MANAGING HOSPITAL DISCHARGE:

SUPPORTING PATIENTS TO MANAGE DISCHARGE FROM INPATIENT SERVICES TO AVOID LONG HOSPITAL STAYS

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Summary of Policy

System wide policy that looks to discharge patients from the acute trust in a timely way once they are medically fit for discharge

Scope

This policy applies to locum, permanent, and fixed term contract employees (including apprentices) who hold a contract of employment or engagement with the Trust, and secondees (including students), volunteers (including Associate Hospital Managers), bank staff, Non-Executive Directors and those undertaking research working within Solent NHS Trust, in line with Solent NHS Trust's Equality, Diversity and Human Rights Policy. It also applies to external contractors, agency workers, and other workers who are assigned to Solent NHS Trust.

Solent NHS Trust is committed to the principles of Equality and Diversity and will strive to eliminate unlawful discrimination in all its forms. We will strive towards demonstrating fairness and Equal Opportunities for users of services, carers, the wider community and our staff.

Review

This document may be reviewed at any time at the request of either staff side or management, but will automatically be reviewed 3 years from initial approval and thereafter on a triennial basis unless organisational changes, legislation, guidance or non-compliance prompt an earlier review.

Southern Health NHS Foundation Trust | Solent NHS Trust | Portsmouth Hospitals NHS Trust | Portsmouth City Council | Hampshire County Council

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Version	4
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Version Tracking

Version	Date Ratified	Brief Summary of Changes	Author
4	18/05/2019	• To include Solent NHS Trust Integrated Discharge Bureau and Inpatient Ward responsibilities.	Linda Stead/Tim Trebble/Sharon McCann
3		• Update policy to ensure include new initiatives and ensure easy use for wards	Clare Cherrington
2	25/04/2018	• Renamed from Management of Expectations on Hospital Discharge Policy	Carla Bramhall
1	16/02/2017	• New policy to replace Home of Choice Policy - v1 16/11/15 • To encompass all discharge options/pathways and reflect	David Allison

		Discharge to Assess framework – system partner review	

CONTENTS

EXECUTIVE SUMMARY

This policy defines the process that Portsmouth and South Eastern Hampshire based NHS trusts and local authority adult social care departments will follow to manage discharge planning throughout a person's inpatient stay, at the point they no longer require inpatient care.

The overarching aim is to reduce delayed transfer of care through early engagement, support and the implementation of a fair and transparent escalation process. This policy is adapted from a national policy approach.

The discharge process is summarised below:

Stages 1 to 3 apply to all patients to provide support and prevent the need for further escalation:

Step	Action
Step 1	Providing standard information and support
Step 2	Assessing need
Step 3	Preparing for discharge
Step 4	**Five day window**
Step 5	Interim placements and packages
Step 6	Escalation
Step 7	Legal

1. INTRODUCTION

1.1. This policy supports people's timely, safe and effective discharge from an NHS inpatient setting once they no longer have a need that can only be met within an acute hospital setting or community in patient setting, to either a transitional or longer term setting which meets their needs. The patient's preferred choice amongst options that are available at the point of discharge will be considered but options may be limited.

1.2. This policy sets out good practice guidance for all staff.

1.3. It applies to all adult in-patients in Portsmouth City, South Eastern Hampshire and Fareham & Gosport NHS provider settings (South Eastern Hampshire CCG, Fareham & Gosport CCG, Portsmouth City CCG, Solent NHS Trust, Southern Health NHS Foundation Trust, Portsmouth Hospitals NHS Trust, Hampshire County Council and Portsmouth City Council).

1.4. The policy needs to be enacted before and during admission to ensure that those who are assessed as medically fit for discharge can leave hospital in a safe and timely way.

1.5. The policy is supported by existing guidance on effective discharge. (Transition between inpatient hospital settings and community or care home settings for adults with social care needs[1] 2015 NICE guidance, 2015) and is based on existing good practice.

1.6. The consequences of a patient[2] who is ready for discharge remaining in a hospital bed might include:

- Exposure to an unnecessary risk of hospital acquired infection[3];
- Physical decline and loss of mobility / muscle use[4];
- Frustration and distress to the patient and relatives due to uncertainty during any wait for a preferred choice to become available;
- Increased patient dependence, as the hospital environment is not designed to meet the needs of people who are medically fit for discharge[5];
- Severely ill patients being unable to access services due to beds being occupied by patients who are medically fit for discharge.

