be actioned.

If there is an empty bed space next to patient's name and no obvious front sheet – find out if we have completed all actions required e.g. have we already discharged them; check against spreadsheet – are they in green (indicating patient has been discharged)?

6.2 SPREADSHEET:

Microsoft Excel spreadsheets are used to record all inpatients referred to our service. These are saved in the shared drive, and are used to manage the caseload and as a summary reference regarding our contacts/input with discharged patients.

See APPENDIX 7 for details regarding the spreadsheet.

7.0 Referrals on and handovers: ensuring duty of care is discharged.

7.1 LETTERS:

Referrals on, handovers, and discharges are documented. This ensures safe care, no delays and that duty of care is discharged.

There must be an official record of this, for general medical inpatients this is done by letter.

See APPENDIX 8 for details of how letters are managed.

7.1.2 Monitor for discharge:

This category of patient case management includes patients for whom there is no active input but who require some further action before duty of care is discharged.

See APPENDIX 8 for details of how monitor for discharge is managed.

7.1.3 Acute hospital discharges:

Patient's are 'discharged' from the caseload when no active input is needed and the duty of clear is closed, or when the patient is discharged from hospital (where we are referring on or transferring the duty of care).

See APPENDIX 8 for details of how discharges are managed.

7.2 PHONE CALLS:

Phone calls are used to handover where the EDS is incorrect or other details need to be corrected or handed over quickly for patient safety, or (in special circumstances) when a telephone review is planned for a patient.

See APPENDIX 8 for details of how phone calls are used in management of inpatient caseload.

APPENDIX 1:
Speech and Language Therapy (SLT) inpatient referral process

4.1 CASELOAD PRIORITISATION: Local standards and remit

CASELOAD PRIORITISATION:
Ideally 2 therapists will be responsible for General Medical morning prioritisation at WRH. The Alexandra General Medical caseload can be prioritised by one SLT, or if not staffed this can be managed remotely via WRH. Those prioritising the caseload will usually work 8-4 to allow caseload allocation as soon as possible and allow time for movement between sites if needed for cover. During bank holiday cover there may be reduced staff but a brief prioritisation will still occur and there may still be contact between sites to agree whether a change in site is needed to optimise cover and capacity.

4.1 Local standards/remit:

- Patients who are NBM without enteral feeding, must be seen on the day of referral unless referrals are received late afternoon (after 15:30, or 15:00 if all staff on site are working 08:00-16:00).
- Every attempt is made to see new referrals on the same day where relative urgency and capacity allow.
- Patients who are 'discharge dependent' (to go that day if seen by SLT) will be prioritised as urgent, and this will be documented.
- Dysphagia referrals are seen within two working days. (Monday-Friday).
- Communication referrals are seen within five working days. (Monday – Friday).
- Requests to escalate or expedite referrals or reviews are responded to as soon as possible, and this will be documented.
- Where it is beyond the control of SLTs to meet these standards, we will inform the ward in order to ensure a plan is in place pending our assessment, and will datix an unacceptable delay (and any other risks for the patient).
- If we are unable to see a patient within remit but can provide advice pending assessment, this will be documented in ward notes. If the SLT is unable to attend the ward to document advice, they will agree with a ward staff member to email (as soon as possible) confirming the advice. The SLT will document in the email that a named staff member has agreed to place the email in the medical notes for accurate and contemporaneous documentation of the advice, and will check they have the correct email address for that person. The SLT will upload the email to CLIP under the inpatient admission. This interaction is recorded as an indirect contact on the spreadsheet but the patient kept in red to highlight that they have not yet been seen.
- Inpatient instrumental assessment reports will be completed the same day where possible for morning assessments, or next day for afternoon assessments. Where this is not possible, all attempts will be made to prioritise the report completion the next working day. There should be documentation in the medical notes that the assessment has occurred, on the same day, and this should state that a report is pending and to contact the SLT Department with any concerns.

