# NHS Choice on Discharge Policy & Guidelines

## Purpose of Agreement

This joint operational policy and guidelines that has been co produced between the providers: - Solent NHS Trust, Southern NHS Trust, University Hospital Southampton Foundation Trust, Southampton City Council, Hampshire County Council.

The policy aims to support people to transfer out of the hospital at the appropriate time, by describing the process by which choice of discharge destination for an individual (and/or their representatives’) will be managed.

## Document Type

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## Reference Number

SNHS Trust/Policies/Clinical Policies/CLS07

## Version

Version 1

## Name of Approving Committees/Groups

- NHS Litigation Authority & Operational Policy Steering Group (Solent) and as per Southern Health/UHSFT organisational arrangements.
- HCC DMT
- SCC Management Team
- SW Unscheduled Care Delivery Group

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## Document developed in consultation with

List the main groups/staff that were consulted with during development

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CHOICE ON DISCHARGE POLICY

1. INTRODUCTION & PURPOSE

1.1 The need to decide to accept care or support at home or live in a nursing or residential care home is a major decision that is often made at a time of considerable change in personal circumstances including adjustment to disability, increasing dependence and potential erosion of social networks. This document is designed to offer guidance and support and a framework in which staff should work with individuals and their representatives.

1.2 When individuals no longer need hospital care there are risks associated with remaining in this environment including the risk of hospital acquired infection and social isolation. Even so, it is essential that people access alternative care and support services in a timely way to ensure the NHS can make hospital services available when people need them.

1.3 When a reablement/residential/nursing placement is required, most people will wish to wait for a place in the home they have chosen and they may be concerned about the possibility of moving to an interim placement until the home of their choice is available. Individuals requiring care or support at home may also have particular wishes about how and by whom this care is provided.

On occasions individuals decline the options that are available and continue to remain in hospital beyond the time that their care needs require. Sometimes it is not until the Individuals or their representatives consider the option of interim arrangements. All staff has a responsibility to refer to social care at the optimum time so that the discharge plan is formulated and agreed as early as possible.

1.4 This document is designed to offer guidance and support and a framework in which to work with individuals and their representatives.

1.5 The aims of the policy & guidelines are to ensure that:

- Planning for safe, effective transfer of care, in collaboration with the person, their representatives and all members of the Multidisciplinary Team (MDT) will be commenced at or before admission.
- Hospital beds will be used appropriately and efficiently for those people requiring in-patient care.
• When individuals no longer need in-patient care and their first choice of nursing or residential care home or community carer is not available, a timely decision will be made regarding an interim care provider or location. The process of offering choice of care provider on discharge and/or discharge destination will be followed in a fair and consistent way throughout the Trust and there will be an audit trail of choices offered to individuals.

• Where the individual lacks the mental capacity to decide their discharge destination and there is not Limited Power of Attorney (LPOA) in place for welfare the principles and guidance within the mental capacity Act 2005 will apply.

2. SCOPE & DEFINITIONS

2.1 This document applies to all directly and indirectly employed staff within Solent NHS Trust, Southern Health NHS Foundation Trust (SHFT) University Hospital Southampton Foundation Trust (UHSFT) and other persons working within the organisations in line with Trust’s Equal Opportunities document. From this point forward the generic term ‘organisation’ will be used to refer to the Trusts covered by this document. The document also applies to all staff within Southampton City Council (SCC) and Hampshire County Council (HCC) directly involved in hospital discharge Individuals from SHFT, Solent or UHSFT.

2.2 This policy and guidelines are relevant to all individuals and/or their representatives involved in making decisions regarding choice of discharge destination and/or care provider on discharge from hospital. The process applies equally to everyone regardless of whether they need ongoing health or social care or whether or not their care and support is publically funded.

2.3 It is not intended that this guidance should apply where individual/relatives/carers/advocates are challenging an eligibility decision with regards to NHS Continuing healthcare. In these circumstances, please refer to the joint eligibility criteria for NHS Continuing Healthcare agreed by the Hampshire Clinical Commissioning Groups, Hampshire County Council and Southampton City Council.

2.4 It is not intended that this guidance should apply if there is a dispute about treatment that is perceived to have not been concluded by the Hospital. If this is the case the onus is on Hospital staff to resolve this directly with the person in dispute.

2.5 Definition of Patient Groups

2.5.1 Where there is reference to the person / individual, this also refers to individuals, clients or service users.
2.5.2 This guidance applies to individuals who have finished their treatment and who are medically fit and transfer ready regardless of the source of funding for care, and includes individuals who are funding their own placements or care and support.

2.5.3 This policy guidance applies to individuals/their representatives who are required to make a decision regarding choice of discharge destination, time or care provider after a period of in-patient care within one of the organisations covered by this policy. Discharge should take place when the person has been assessed as fit, ready and safe for discharge from hospital and may include discharge to their own home with support or to a placement in a nursing or residential care home funded by the patient, NHS continuing health care and/or social care.