1.7. Patients and families can find it difficult to make decisions and/or make the practical arrangements for a range of reasons, such as:

- A lack of knowledge about the options and how services and systems work;
- Concerns about either the quality or the cost of care;
- Feeling that they (patients / carers) have insufficient information and support;
- There is uncertainty or conflict about who will cover costs of care;

[1] https://www.nice.org.uk/guidance/ng27
[2] The term 'patient' is used throughout this policy to refer to the individual receiving treatment
[3] Hassan, M. et al, 2010. *Hospital length of stay and probability of acquiring infection.* International Journal of Pharmaceutical and Healthcare Marketing. 4(4):324-338.
[4] Kortebein, P. et al (2008). *Functional impact of 10 days of bed rest in healthy older adults.* J Gerontol A Biol Sci Med Sci. 63(10):1076-81.
[5] Monk, A. et al. 2006. *Towards a practical framework for managing the risks of selecting technology to support independent living*. Applied Ergonomics, Vol.37(5).

- Concerns about moving into interim accommodation and then moving again at a later stage
- The choices available do not meet the patient's preferences
- Concerns that their existing home is unsuitable or needs work done to ensure a safe environment for discharge
- Worry about expectations of what family and carers can and will do to support them.

1.8. The principles of the 6Cs[6] should be applied to this process – care, compassion, competence, communication, courage and commitment.

1.9 This policy also supports the principles of Home First that professionals to think 'why not home, why not today'. The principles of Home First are included in appendix 6.

2. PURPOSE

2.1. The purpose of this policy is to ensure that choice is managed sensitively and consistently throughout the discharge planning process, and that people/patients/carers are provided with relevant information and support to make a choice at the point a patient is medically fit to be discharged.

2.2. This policy sets out a framework to ensure that NHS inpatient beds will be used appropriately and efficiently for those people who require inpatient care, and that a clear escalation process is in place for when patients remain in hospital longer than is clinically required.

2.3. Where the patient lacks capacity to make[7] decisions about their discharge destination from hospital, then the application of the policy should be adapted as explained in Appendix 2, following the Mental Capacity Act 2005 responsibilities.

2.4. When implemented consistently, this policy should reduce the number and length of delayed discharges and result in patients being successfully transferred to appropriate community services. Ultimately it aims to improve outcomes for patients.

2.5. This scope of this policy includes patients with very complex care needs, who may have been in hospital for many months or years, and people at the end of their life.

3. PRINCIPLES

SUPPORTING PEOPLE TO MAKE DECISIONS

3.1. Patients should not be expected to make decisions about their long-term future while in an acute hospital or a community inpatient unit; home care, reablement, intermediate care or other supportive options should be explored first, where that is appropriate to meet individual need or understand their longer term needs.

3.2. When it is the patient's wish and where appropriate, all possible efforts should be made to support people to return to their homes instead of residential placements, with options around home care packages and housing adaptations considered first. The Home First principle has been rolled out within the Trust and there is continued

[6] https://www.england.nhs.uk/nursingvision/compassion/

[7] Due to their difficulty understanding, retaining or using information given, or in communicating their views, wishes or feelings, as a result of a disturbance or impairment in the functioning of the mind or brain, as set out in the Mental Capacity Act 2005

support for the wards from the Integrated Discharge Service (or equivalent in the community in-patient setting). Where this is not possible straight away, a transitional or 'sideways' move should be considered where appropriate. A patient should not remain within an in-patient bed where suitable transitional arrangements have been identified and offered. People should be provided with high quality information, advice and support in a form that is accessible to them[8], as early as possible before or on admission and throughout their stay, to enable effective participation in the discharge process and in making an informed choice.

3.3. Patients should be involved in all decisions about their care, as per the NHS Constitution, and should be provided with high quality support and information in order to participate, where possible. In the context of a discharge decision, the information relevant to the decision will include an understanding of their care needs on discharge, the process and outcome of the assessment of needs, offers of care and options available.

3.4. Where it is identified that the patient requires a needs assessment under the Care Act 2014, but would have substantial difficulty in engaging in the assessment and care planning process, i.e. the person has a dementia, then the principles laid out in the Mental Capacity Act 2005 should be followed.