APPENDIX 2:
Speech and Language Therapy (SLT) inpatient referral process

4.3 CASELOAD PRIORITISATION:
Supporting information and history for new referrals:

Staff should attempt to gain the information necessary to know the reason for referral, urgency and any risk. This should be included in the ICE referral if completed correctly. Get additional background information for any patients you are seeing, if needed, via phone call/email with community SLT, CLIP, PACS (CLIP will identify if patient has had input from relevant specialisms e.g. ENT, gastro, neuro, and it may be patient has had investigations e.g. barium swallow, OGD, videofluoroscopy). Please do not assume the referral has all relevant information – checking background and knowing the patient is the responsibility of the assessing clinician. Continuity of care should help optimise the time spent on this essential aspect of care.

OASIS feed at risk alerts:
You can check 'staff alerts' on OASIS to see if the patient is fed at risk. This information may also be accessed via a CLIP history check, but occasionally there will not be documentation on CLIP or OASIS alerts that originated with the community SLT service. In that case we can ask community for an email to confirm the patient is feeding at risk, and ensure it is uploaded to CLIP under correspondence. (If you need help in learning how to record feed at risk alerts and community advice, please ask).

CLIP history check:
Check CLIP for SLT correspondence (e.g. with previous recommendations), relevant clinical history (eg ENT or neurology input), Outpatient History sheets from SLT or AHP appointment (Head and Neck/ENT). This may include previous investigations of interest, pending outpatient appointments, infection control status (e.g. Covid) if necessary.

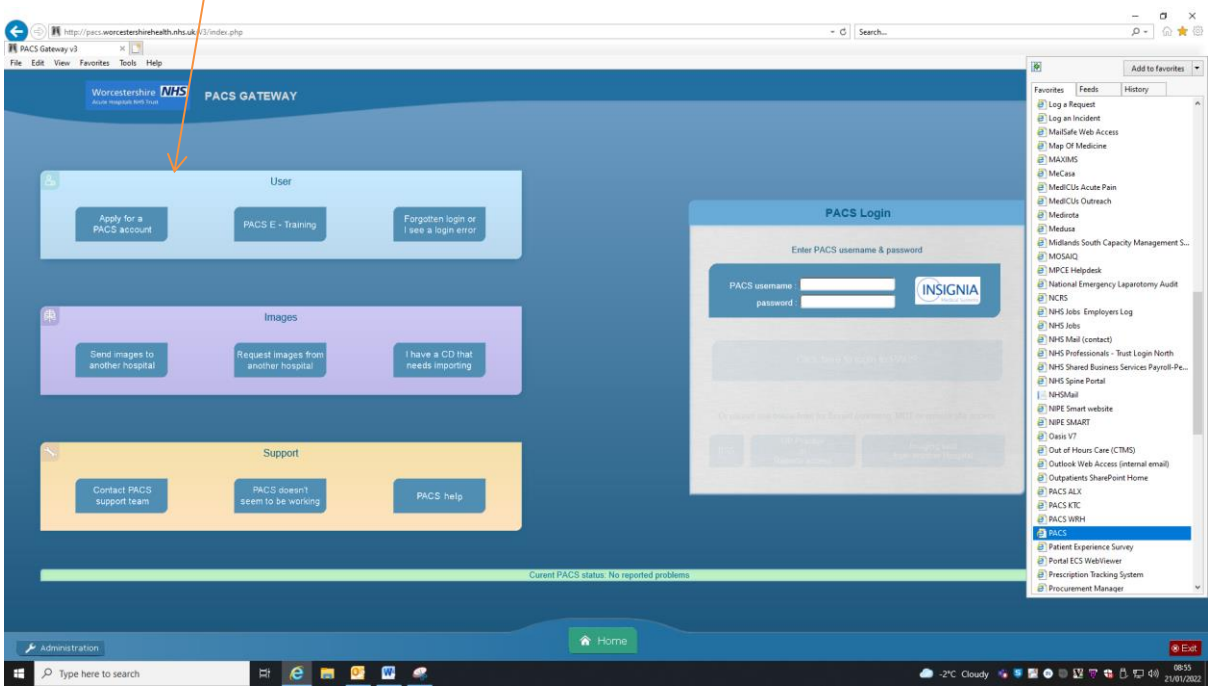
PACS and Unisoft:
If you know it is applicable, PACS can be used to look up results of certain investigations e.g. MRI, x-rays, swallow investigations. You can review the report and images to help inform management. All staff will need to apply for a PACS log-in, via the PACS homepage, in order to do this. PACS can also be accessed via CLIP. Unisoft can be used to access GI (eg endoscopy) reports, via the intranet clinical systems portal or via CLIP (see below). Unisoft will only require your WHITS log-in.