2.6 Definition of Terms

Carers Assessment – the statutory assessment of a Carer to identify support needs and how these needs will be met
CCG – Clinical Commissioning Group
CHC - NHS Continuing Healthcare
CQC - Care Quality Commission
Delayed Transfer of Care (DToC) – A delayed transfer of care occurs when a patient is medically fit, safe and ready for transfer from a hospital bed but is unable to be discharged due to one or more reasons (e.g. awaiting a placement).
Discharge - The process whereby a person is discharged from an NHS Trust providing acute, community or mental health & learning disability services or independent sector providers of NHS care. Hospital discharge should be viewed as a process rather than an event.
EDD – Estimated Discharge Date: A target date by which time it is predicted that the individual should be fit/stable, ready and safe to be discharged. All agencies will apply the discharge process simultaneously to ensure that discharge occurs on the target date.
GP – the General Practitioner with whom the individual is registered
IMCA - Independent Mental Capacity Advocate
MDT - Multidisciplinary Team – A team of health and social care professionals involved in the individual care and assessment of each person.
LA – Local Authority
Medically Fit - Clinically fit / stable, ready and safe for transfer.
PALs – Patient Advocacy and Liaison Services
Representative - In this policy this is taken to mean the individuals preferred family, next of kin, advocate or other named representative.
**Safeguarding** - The term refers to expected response of all staff to cases of suspected or actual incidents of abuse.

**Self funder**: A person who financially meets the full cost of their social care needs, whether because their personal financial capital exceeds the threshold for public funding or because they or a representative choose to pay for their care.

**Social Care Assessment** - Under the Community Care Act (2003) all individuals are entitled to an assessment of their social care needs.

**SW** - Social Worker or Care Manager allocated by Adult Services.

**Transfer** - The process whereby a person is moved between clinical areas/departments on a temporary or permanent basis within the organisation; or as a result of the decision to transfer the responsibility for care and support to another organisation.

3. **PROCESS & REQUIREMENTS**

3.1 **General principles**

3.1.1 The hospital environment is not designed to meet the needs of people who have reached their potential for discharge. The consequences of people remaining in a hospital bed beyond the Estimated Date of Discharge (EDD) are:

- The risk of increasing dependence, and greater demand for social care and support in the community.
- Potential for prolonged exposure to an unnecessary risk of healthcare associated infection.
- Whole system pressure as people are unable to access a more intensive environment
- Failing to meet the expectations of individuals and their representatives.

3.1.2 Individuals and/or their representatives may find it difficult to choose a discharge destination or care provider for many reasons including:

- Alternative perceived as an inconvenient location
- Uncertain timescale
- Uncertainty about quality or cost of care
- Anxiety
- Strong, sometimes unrealistic expectations of their ability to cope
- Time needed to come to terms with change of circumstances
- Mental capacity issues
- Ethnic or religious beliefs that limits providing a certain type of service

3.1.3 In managing choice on discharge the following general principles should be applied:
• Individuals will continue to receive the appropriate level of care whilst in hospital.
• Equity and fairness.
• Risk assessment of the individual and their circumstances is applied by the multidisciplinary team (MDT).
• The MDT will act in the best interests of the individual.
• No decision without individuals, and/or where appropriate their representatives, being involved. Consideration will be given to the need for an advocate or IMCA in these circumstances.
• Legal frameworks adhered to; the individual is kept informed, verbally and in writing of all reviews and assessments that have taken place and the rationale for decisions.
• Contemporaneous records will be kept and confidentiality maintained.
• Adult safeguarding policies will apply

3.1.4 When a person is fit for discharge or transfer they should have already considered their on-going care provision. This relies on clear communication by the MDT or named worker.

3.1.5 If their preferred choice is not available the emphasis should be around support and guidance. This may mean offering an alternative location or care provider whilst the individual await availability of their first choice. The NHS Trust, the individual’s LA and/or their CCG will work jointly to offer support and choice.

3.1.5 People who are “self-funding” care will be provided with the same advice, guidance and assistance on choice as those fully or partly funded by their LA/CCG. This should include signposting to social care information and websites such as Care Choice and CQC website to support discharges and choice. If such persons refuse to accept advice, guidance and assistance from the Local Authority, the Local Authority will then have no responsibility for the hospital discharge unless there are specific safeguarding concerns.
### 3.2 National Guidance

#### 3.2.1 This is not a new problem. Figure 1 below illustrates the policy environment 2000 to 2007

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| 2007 | The Commissioning Framework for Health and Wellbeing: Guidance
      | The Local Government and Public Involvement in Health Act 2007 |
| 2006 | Our Health, Our Care, Our Say: a new direction for community services (White Paper) |
| 2005 | Independence, wellbeing and choice: Our Vision for the Future of Social Care for Adults in England (Green Paper) |
| 2004 | Local Area Agreements Guidance |
| 2003 | National Assistance Act 1948 (as amended) |
| 2003 | NHS Act 1948 (as amended) |
| 2003 | Community Care (Delayed Discharges etc) Act 2003 |
| 2002 | NHS Performance Indicators: Total time in A&E, four hours or less, March 2002 |
| 2001 | Reforming NHS Financial Flows: Introducing payment by results |
| 2001 | Health and Social Care Act 2001 |
| 2000 | The National Service Framework for Older People |
| 2000 | The Local Government Act 2001 |