3.5. Many patients will want to involve others to support them, such as family or friends, carers or others. Where the patient has capacity to make their own decisions about confidentiality and information sharing, confidential information about the patient should only be shared with others with the patient's consent.

3.6. Where the patient has been assessed as lacking capacity in this respect, information may be shared in his or her best interests in accordance with requirements set out in the Mental Capacity Act 2005 Code of Practice and Appendix 2 of this document.[9]

3.7. Where someone is providing care or considering providing care post-discharge, unpaid as a carer, they must be informed and invited to be involved in the discharge process and informed about their rights and sources of support. People have a choice about whether or not to provide care for other adults and people must be informed about their choices when establishing whether they are willing and able to provide care.

3.8. Carers must be offered the information, training and support they need to provide care following discharge[10], including a carer's assessment.

3.9. The process of offering choice of care provider and/or discharge destination will be followed in a fair and consistent way and there will be an audit trail of choices offered to people.

3.10. Interactions with patients will acknowledge and offer support to address any concerns.

3.11. If a patient is not willing to accept any of the available and appropriate alternatives being offered to them, then it may be that they are discharged, after having had appropriate warning of the risks and consequences of doing so.

[8] Equality Act 2010 and Human Rights Act 1998, regarding disability and heritage languages; Accessible Information Standard to be introduced in July 2016
[9] Mental Capacity Act 2005 Code of Practice available at: https://www.gov.uk/government/publications/mental-capacity-act-code-of-practice
[10] Care Act 2014 s10

3.12. This option would only be pursued following the offer and the patient's rejection of available and appropriate options of care. Appropriate safeguards and risk assessments (see section 4.50) would need to be considered and follow up arrangements made as appropriate. For patients who may lack capacity to make their own discharge decisions, see Appendix 2.

TIMELY DISCHARGE FROM ACUTE CARE

3.13. If a patient is medically fit for discharge, it is not suitable that they remain in hospital due to the negative impact this can have on their health outcomes.

3.14. Patients do not have the right to remain in hospital longer than required[11].

3.15. The discharge process must not put the patient or their carers at risk of harm or breach their right to respect for private life. It should not create a situation whereby the independence of the carer or the sustainability of their caring role is jeopardised.

3.16. Planning for effective transfer of care, in collaboration with the patient and/or representatives and all Multi-Disciplinary Team (MDT) members, should be commenced at or before admission, or as soon as possible after an emergency admission. The SAFER patient flow bundle[12] should be applied to support timely discharge.

3.17. The process and timelines within this policy should be clearly communicated to the patient so that by the time a patient is medically fit for discharge they are aware of and understand the discharge process, the decisions and actions that they may need to undertake and the support they will receive.

3.18. If a patient's preferred care placement or package on discharge is not available when they become medically fit for discharge, an available alternative which is appropriate to their health and care needs will be offered on an interim basis, whilst they await availability of their preferred choice.

TIMELY DISCHARGE FROM COMMUNITY IN-PATIENT SETTING

3.19 if a patient is medically fit for discharge, it is not suitable that they remain in hospital due to the negative impact this can have on their health outcomes.

3.20 Patients do not have the right to remain in hospital longer than required[13].

3.21 The discharge process must not put the patient or their carers at risk of harm or breach their right to respect for private life. It should not create a situation whereby the independence of the carer or the sustainability of their caring role is jeopardised.

[11] Barnet PCT v X [2006] EWHC 787. A patient has no right to demand / the NHS has no obligation to provide something not clinically indicated, (*R (Burke) v GMC* [2005] EWCA Civ 1003), including provision of an inpatient bed and a patient who lacks mental capacity for the relevant decisions has no greater right to demand this (*Aintree University Hospitals NHS Foundation Trust v James* [2013] UKSC 67).

[12] http://www.fabnhsstuff.net/2015/08/26/the-safer-patient-flow-bundle

[13] Barnet PCT v X [2006] EWHC 787. A patient has no right to demand / the NHS has no obligation to provide something not clinically indicated, (*R (Burke) v GMC* [2005] EWCA Civ 1003), including provision of an inpatient bed and a patient who lacks mental capacity for the relevant decisions has no greater right to demand this (*Aintree University Hospitals NHS Foundation Trust v James* [2013] UKSC 67).