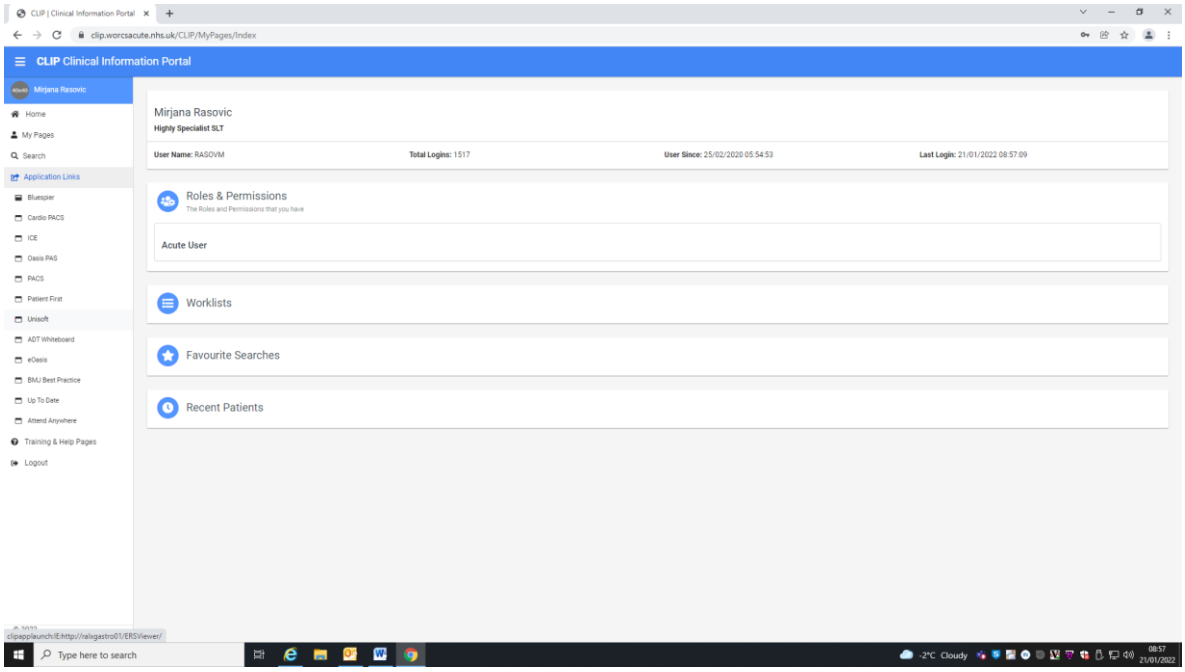
See next page for example.

Community SLT:
If it is apparent that the patient may have had previous SLT input (e.g. they have a progressive condition, they are have been referred to community before by acute, they have recommendations which were not given in acute etc), call or email a Community SLT service enquiring whether they are known to that service and the most recent impressions and recommendations. Please request a reply to the group SLT email as well as yourself or others on the caseload that day, to avoid delay in case of leave or absence.