#### 3.2.2 There are numerous legislation and guidance that are relevant to the procedures and processes MDTs operate. These include:

- National Assistance Act 1948 (as amended)
- NHS Act 1948 (as amended)
- Department of Health
- Carers Act 2003
- Mental Health Act 2005
- Our Health Our Care Our Say
- Human Rights Act
- Mental Capacity Act 2005
- Local Authority Guidance
3.3 Process

3.3.1 The MDT will follow the guidelines set out within this document and within the organisation's admission, transfer and discharge policies, taking a proactive approach to managing choice of care.

The discharge plan should be developed whilst the individual still requires hospital care. It is key that the MDT should fully involve the individual and their carers. The discharge plan will include an agreed EDD. The MDT will determine when the person no longer requires in-patient hospital care and is fit/stable, ready and safe to leave hospital.

3.3.2 There are occasions when the preferred care provider or location is not available, such as when the patient's own home is not ready (e.g. it might require adaptation, cleaning or refurbishing) or a preferred care home may have no vacancies. Individuals have the right to refuse available care options or locations; however individuals cannot remain in a hospital bed just because their preferred option is not currently available.

**STAGE 1 – GIVE STANDARD INFORMATION ON ADMISSION**

a. Written discharge planning information will be given to all adult individuals or their representatives on admission. The named nurse or an equivalent role will discuss the content with them to ensure that they are aware of the hospital policy regarding discharge and choice. Both the leaflet and notification letters (see appendices 1-4) should stress the expectation that individuals will move out of hospital as soon as their need for inpatient treatment ends.

b. All individuals will have a recorded Estimated Date of Discharge (EDD) set on admission and they will be kept informed of any changes. The EDD highlights when support will be required to facilitate discharge at the earliest opportunity.

c. For individuals in Mental Health settings the discharge date and destination will be set and agreed through the Care Programme Approach (CPA) review process by the specialist mental health services. The Section 117 requirements will also be assessed in a timely manner.

d. For those people in general settings without capacity the process will involve relatives and advocates as required under the MCA framework.
e. The named nurse (or equivalent role) will coordinate all stages of the patient’s progress. The discharge planning process will be led at ward level by the multidisciplinary team, who may be assisted by a discharge facilitator/coordinator where available. This process relies on liaison at the earliest opportunity with all professionals currently involved in the person’s care and those who need to be involved after discharge and agreeing the transfer of responsibilities on discharge.

f. A “Section 2” referral to the patient’s LA for a community care assessment will be made and a Continuing Health Care (CHC) checklist will be completed as soon as the patient’s likely needs on discharge can be gauged and are stable. The MDT will not wait until a patient is fit, ready and safe for discharge to complete a CHC checklist.

STAGE 2 – DURING ADMISSION: ASSESS LIKELY CARE NEEDS ON DISCHARGE

a. On receipt of the “section 2” a Social Worker/Care Manager will be allocated where appropriate.

b. On completion of all relevant assessments the Multidisciplinary team (including the social worker) will agree the EDD and this is communicated to the individual and their carer / and or representative.

c. If on-going care and support is required the MDT consideration must involve Social care this care and support may then include:

- reablement at home;
- reablement in bed based setting;
- on-going domiciliary care and community health support in the patient’s home;
- short-term nursing or residential care home placement e.g. when adaptations required at home or long-term nursing or residential care home placements.

d. Any decision should always include the individual and/or their representative and if necessary an advocate. Assessments at this stage should include consideration of whether interim arrangements are appropriate if the patient’s first choice of care provider is not available. This will include a full risk assessment (including mortality) on the issues related to the potential move on to their discharge destination. This assessment should take into consideration the patient’s mental capacity and best interests.

e. If the CHC checklist indicates that the patient meets the criteria for a full assessment then it should be undertaken using the Decision Support Tool (DST).

f. The Social Care representative will give the patient and/or their representative comprehensive information regarding the range of care providers and/or locations available in the requested area at the earliest appropriate stage. The patient and/or their representative should be advised on likely availability and waiting times, costs, and on their right to seek inspection reports from the CQC.
g. Unless someone is returning to a placement the discussion about care homes should be led by the Social Care representative. All staff should be mindful of problems resulting from lack of availability, costs of placement, capital depletion and Social Care limits on funding. Reference to the Carer’s Together pamphlet would ensure that individuals are made aware of relevant issues.