3.22 Planning for effective transfer of care, in collaboration with the patient and/or representatives and all Multi-Disciplinary Team (MDT) members, should be commenced as soon as possible after admission or when a patient has reached their optimum level of health and wellbeing.

3.23 This includes those patients originally admitted for end of life care and who become medically stable and are no longer assessed as being in a terminal stage of disease. In these cases, patients should be further assessed for on-going care needs and support from either health, social or jointly part of the NHS Continuing Healthcare process.

3.24 For those patients who have undergone completion of a CHC checklist and found to require full assessment of eligibility for NHS continuing healthcare the process will commence with assessment of the patient's needs by the multi-disciplinary team (MDT) and is made up of two or more health or social care professionals involved in the patient's care.

3.25 These assessments are then used to complete a 'Decision Support Tool' following which a recommendation is made as to the eligibility for funding. Dependant on which, suitable and appropriate arrangements for discharge are commenced.

3.26 Where patients whose primary admission was for fast track end of life but after a period of time and medical examination are no longer deemed to be imminently in the final stages, the CHC process should be commenced through the use of the DST.

FUNDING ARRANGEMENTS

1.1. This policy applies equally to people regardless of the funding arrangements and the nature of their on-going care.

1.2. Those self-funding care will be offered the same level of advice, guidance and assistance regarding choice[14] as those fully or partly funded by their local authority or NHS Continuing Healthcare (CHC), although it is likely that some of the content will need to differ.

1.3. A full assessment for NHS CHC should only be undertaken where the longer-term needs of the individual are clear.

[14] Care Act 2014 s4

2. OVERVIEW OF PROCESS (General/acute) – with timeline

On Admission Step 1 - Providing standard information and support (Ward Team)	• Start discussions about discharge with patient before or as soon as possible after admission. • Determine whether the patient has mental capacity and if not, put in place appropriate measures (see Appendix 2) • Identify **discharge coordinator**, and other people who have the patient's consent to be involved in discussions and decisions, e.g. carers, relatives • Provide **Patient Information Leaflet Regarding Discharge Process**
When patient is assessment fit (do not wait until patient is medically fit) Step 2 - Assessing need (Ward Team, IDS)	• Refer patient and any carers to required health and care services when they are ready to have their needs assessed for discharge (access this via the Integrated Discharge Service (IDS)Do not wait until the patient is medically fit - the IDS will start working when sure of likely discharge destination • Ensure assessments to clarify care needs and carers' needs are completed • Ensure MDT meeting takes place within two days of being assessment fit if required
When patient's onward Discharge Desination has been agreed Step 3 - Preparing for discharge (Ward Teams, IDS)	• Discuss available and appropriate options with patient • Refer to support services and/or advocacy, as required • Explain to the paitent the decision-making process, including how to appeal any decisions, and advise that the hospital will expect discharge within the five day window • **WARD MANAGER TO PROVIDE LETTER B NOW** and tailored information options which are suitable to meet assessed needs and available funding. All letters must be copied and sent to IDS Hub admin.
Period of five days from issue of letter B Step 4 - Five day window (Ward Manager/Matron, IDS)	• **Initiates upon provision of Letter B** and information on choices to patient, in advance of the estimated discharge date • Allow up to five consecutive days for the patient to consider their available options • Support the patient to make a decision, respond to concerns and offer advice, support and encouragement
Five days after the issue of letter B Step 5 - Interim placements and packages (Case Manager from IDS, Ward Team)	• If decision and/or discharge has not been achieved with five consecutive days, IDS to liaise with patient and arrange the offer of an interm placement or package which meets assessed needs • Advise the patient that an interim arrangement f**or a given length of time** is offered with a proposed date for discharge. Details should be provided of how interim funding arrangements relate to funding of subsequent care. • **WARD MANAGER TO PROVIDE LETTER C NOW.** All letters must be copied and sent to IDS Hub admin.
Any time during the process when family/patient disagree with MDT plan (allow five days to work with family/patient) Step 6 - Escalation (Case Manager, IDS Organisational Lead, CSC General Manager/Head of Nursing, Clinical Lead, Matron)	• If no agreement has been reached regarding discharge, and/or transfer arrangements are challenged, senior staff to hold formal meeting **(step 6 meeting to be arranged by Divisional Matron)** with patient to understand and resolve issues and reiterate policy • **Letter D to be sent following formal meeting by the Divisional Matron or if patient does not engage in formal meeting [note: this applies where reasonable options have been rejected and there are no ground to challenge]** • All letters must be copied and sent to IDS Hub admin and PHT Discharge Lead to be informed • If there is a family/patient delay of more than five days in the process this step must be followed • Consult local legal advisors, if neccessary
Five days following Formal Meeting Step 7 - Legal (Executive team and Legal)	• If no agreement after formal meeting; case is handed to Executive and Legal teams to progress compulsory discharge, provide necessary correspondance and liasion with patient • Ensure Senior Lead Nurse of Division, IDS Hub Admin and PHT Discharge Lead are informed