Bear in mind that the Community Stroke Team, the Community SLT service and the Learning disability (LD) SLT service are different services/contact details. See blue address book in office or list of community contacts on shared drive for contact details.
For patients with LD, you may need to print out the most recent eating and drinking guidelines (these are very specific), attach an SLT copy to the front sheet and bring a copy to the ward for the medical notes /ward staff. You can also contact the LD CNS in the acute trust to get access to information.

All staff need a PACS log in in order to access images.





Unisoft requires your standard WHITS log in, and gives you access to all upper GI/ endoscopy results

APPENDIX 3:

Speech and Language Therapy (SLT) inpatient referral process

4.4 CASELOAD PRIORITISATION:
Monitoring patient location to ensure efficient working and timely handover/discharges:

- Check CLIP worklist for patient location of active caseload (see 6.1)
    - To ensure optimised efficiency of working (e.g. stay on a ward/area if possible, avoid wasted time going to new locations) and prioritise discharge letters or urgent handovers. Ensure any ward changes are recorded on the spreadsheet. If changing site you can cut and paste between SLT Gen Med spreadsheets – which is why they are to remain identical in formatting.
- Create a caseload list for the day:
    - Update spreadsheet (see 6.2) use the sort function (to re-organise patients by review date) and print selection for patients to be seen that day. Check your front sheets (which are kept in the filing cabinet) against your spreadsheet list to ensure numbers and names correlate and no-one is missed.

APPENDIX 4:
Speech and Language Therapy (SLT) inpatient referral process

4.5 CASELOAD PRIORITISATION:
Demand, cover, capacity, workload, and escalation plan as it relates to prioritisation/triage of the caseload, and task allocation:

The SLT Department operates an escalation system which adjusts SLT processes and standards according to the level of demand and cover/capacity in the department. The level of escalation (green, yellow, amber, or red) is set in response to changes in demand and capacity/cover by agreement by Band 7/8 SLTs, and changes to practice are described. See below for a copy of this document. Updates regarding changes in escalation levels are cascaded via email.

- SLTs should be mindful of the current SLT escalation level and implications for urgency/priority when organising the caseload.
- If when checking messages, there are absences, SLTs should consider whether this means escalation level may need to change, and discuss this with a Band 7/8 SLT if they feel this is the case.

Note regarding urgency/priority and discharge planning:
In the SLT escalation plan, it is acknowledged that SLT entries to medical notes should ensure that:

'Documentation clearly states a plan for management and a plan for community follow-up in case a patient is discharged before next review – applies to all escalation levels.'

This should:
1. Allow for criteria-led discharge planning and better patient flow.
2. Help avoid any delays where the patient could be safely discharged on current recommendations but instead the ward team await SLT review prior to discharge.
3. Assure patient safety via clear management plan and recommendations, and documentation of any liaison/education/handouts to ensure patient/family/carers know these recommendations. Any reason acute SLT is essential and the patient cannot safely be managed in the community, must be clearly stated in the management plan.

Speech and Language Therapy "Escalation" Guidelines

These are guidelines and may be adapted depending on circumstances.

Escalation Status	Criteria	Action Required
Green	• All staff present • Staff capacity ≤ caseload demand	• Normal caseload management, all priorities of assessment and reviews seen. • Same day assessment for new referrals. Decide review period based