A lack of vacancies can result in long waiting lists for some of the more popular care homes. The individual and/or their representative should be helped to make informed choices that can be realised within the timescales required. If the choice of care homes is severely restricted, the individual may be asked to consider a move to an alternative care home on an interim or even permanent basis. The care homes chosen may be ranked in order of preference but all choices should be pursued simultaneously.

h. Where a patient is assessed as needing to move to a care home, in all cases where suitable and if resident in Southampton they should be offered the Care Closer to Home service.

i. Where there are financial issues, general advice will be provided by the Social care representative.

j. A financial assessment can be arranged at the appropriate point to avoid unnecessary delay in the discharge planning process. If Social Care confirm a patient’s ‘Self Funding’ status, the named nurse will establish whether the individual already has care arranged and discuss what support if any they require from the LA. The Social Work representative will provide information on the basis of what the people require.

k. The outcomes of the multi-disciplinary assessment will be recorded in the individual records by all disciplines and the person informed that the assessment process has confirmed the level of ongoing care and support required.

**STAGE 3 – PREPARING FOR DISCHARGE**

a. The named nurse/discharge facilitator will ensure that any potential barrier to discharge is discussed at the Discharge Planning Meeting/Multidisciplinary Team meeting.

b. Regular contact will be made with the designated Social Worker or family/advocate to discuss progress, identify any barriers to the transfer and check whether further help is required.

c. Any unresolved issues will be escalated to the Ward Manager

d. If an individual and/or their representative refuse to make arrangements to facilitate discharge, staff involved should make all reasonable efforts to find out the reason for refusal and consult with the most relevant professional so as to resolve any issues.
e. For self-funders the allocated SW/Continuing Healthcare nurse/ward staff should seek to progress, in liaison with the organisation’s staff, the individual and their representative’s practical discharge arrangements as appropriate. If the agreed EDD is reached and discharge has not been realised due to a patient/family choice decision, the patient and/or their representative will be notified in writing that discharge is required within 2 weeks (Template letter 1 at appendix 1).

f. At this stage the MDT must ensure:
   - That the individual (and/or their representative) has had clear explanation verbally and in writing of discharge and on-going care arrangements.
   - All relevant information is available to enable an informed decision to be made.

   g. The Delayed Transfer of Care (DToC) Escalation Process will be followed throughout.

**STAGE 4 – FORMAL MEETING 1**

a. Where there are concerns the named nurse/Discharge Facilitator (or equivalent role) will consult with the MDT and arrange a case conference to discuss the plans for discharge (formal meeting 1). The case conference should take place within 7 days post EDD and where necessary/appropriate include the Social Care representative (for example could be a self funder and refusing Social worker intervention). The individual and/or their representative should be invited to the meeting in writing and the letter should confirm the aims of the meeting, date, time and venue – Template letter 2 at appendix 2.

b. The individual and/or their representative will be given information about the role and function of the Patient Advocacy and Liaison Service (PALS) or organisational equivalent. It could be that a carer’s assessment is required. Or the carer’s issues are referred to a third sector organisation like Carer’s Together or Age Concern.

c. The lead hospital professional should ensure appropriate information and support is available to enable the individual/ or their representative to make appropriate care arrangements.

d. Following the meeting the Chair will write to the individual/ or their representative (see example - template letter no 3 at appendix 3, which should be adapted as required and sent within 24 hours of the meeting). The letter should be copied to all parties present at the meeting and a copy placed in the individual healthcare records.

e. At this meeting a date should be set for a follow up meeting in 7 days, or as near as appropriate, which should be used if discharge arrangements have not been progressed. The emphasis around this meeting is around support, negotiation and resolution and needs to be conducted in a firm but supportive way.

f. The Social Care representative and/or ward staff will continue to support the individual where possible to finalise plans for discharge during this time and will
search for available care options if required. The individual and/or their representative must be given the necessary information, in writing if appropriate, to enable them to make an informed decision.

**STAGE 5 – FORMAL MEETING 2**

a. If further progression with discharge is not made following the initial case conference the Matron will arrange a 2nd case conference by 14 days post EDD (formal meeting 2). Template letters 2 and 3 will be used to invite the patient and/or their representative to the meeting and feedback the outcomes and agreed actions following the meeting.

b. The aims of the meeting will be to discuss any issues preventing discharge and clarify the discharge process. If possible the date for transfer to interim care should be agreed where appropriate.

c. Where there is a dispute relating to the proposed discharge to interim accommodation, MDT members should try to reach a consensus view with the patient and/or their representative. The allocated SW/PCT CHC nurse/ward staff (for self funders) should lead the process of making arrangements for the patient to move on their EDD to the appropriate care home or alternative accommodation.

d. The Head of Service/Division should be informed in cases where a second case conference is needed.

**STAGE 6 – FINAL STAGE: EVICTION PROCESS**

a. If no agreement has been reached about discharge arrangements after stages 1 – 5, the Head of Service will support the Matron to continue plans for transfer to an interim location/care provider. The Head of Service will consult the appropriate Senior Manager and Safeguarding Nurse/Lead to consider the need for legal proceedings with the Trust Legal Advisor. The Senior Manager will advise the Chief Officer/Chief Executive. The aim will be to ensure discharge from hospital so as to safeguard the health and wellbeing of other individuals by making the bed available and to safeguard the patient against the risks of being in hospital when fit for discharge (see 3.1.1).

b. The Head of Service will send notification to the patient and/or their representative that eviction proceedings will be followed (see example/ template letter no 4 at appendix 4, which should be adapted as required).