Overview of Process (Community in-patient setting CHC)

Step 1 - Providing standard information and support (Nursing/Therapy)	• Start discussions about discharge with patient before or as soon as possible after admission • Determine whether the patient has mental capacity and if not, put in place appropriate measures (see Appendix 2) • Identify other people who have the patient's consent to be involved in discussions and decisions, e.g. carers, relatives. If possible identify need for possible Care Manager (CM)/ Social Worker (SW) support. • Arrange induction meeting with patient/family within 48 hrs of admission • Identification of named nurse to support discharge planning • Provide **Factsheet A within 48 hours of admission & CHC leaflet**
Step 2 - Assessing need (MDT)	• Complete CHC consent and checklist tool to ascertain if patient triggers eligibility for a full CHC assessment (usually 5-10 days after admission) • Refer patient and any carers to required health and care services when they are ready to have their needs assessed for discharge • Ensure assessments to clarify care needs and carers' needs are completed (DST) • **Identification of Care Social Worker involment <7 days**
Step 3 - Preparing for discharge (MDT/SW)	• Discuss available and appropriate options with patient • Refer to support services and/or advocacy, as required • Explain the decision-making process, including how to appeal any decisions, to the patient and advise that the hospital will expect discharge within the five day window • MDT to establish PDD with clear communication to patient and carers. • **Provide Letter B** and tailored information on options which are suitable to meet assessed needs and available funding
Step 4 - Five day window (Ward Lead/SW)	• **Initiates upon provision of Letter B** and information on choices to patient, in advance of the estimated discharge date • Allow up to five consecutive days for the patient to consider their available options • Support the patient to make a decision, respond to concerns and offer advice, support and encouragement
Step 5 - Interim placements and packages (MDT/Ward Lead/SW)	• If decision and/or discharge has not been achieved with five consecutive days, MDT to liaise with patient and arrange the offer of an interm placement or package which meets assessed needs • Advise the patient that an interim arrangement f**or a given length of time** is offered with a proposed date for discharge. Details should be provided of how interim funding arrangements relate to funding of subsequent care. • Give appropriate **version of Letter C** and offer further support
Step 6 - Escalation (Ward Matron/Ward Lead/Clinical Lead)	• If no agreement has been reached regarding discharge, and/or transfer arrangements are challenged, senior staff to hold formal meeting **(step 6 mtg)** with patient to understand and resolve issues and reiterate policy • **Letter D** to be sent following formal meeting or if patient does not engage in formal meeting [note: this applies where reasonable options have been rejected and there are no ground to challenge] • Consult local legal advisors, if neccessary (SNHS.LegalServicesSolent@nhs.net). Involve/inform Integrated Service Manager and Operations Director
Step 7 - Legal (Exec team and Legal)	• If no agreement after formal meeting; escalated to the Executive team and a decision will be made as to whether legal advice is required to progress compulsory discharge. (Ports Sarah Austin-023810-32049 Sarah.austin4@nhs.net) Involve/inform Integrated Service Manager and Operations Director .

STEP 1 – PROVIDING STANDARD INFORMATION AND SUPPORT

2.1. A discharge coordinator[15] or named nurse for community in-patient settings should be identified for each patient and they will explain the discharge planning process to the patient on admission.

2.2. Patient Information Leaflet Regarding Discharge Process should be given to and discussed with the patient.

2.3. The discharge coordinator will ensure that the patient is aware of this policy and of the circumstances in which an interim placement or package might be necessary. All communication will clearly set out the process that the hospital will follow in order to work towards the patient's safe and timely discharge when their need for inpatient treatment ends. It should be made clear that they will receive advice and support in making a decision[16].