Green	• Capacity to absorb normal fluctuations in staffing due to training, sickness and annual leave without affecting service provision	on SLT judgement of clinical need. • Documentation clearly states plan for management and a plan for community follow-up in case patient is discharged before next review – applies to all escalation levels. • Time as agreed for non-clinical tasks e.g. service development.
Yellow	• Planned Leave only (annual / study / TOIL) • Staff capacity < caseload demand • OR short term sickness (<1/52) • OR vacancy	• Team to cover absence • Team to prioritise caseload – aim to see high and medium priorities. Defer low priorities. • Next day reviews only if highly likely to have a significant impact on management/discharge. • Therapy (e.g. communication) only for severe impairment or where appropriate based on rehab potential and it is very likely to impact significantly on outcomes or discharge. • Avoid outpatient cancellations. • Consider relative priority of meetings, training, supervision, non-patient-related activity – cancel/postpone as appropriate.
Amber	• Planned Leave PLUS unplanned. • OR exceptional volumes of referrals/reviews. • OR long term sickness (>1/52) • OR >1 vacancy.	• Senior SLT to liaise across sites/caseloads re capacity – consider distributing staff or patients across one combined caseload for specific days or the week. Inform SLT manager. • See high priority patients. Medium priority if capacity allows. • Assessment for new referrals within RCSLT guidelines (2 working days). • No therapy. • No extra advocacy work (e.g.: monitoring tolerance/compliance, chasing referrals/meetings/feeding management decisions. • Consider risk to patient of non-attendance of MDTs and family meetings. Handover SLT input unless SLT presence is essential for changes in management plan, discharge planning, etc. • Consider limiting participation in SNNAP and other trust-level or national service delivery standards. Communicate any significant change to SLT manager and relevant others, including any associated risks. • Consider re-assigning new outpatients (not yet seen) or urgent follow-ups to another therapist if their usual provider will not be available within the month. If usual provider is away more than 2

		months, reassign follow-up outpatients to other therapists as capacity allows. • Cancel non-essential: meetings, training/CPD (not mandatory training), non-clinical activity (e.g. service development).
Red	• Planned Leave PLUS unplanned leave for >1 staff member. • OR exceptional volumes of high priority referrals/reviews. • OR long term sickness (>1/12) • OR >2 vacancy.	• SLT Manager to consider pooling staff across caseloads and operating as one combined caseload for a week or more. • See new or high priority patients once only and discharge if stable on recommendations, with a request for re-referral if review is very likely to make a significant change in patient experience, management plan, or discharge planning. • No therapy. • Cancel all outpatients except category 1 urgent outpatients. Follow trust process. • Documentation clearly states management plan and/or community follow-up with the clear expectation the patient will not be seen before discharge to the community. • Halt participation in MDTs and family meetings, if time allows give handover of SLT input. Occasionally attendance may be prioritised if SLT presence is essential for changes in management plan, discharge planning, etc. and this cannot be organised through other MDT members or the consultant. • Stop participation in SNNAP and other trust-level or national service delivery standards. Communicate this and any associated risks, via SLT Manager to senior management and relevant others.

NB Trust Escalation Status may also trigger the teams to implement Yellow, Amber or Red actions.

- Team status to be determined by Senior SLT, as warranted.
- Changes to status to be cascaded via email.
- Avoid issues in leave approval that will trigger an increased escalation level where possible.