Appendix 5 provides document to track the actions at each stage.
3.4 **Interim care**

3.4.1 Where people who are funded by the LA or CCG make an interim move into a care home or use an interim care provider the LA/CCG will continue to work with individuals and their families post discharge regarding their long term care options.

In self funding cases the patient (or their advocate) should negotiate directly with the home of choice.

3.4.2 Consideration of interim arrangements must be accompanied by a full risk assessment including the morbidity / mortality risks of move on from interim placement.

If the NHS Trust is considering implementing a discharge, hospital legal advisers must be consulted on procedures to be followed and where the individual is funded by the local authority the LA legal advisers must be consulted.

**This process guidance must not be taken as authorising the forcible removal of such person from the hospital.**

3.5 **Mental Capacity Act**

3.5.1 Most Individuals have the capacity to participate in making some choices relating to discharge planning and even those people who appear to lack the capacity to do so may be able to do so with support. The MDT should engage with approaches to communication that might support decision making and maximise the patient's ability to make choices. If the patient individual appears unable to make choices regarding discharge, despite efforts to help them communicate their wishes, then a Mental Capacity Assessment and Best Interests Consultation will be required in line with the Mental Capacity Act (2005). This will involve consulting with the individuals representatives or appointing an IMCA if the patient is 'unbefriended'.

4. ROLES AND RESPONSIBILITIES

4.1 Chief Officer/Chief Executive and Trust Board
The Chief Officer has overall responsibility for the strategic and operational management of the Trust including ensuring that there are processes in place for the safe, effective and timely discharge of Individuals.

4.2 Director of Nursing and Quality and Medical Director
The Director of Nursing & Quality and Medical Director have joint delegated Executive responsibility for ensuring that appropriate standards for patient transfers and discharges are followed.

4.3 Chief Operating Officer and Clinical Associate Directors
The Chief Operating Officer is responsible for ensuring that the Senior Managers take clinical ownership of the implementation of these guidelines.

4.4 Heads of Clinical Services/Clinical Site Management Team

4.4.1 The responsibilities of the Heads of Clinical Services are to:

- Manage these guidelines and their implementation ensuring that staff are fully conversant with them.
- Ensure that adequate resources are in place to allow for the safe, effective and timely discharge of Individuals.
- Monitor the completion of audits associated with the monitoring of the guidelines’ implementation.
- To support staff in any corrective action or interventions if an incident occurs relating to the implementation of this guidance.
- To ensure any staff with training needs in relation to managing patient choice on discharge, have these training needs met.

The Clinical Site Manager (UHSFT) is responsible for resolving any operational issues relating to the discharge of Individuals that have been escalated after care group resolution has not been achieved.

4.5 All staff involved in planning the discharge of Individuals.

4.5.1 All staff involved in planning the discharge of Individuals are responsible for applying the principles of safe, effective and timely discharge planning; providing support and advice to Individuals and their families/carers.
4.5.2 Responsibility for the discharge process will remain with the named nurse or key worker, who will ensure that MDT assessments are available to inform decisions about needs on discharge. The ward manager will offer the appropriate level of guidance and support. All ward staff will proactively progress the timeliness of patient discharges.

4.5.3 To report to their line manager any deficits in relation to their knowledge, resources or processes in place to affect the timely discharge of Individuals through managing patient choice, or the occurrence of incidences that may have resulted from a deficit in any of these areas.

4.5.4 To advise the patient and their carers or family of any requirements such as their responsibilities within the discharge process.

4.5.5 To report any discharge related issues to their line manager and complete an adverse incident reporting form in line with Trust policy.

4.6 Integrated Discharge Bureau Team based at UHSFT

4.6.1 The Integrate Discharge Bureau Team is responsible for:

- Supporting all members of the multi-disciplinary team in the discharge of Individuals
- Advising staff on the discharge planning process
- Advising and, where appropriate, leading the multi-disciplinary team on complex discharge and continuing healthcare needs
- Assessing the suitability of Individuals for transfer to the community hospitals and into intermediate care services
- Assessing and assisting in the discharge of Individuals directly from the Emergency Department and the Surgical and Medical Assessment Units
- Assessing Individuals and supporting the discharge of NHS continuing Healthcare – fast track criteria
- Monitoring and where possible preventing delayed discharges
- Reviewing and continually developing this policy to ensure it continues to meet the requirements of the Trust and its Individuals
- Providing an ongoing programme of education for ward/department
- Collating delayed discharge data.

4.7 Responsible Consultant

The Consultant has the primary responsibility for Individuals care and discharge, although this may be delegated to appropriately trained staff. A decision regarding expected date of discharge (EDD) should be made at the earliest opportunity
following admission. Wherever possible this will be done at the first ward round or multidisciplinary team meeting following admission and documented in the Individuals notes. This will be used as a reference point for all care and treatment planning in conjunction with the multidisciplinary team.