APPENDIX 5:
Speech and Language Therapy (SLT) inpatient referral process

4.6 CASELOAD PRIORITISATION:
Brief guide to caseload allocation to therapists/support-workers:

- Aim for 7 patients a day per therapist.
- For a full day a therapist should preferably have a mix of new referrals and reviews. They may have a mix of indirect and direct contact tasks. All tasks will be prioritised and allocated. (E.g.: family meeting equals one new direct contact; 4 letters equal one new direct contact.) Staff should make themselves aware of the relative urgency of patients and tasks. Instrumental assessments may require more time to complete reports etc. in good time.
- Number of patients per therapist to be adjusted based on their other commitments for the day and on patient complexity or need (therapists are responsible for updating the whiteboard with other commitments e.g. training, meetings, to allow for forward planning of cover). Supervision or joint working may influence the number of patients seen and can be adjusted for by agreement during caseload allocation. See below about expectations regarding students. Therapists and support workers should ensure the people prioritising are aware of their other commitments for the day.
- Write the therapist's initials on the printed spreadsheet against the patients they have been allocated.
    - This helps locate the right therapist via bleep if a message about that patient or escalating care is received while they are out of the office.
- Therapists should be going to the wards by 09:00 hours where prioritisation starts at 08:00 hours.
    - If necessary to help achieve this, therapists can be given cases to see while prioritisation is on-going then return to the office for the rest of their caseload.
- Prioritisation is reviewed at lunch time and at any relevant points during the day.
    - Therapists may receive bleeps while on wards if urgent re-prioritisation is needed. Bleeps should be assigned before people leave for the wards so staff can be reached.
- There will be an attempt to ensure continuity of care with a maximum of 3 SLTs for a particular patient during their care journey (except where joint-working is needed or the patient moves to another caseload).
- There will be an attempt to acknowledge the development needs of SLTs especially those who are training or who are leading on a clinical area (e.g.: assigning them patients in their area of specialism or development need where possible).
- The support workers will be allocated clinical tasks within their scope of practice and allowing for their other workload or relative urgency of work for other caseloads. There will be an attempt to plan clinical tasks in the mornings where possible. Where appropriate they will be given a named SLT to discuss outcomes/arising actions with or escalate concerns to, before they leave for the wards.
- Where it is appropriate, joint-working or MDT working may be scheduled depending on cover and capacity, on clinical complexity, or on staff development/support need. This should be agreed before leaving for the wards if possible, but the plan may be changed if demand on the service changes during the day, unless the joint working is essential for patient care.
- During a student's initial 2 weeks with the service, the SLT they are with should take an ordinary caseload in order for students to have a real-world experience of SLT working and realistic expectations. It is acknowledged that teaching/support of teaching of students can place extra demands on SLTs, which may be taken into account in caseload allocation after the initial 2 weeks, especially any scheduled meetings or liaison with the university or other placement educators. See above re supervision tasks.

- Q52 will be recorded on the spreadsheet and front sheet for patients who have a review planned (based on clinical reasoning) but where demands exceeds our capacity to see them on the planned date. This can be recorded by a therapist who has planned to see the patient but been unable to. It can also be recorded in advance by the person prioritising (if it is clear that it is futile to attempt to see the patient based on overall caseload priorities with an expected 7 patients caseload per staff member). (An added benefit is avoiding unreasonable demands or expectations on staff). When there have been two consecutive Q52s, the patient's priority level will be raised one level. If an attempt is made to see the patient but direct contact is not possible (e.g. patient at CT, patient refused, etc.) this is recorded with the therapist initials in brackets on the spreadsheet as an indirect/attempted contact and is not a Q52. New referrals do not have an open duty of care until seen and accepted as appropriate for our input, and so are not recorded as Q52s.
- Before the end of the day, based on the updated spreadsheets, cover and capacity is considered for the following day and changes to staff site/location/caseload can be discussed if necessary. For this reason staff are encouraged to update the spreadsheet with review dates before 16:00 if at all possible.

APPENDIX 6:
Speech and Language Therapy (SLT) inpatient referral process

5.0 CASELOAD PRIORITISATION:
Receipt of referrals:

5.1 Telephone: Internal referrals will be taken via telephone only from the Accident and Emergency Department or Ambulatory Emergency Care (because they do not have access to ICE). If the referral is from elsewhere it will only be taken via phone where it would be detrimental to the patient to request the ward refer via ICE (eg: cause unacceptable delays). We can advise staff get advice on how to use ICE from their ward manager, access the IT training user guide for ICE referrals, or, if we have time and capacity, we can help talk them through the process.
The phone will be checked first where possible, as staff absence messages may change cover and affect capacity and this should be taken into account as soon as possible.

PHONE:
Check and action phone messages from WRH base.
Step-by-step instructions for accessing messages and the most recent pin code are on a laminated sheet by the phone. Messages can be checked from other telephones during bank holiday working (the laminated instructions should be left with bank holiday working supplies).
Messages should be checked 3 times a day: morning, lunchtime, afternoon. Additional checks as able.
Therapist checking messages takes responsibility for actioning them or delegating this to avoid delays. Write messages in the message book. Once actioned, mark/tick it in the book or state what is still outstanding. This forms part of the prioritisation process, particularly in the morning. Staff are encouraged to consider leave and other potential causes of delays, when forwarding messages via email.

5.2 Internal referrals will be via ICE wherever possible.

ICE REFERRALS:
All inpatient referrals should now be received via ICE, exceptions are referrals from ED/EAC and ASU.
Head and Neck SLT have a separate system for referrals and are not using ICE.
If referral received via phone contact the ward and request ICE referral.
Write front sheets/print ICE referral.
Accept, or reject referral. Be mindful that wards usually do not check the system after referring, consider calling the ward if rejecting or querying a referral to ensure the ward are aware, ensure this is documented (on front sheet and via email if appropriate).
Add patient to spreadsheet and CLIP worklist.

The ICE referral process for ward staff/SLTs is described in the IT Training intranet page for the Trust, in the ICE section, via the links to the ICE Referrals User Guide and ICE Referral e-Learning package.

5.3 Group SLT email account SPEECHLANGUAGETHERAPY (WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST) wah-tr.SpeechLanguageTherapy@nhs.net is monitored daily for referrals from the community SLT department or other out-of-trust inpatient referrals.

GENERIC EMAIL:

Ensure someone has checked and actioned relevant **inpatient or general** emails from WRH base.

The SLT Support Worker will also be checking and actioning the generic email during the day.

Leave emails relating to voice, head and neck or dysphagia outpatients as 'unread' so the appointed therapist is aware these have not yet been actioned.

Email should be checked 3 times a day: morning, lunchtime, afternoon. Additional checks as able.

Move actioned emails to relevant archive folder.

Where an email has not been actioned, please ensure its status remains is 'unread' so that the need to action it is obvious to the next therapist accessing the generic email box.

APPENDIX 7:
Speech and Language Therapy (SLT) inpatient referral process

6.2 CASELOAD PRIORITISATION:
Spreadsheet:

Microsoft Excel spreadsheets are used to record all inpatients referred to our service. These are saved in the shared drive.

There is a separate spreadsheet for WRH and ALX. These should be formatted the same so patients can be copied and pasted between spreadsheets on transfer between sites. Stroke caseload patients are on a separate spreadsheet document.
A new spreadsheet is created at the beginning of each month. Past spreadsheets are archived and may be used to deal with enquiries about our contact with patients.

The spreadsheet is colour coded to delineate the patient's journey with our service.

Colour	**Meaning**
Red	New referral, not yet seen.
Black	Active on caseload – for General Medicine inpatient review.
Pink	Stroke active on caseload.
Blue	Phone review (left hospital, not yet discharged from our caseload – open duty of care).
Orange	Letter needs to be written and/or sent.
Purple	Monitor for discharge – patient not on active caseload, letter has been drafted.
Green	Discharged – patients who do not/no longer need SLT as inpatient or who have been discharged from hospital and all actions completed e.g. letter sent, onward referral made. Closed duty of care. May include patients who are deceased/RIP.

Therapists are responsible for updating the spreadsheet when they have seen their patients.
NB only put the date in the review date column otherwise the sort function doesn't recognise won't recognise it and a patient could be missed.

During the day as patients are seen, the spreadsheet should be updated. See above re Q52 for planned reviews not seen. See above re next day cover and capacity.

Review dates are added based on clinical reasoning. Next day review should only be for urgent or very unstable patient reviews where care is likely to change as a result. For stable patients the 'discharge to assess' (DTA) model may be used if needed (see Escalation plan, inserted above (4.5).

APPENDIX 8:
Speech and Language Therapy (SLT) inpatient referral process

7.0 CASELOAD PRIORITISATION:
Referrals on, handovers, and discharging duty of care:

7.1 LETTERS:

Referrals on, and handovers, and discharges are documented. This ensures safe care, no delays and that duty of care is discharged.