The decision to discharge should be made in partnership with the multidisciplinary team, patient and carer. This decision should be clearly documented in the medical notes.

4.8 Matrons
Matrons are responsible for supporting the ward managers and their teams in adhering to the discharge process.

4.9 Ward Managers
Ward Managers are responsible for ensuring that the standard for the discharge process is followed in their ward areas.

4.10 Discharge Facilitators
Discharge Facilitators are responsible for the coordination of the Discharge process and to ensure all appropriate assessments are completed in a timely manner.

4.11 Multi-Disciplinary Team
The Multi-Disciplinary Team are responsible for agreeing that the patient is medically fit and safe for transfer and ensuring that assessments are completed in a timely manner.

4.12 Social Care Representative
The Social Care Representative is responsible for undertaking an assessment of needs for community care services and to work with the patient and the family to determine how these needs will be met.

4.13 Organisational Serious Incident Review Groups
The Serious Incident Review Group or organisational equivalent is responsible for providing a high level forum in which to oversee and monitor the reporting and review of serious untoward incidents relating to discharge issues and for ensuring that recommendations arising from investigations are implemented as required and that organisational learning has taken place. In addition the Groups will escalate any appropriate risks to the relevant Risk Committee for inclusion on either the Assurance Framework or the Risk Register.

4.14 Organisational Governance Committees
It is the responsibility of organisational Governance Committees to monitor adverse incidents and near misses, to identify and emerging trends. The teams will also support the implementation of any associated action plans and ensure cross organisation learning as necessary.

5. **TRAINING**

5.1 All staff should be given opportunity to familiarise themselves with the policy and guidelines and be enabled to access adequate training to allow them to implement them correctly. Where possible a multidisciplinary and multiagency approach to this training should be adopted.

5.2 Specifically staff should ensure that they have had training before they undertake assessments in the following areas:

- The Continuing Health Care Eligibility Criteria.
- Mental Capacity Assessment
- Deprivation of Liberty Assessment (DOLS)
- How to Discharge and Transfer Individuals from E-Camis

6. **EQUALITY & IMPACT AND MENTAL HEALTH ASSESSMENT**

6.1 These guidelines aim to ensure the safe and timely discharge of Individuals. As part of Trust policy an equality impact assessment (Steps1 & 2 of cycle) was undertaken (Appendix 6).

7. **MONITORING OF EFFECTIVENESS**

7.1 These guidelines will be monitored via the following methods to ensure compliance:

- Adverse Event Forms will be examined to identify if any event has happened during or as a result of a patient discharge
- Complaints will also be used to identify poor patient experience during discharge and both adverse events and complaints will be examined via the continuous improvement process and improvement plans devised as a result. This will include concerns raised via the Patient Experience Team.
- Monitoring delayed transfers of care as a measure of staff’s effective discharge planning.
- Performance dashboards relating to length of stay.

It is suggested that the audit trail template in 7 can be used by managers as a quick check audit tool.
7.2 The process for reviewing the results of monitoring will be:
   - Discussions of results of audit activity will be held via organisation’s quality and/or patient safety committee where further actions, if appropriate, will be requested and monitored.
   - The Patient Experience Team will also regularly report trends and analysis of complaints and patient satisfaction.

8. REVIEW

8.1 These guidelines may be reviewed at anytime at the request of either staff side or management, but will automatically be reviewed on a 3 yearly basis.

8.2 The guidelines will be regularly reviewed in order to reflect current legislation.

9. LINKS TO OTHER DOCUMENTS

9.1 The current policy links to the following existing policies and documents:

- Hampshire and Isle of Wight Strategic Health Authority “Policy and Eligibility Criteria for Continuing Care” October 2002.
- Organisational Admission, Transfer and Discharge policies
- Organisational Safeguarding Vulnerable Adults policies.

10. REFERENCES


Date

Dear [name]

We are pleased to confirm that you are now able to leave hospital. You have agreed in consultation with the multidisciplinary team involved in your assessment that your care and support needs can best be met by returning home with an appropriate domiciliary care package with the support comprising [x & y times a day] and your community health service <OR> moving into a reablement service prior to a care home/nursing home

As I am sure you are aware it is not in your best interests to remain in hospital longer than necessary. It may be helpful for you to know that prolonged unnecessary time spent in hospital can lead to a decline in physical and psychological wellbeing, as acknowledged by the Department of Health and Age Concern. Your clinical team would therefore recommend that you return home <OR> move to a reablement bed prior to an appropriate care home/nursing home at the earliest opportunity and within 2 weeks of the date of this letter.

If you are having problems identifying an available care option or your preferred option is not currently available, you/ [name] may need to consider an interim care home/care provider. We recognise that this is an important decision at a particularly stressful time. If you are eligible for local authority funding support a social care representative will continue to support you in the process and clarify funding issues with you.

The ward team and Social Care representative will work closely with you and your relatives/carers. A further meeting will be arranged with you within 7 days to discuss any issues or concerns you may have regarding your/your relative's discharge from hospital and to assist you in making arrangements.

If you have any queries, or concerns, please do not hesitate to contact me.

Yours sincerely,

Ward Manager
[Trust Name]
Tel: direct line
APPENDIX TWO – TEMPLATE LETTER 2

Date

Dear [Person/representative’s name]

Following the telephone conversation on the XXXX

<OR>

We have been unable to contact you by telephone on the XXX, XXX, and XXX so in order to facilitate your relatives discharge.

I am writing to invite you to a meeting at (TIME) on (DATE) in (LOCATION). The purpose of the meeting is to discuss the progress made in finding a suitable residential or nursing home placement <OR> care provider for you/person’s name. Members of the team caring for you/person’s name will also be invited to participate in the meeting. You may wish to bring family members, a close friend or an advocate to the meeting and you are very welcome to do so. The Patient Advocacy and Liaison Service (PALS) may be able to provide an advocate for you and they can be contacted on (contact number).

It is hoped that you will have made some progress in identifying discharge options. You may have already found a suitable residential or nursing home <OR> care provider. If so, please continue discussions with them and the Ward Manager or Matron. Please bring details of any placements and/or questions you may have to our meeting.

If you are unable to attend the meeting please contact me on the telephone number above to discuss an alternative time. Every effort will be made to arrange a convenient date for all parties to meet within the constraints of this busy unit and to be flexible in the light of your domestic arrangements.

It is important that we hear from you as soon as possible in order to arrange a date for a safe discharge from the Hospital. If you are unable to meet for any reason please contact the named person above. In the meantime the clinical will continue to work with you/ your relative to facilitate discharge.

(If no contact by telephone) Please can you confirm attendance at the above meeting. If you have not contacted us the meeting will proceed to discuss the discharge plan.

If you have any queries, or concerns, please do not hesitate to contact us on XXX contact name XXXX

Yours sincerely
Dear Person/representative’s name

The meeting today was to discuss the need for you/person’s name to be discharged now that inpatient hospital care is no longer required. I am sorry you were unable to attend.

All required assessments of [your/person’s name] needs are now complete and you/he/she is ready for discharge. In discussion with the consultant and the clinical team it has been agreed that your/person’s name needs would be best met by returning home with appropriate domiciliary care <OR> moving into a reablement bed prior to a care home with/without nursing <OR> adapt as appropriate.

The following actions were agreed at the meeting:

- 
- 

All agreements to funding for social/health care needs require approval by the Local Authority/Clinical Commissioning group and will normally be based on the rate which the Local Authority/Clinical Commissioning Group expect to pay for this type of care support and your allocated Social Care representative/NHS Continuing Healthcare Nurse will supply/have supplied you with options available within this range.

If you are unable to identify any available care option that you consider meets your/person’s name requirements or your preferred option is not currently available, you/person’s name may need to temporarily accept an interim care home/care provider whilst you wait for your preferred choice. A Social Care representative will support you.

We have made arrangements to meet with you again on [Date, time, venue]

If you have any queries, or concerns, please do not hesitate to contact me.

Yours sincerely,

Ward Manager
[Trust Name]
Tel: direct line
Date

Dear Person/representative’s name

FINAL NOTIFICATION OF INTERIM CARE

I am writing further to the letter dated [date] sent to you by name, job role, and subsequent meeting on [date]. You/person’s name needs to be discharged from [ward name] now that you/they no longer require hospital care. I understand that you have not yet chosen either a permanent or interim option for your/person’s name on going care.

It is in your/person’s name best interest that discharge is now arranged as soon as possible. Your/person’s name will not be able to remain in the hospital while you are waiting for your preferred choice of care or while you explore alternatives. With this in mind we have identified an interim care provider/care home/nursing home placement. The name of this provider is < name/contact details > and is available from < date >. You may like to consider this as an interim option whilst you continue your search for/await availability from your chosen care provider. We will endeavour to make arrangements for safe transfer to their care within the next 7 days. I have asked your Local Authority Social Care Representative to continue to support you in making this decision (delete if self funding or CHC funding).

If you are in the process of an appeal regarding the outcome of an NHS Continuing Healthcare (CHC) panel then the Clinical Commissioning Group (CCG) may pay all care costs until the outcome of this appeal. Please discuss this with your allocated CHC nurse.

On receipt of this letter we ask that you agree to the interim care offered or make independent arrangements to leave hospital within 5 working days from the date of this letter. If we do not hear from you within the next 5 days the Trust may start legal proceedings to facilitate discharge if you would like any further information or support regarding these arrangements or you wish to discuss the content of this letter in more detail, please contact Matron’s name and contact number.

Yours sincerely

Matron
[Trust Name]
Tel: direct line
## APPENDIX FIVE – CHOICE PATHWAY (CHOICE AUDIT TRAIL)

### Individuals name .......................................................... Hospital number ..............................................

### Hospital .............................................................. Ward representative.................................