There must be an official record of this, for general medical inpatients this is done by letter. Where a patient is back at baseline and if there is no need to liaise with anyone about their episode of care, the discharge can be documented only in the medical notes without a letter. Email referrals are accepted by LD SLTs but must be uploaded to CLIP in correspondence as an official record.

Letters must include the current impression and recommendations (e.g. dysphagia type/severity, IDDSI levels, how to facilitate communication, etc.), risk/safety advice (e.g. supervision need, feeding at risk advice, etc.), and any requested follow-up actions (e.g.: SLT review of swallow/communication (state the urgency); prescription of thickener; consideration of syrup or non-oral medications etc.). If the patient is back to baseline and no requests are being made, state why you are writing (e.g.: for information about patterns of fluctuation in swallow for patients with progressive conditions, etc.).

Information leaflets regarding recommendations (e.g. Dysphagia Passport, IDDSI Diet sheets) can be included if helpful, if they are included with the letter or have already been given on the ward, refer to this in the letter. If education was given (e.g. dysarthria advice sheet; call to family regarding thickening drinks) include this in the letter.

Therapist most involved with a patient to write the letter wherever possible if this does not cause delays.

Templates are available for drafts and on Bluespier for feed at risk advice letters, discharge letters to GP, referral to community SLT (which can be adjusted for LD SLT referrals), and community stroke team referrals.

7.1.2 Monitor for discharge: This category of patient case management includes patients for whom there is no active input but who require some further action before duty of care is discharged.

On completion of active patient management, a letter should be drafted on the same day. Where this is not possible e.g. due to low staffing capacity, then aim to draft the letter the next working day. Draft letters are written in a Word document and saved in the shared drive. Update the spreadsheet with your initials and 'letter drafted' in the date box. Change the patient to purple where a letter has been drafted. Leave patient in orange if letter still to be drafted.

7.1.3 Acute hospital discharges:

Patient's are 'discharged' from the caseload when no active input is needed and the duty of clear is closed, or when the patient is discharged from hospital (where we are referring on or transferring the duty of care).

Letters need to be finalised and sent within 2 working days of our knowledge of the patient's discharge from hospital. If a letter has been drafted then transfer the contents to Bluespier. If no letter has been drafted then compose the letter directly on Bluespier. After writing the letter directly on Bluespier you

should go to 'dictation and documentation' to ensure the letter is checked, uploaded and removed from the list.

Ensure a safe and timely handover (via telephone) to people for any urgent or safety related information that is not on the EDS. If the handover is to the GP, the electronic system should be rapid, and a phone call is only required if the specific GP is not using the electronic system. (See below 7.2). This handover can be documented in the discharge/referral letter including any attempts to call where you were unable to get through. You must check the letter content is accurate before sending – compare EDS information with SLT information. Complete a Datix where the EDS is incorrect for SLT eating and drinking recommendations; use heading of 'Nutrition and Hydration Incident' in the 'Incident Description' section if available. Send the letter to all relevant parties. When letters are cc'd and the GP is not automatically populated from Bluespier (or if the GP does not have access to the electronic system) you will need to print and send the letter. Delete the patient from the CLIP worklist. Update the spreadsheet with your initials and 'letter sent' etc. in the date box and change the patient to green.

7.2 PHONE CALLS:

Phone calls are used to handover where the EDS is incorrect or other details need to be corrected or handed over quickly for patient safety, or (in special circumstances) when a telephone review is planned for a patient.

Where the EDS is incorrect, a phone call should be made to the discharge location to ensure safe handover of recommendations and advice. Include this as an action taken in the datix (see 7.1.3 above). The letter should acknowledge the discrepancy and what is correct, and that our team will report this error. See 7.1.3 above – urgent advice may also need a phone call.

A phone review may be arranged in specific circumstances before full discharge is complete but after the patient has left the acute hospital – see escalation plan 4.5. If planned this is in blue on the spreadsheet see 6.2.