<table>
<thead>
<tr>
<th>Action</th>
<th>Date</th>
<th>Signed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Discharge Planning patient info leaflet and EDD given and discussed</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CHC checklist / Section 2 notification completed</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>1st LETTER SENT</strong> from Ward Manager/Discharge Facilitator</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>1st MEETING BOOKED</strong>: If patient/ representative has not informed ward of care home booking/ arrangements for transfer – <strong>Template letter 2</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>1st FORMAL MEETING WITH PATIENT AND/OR REPRESENTATIVE:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Date:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Invited:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Actually attended:</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>TEMPLATE LETTER 3 SENT</strong> following meeting</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>2nd MEETING BOOKED</strong>: If patient/ representative has not progressed decision regarding discharge. <strong>Template letter 2</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>2nd FORMAL MEETING WITH PATIENT AND/OR REPRESENTATIVE:</strong></td>
<td></td>
<td></td>
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<tr>
<td>Date:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Invited:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Actually attended:</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>TEMPLATE LETTER 3 SENT</strong> following meeting</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>INTERIM PLACEMENTS OFFERED:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1)</td>
<td></td>
<td></td>
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<tr>
<td>2)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>INTERIM PLACEMENT ARRANGED</strong> if appropriate</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>TEMPLATE LETTER 4 SENT</strong>: from Chief Officer having taken legal advice</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>REASON PROCESS TERMINATED:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(Start new form if process re-started)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### APPENDIX SIX – EQUALITY IMPACT ASSESSMENT

#### Step 1 – Scoping: identify the policies aims

<table>
<thead>
<tr>
<th>Question</th>
<th>Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. What are the main aims and objectives of the policy?</td>
<td>The aims of the guidelines are to ensure that:</td>
</tr>
<tr>
<td></td>
<td>- Planning for effective transfer of care, in collaboration with the patient, their representatives and all members of the MDT will be commenced at or before admission.</td>
</tr>
<tr>
<td></td>
<td>- Hospital beds will be used appropriately and efficiently for those Individuals requiring in-patient care.</td>
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<tr>
<td></td>
<td>- When Individuals no longer need in-patient care and their first choice of nursing or residential care home or community carer is not available, a timely decision will be made regarding an interim care provider or location. The process of offering choice of care provider on discharge and/or discharge destination will be followed in a fair and consistent way throughout the Trust and there will be an audit trail of choices offered to Individuals.</td>
</tr>
<tr>
<td></td>
<td>- Where a patient is unable to express a preference, an advocate will be consulted on their behalf.</td>
</tr>
<tr>
<td>2. Who will be affected by it?</td>
<td>All Individuals admitted or transferred to the organisations covered by this document. Staff and agencies involved in the admission, transfer and discharge of Individuals.</td>
</tr>
<tr>
<td>3. What are the existing performance indicators/measures for this? What are the outcomes you want to achieve?</td>
<td>Patient experience feedback: complaints, compliments and patient satisfaction feedback. Incidents regarding discharge. Delayed discharges are monitored and reported weekly. Outcomes: The safe and appropriate discharge of Individuals to/from the Community Inpatient settings.</td>
</tr>
<tr>
<td>4. What information do you already have on the equality impact of this policy?</td>
<td>A low number of complaints are received by the service regarding the admission, transfer and discharge of Individuals.</td>
</tr>
<tr>
<td>5. Are there demographic changes or trends locally to be considered?</td>
<td>No</td>
</tr>
<tr>
<td>6. What other information do you need?</td>
<td>None</td>
</tr>
</tbody>
</table>

#### Step 2 - Assessing the Impact; consider the data and research

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
<th>Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Could the policy unlawfully discriminate against any group?</td>
<td>✓</td>
<td></td>
<td>The policy is written in English however translations can be accessed or the information communicated differently (e.g.</td>
</tr>
<tr>
<td>Question</td>
<td>Answer</td>
<td></td>
<td></td>
</tr>
<tr>
<td>-------------------------------------------------------------------------</td>
<td>--------</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Can any group benefit or be excluded?</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Can any group be denied fair &amp; equal access to or treatment as a result of this policy?</td>
<td>✓</td>
<td>The policy promotes that all Individuals are treated equally and fairly.</td>
<td></td>
</tr>
<tr>
<td>4. Can this actively promote good relations with and between different groups?</td>
<td>✓</td>
<td>Communication of clear discharge criteria.</td>
<td></td>
</tr>
<tr>
<td>5. Have you carried out any consultation internally/externally with relevant individual groups?</td>
<td>✓</td>
<td>Internally – with staff. Externally – with Social Services.</td>
<td></td>
</tr>
<tr>
<td>6. Have you used a variety of different methods of consultation/involvement</td>
<td>✓</td>
<td>As above. Direct and indirect consultation undertaken.</td>
<td></td>
</tr>
<tr>
<td>Mental Capacity Act implications</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Will this policy require a decision to be made by or about a service user? (Refer to the Mental Capacity Act policy for further information)</td>
<td>✓</td>
<td>Decisions will be made regarding Individuals' discharge with their involvement or the involvement of their carer/advocate where they do not have mental capacity.</td>
<td></td>
</tr>
</tbody>
</table>

If there is no negative impact – end the Impact Assessment here.