2.4. All patients will be given an Estimated Date of Discharge (EDD) as soon as possible after admission by a consultant or senior clinician. Regular review and discussion about the EDD as part of 'board rounds'[17] will ensure all parties understand when support will be required to facilitate discharge.

2.5. Patients should be involved in all decisions about their care[18] and supported to do so, where necessary.

2.6. At this point, it should be clearly identified who else the patient wishes to be informed and/or involved in the discussions and decisions regarding discharge, and appropriate consent received (if the patient lacks capacity then other legal basis needs to be established – see Appendix 2). This can include, but is not limited to, any formal or informal carers, friends and family members.

2.7. The discharge coordinator will ensure that any carer(s) of the patient are identified and supported through the discharge process. This includes providing information on Carer's Assessments and support services and/or referrals to the relevant support services. Ensuring the carer has adequate support in place will reduce the risk of unnecessary readmission of the patient.

STEP 2 – ASSESSING NEED

2.8. The likelihood of the patient and any carers needing health (including mental health) care, social care, housing, or other support after discharge will be considered as soon after admission as possible.

[15] The term 'discharge coordinator' is used throughout this policy to refer to the named individual responsible for coordinating a patient's discharge – this could be a named nurse from the ward, the case manager from the IDS, a named social care professional from the local authority, an appropriate person from a voluntary sector organisation contracted to co-ordinate statutory services and act as patient advocate, or a named CHC health professional.
[16] Care Act 2014 s4 Providing Information and Advice
[17] A 'board round' is a rapid review of progress against the care plan, typically involving the consultant, the medical team, the ward manager and therapists (and sometimes a social worker). It is usually held by a wards 'at a glance' white board. The aim is to ensure that momentum is maintained and deteriorations identified and managed promptly.
[18] NHS Constitution

2.9. If the patient is likely to have ongoing health, housing or social care needs after discharge the discharge coordinator will ensure timely referral to these other services for assessment[19]. This assessment should be from a holistic and patient-centred perspective of a person's needs and the care and support options may include, for example:

- Intermediate care (or step down care), either bed based or community based;
- Social care assessment;
- Community nursing services, including specialist services e.g. respiratory
- Reablement;
- Short-term placement in a care home;
- Care at home support package;
- Financial assessment and benefits advice;
- Eligibility for NHS Continuing Healthcare or Funded Nursing Care;
- Home assessment for aids, adaptations and / or assistive technology;
- Other local health, social or voluntary service.

2.10. For acute settings, all these services are coordinated via the Integrated Discharge Service (IDS) and accessed via referral, on completion of an assessment notice (AN). This is to be completed when the patient is 'assessment fit', and not wait until a patient is medically fit for discharge. For community in-patients this will be managed by the MDT.

2.11. For PHT ?patients who require a restart of an existing care package or return to placement, the PHT Trusted Professional model can be utilised. (see Appendix 5).

2.12. It should be made clear to the patient (and their carers, where appropriate) what the assessment in hospital is for, and what further assessments they can expect in the places they are transferred to.

2.13. Any carers of the patient should be advised of their rights to have a carers' assessment, with appropriate information and support, and referral to relevant support services.

2.14. Patients should be actively involved in the assessment process and in the development of care plans to enable full and effective assessments and support planning.

2.15. Patients should be informed of the rights they have to complain about an assessment or decisions about their need for support.

STEP 3 – PREPARING FOR DISCHARGE

2.16. Letter B (version dependent upon destination) will be prepared and given to the patient by the ward manager. The Discharge Coordinator will explain the process to the patient and ensure they are aware of all timelines and steps.

2.17. The prepared letter will be signed by a clinician. This does not need to wait for the lead clinician.

[19] Care Act 2014, s9 Assessment of an adult's need for care and support; NHS Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) Regulations 2012, reg 21

2.18. Tailored information should be provided to the patient about the care options available to them, including details of costs. The conditions of funding for interim, intermediate and reablement places, (and the 12 week property disregard[20] of fees for the circumstances when the patient transfers directly to a care home) should be made clear.

2.19. The patient will be referred to the relevant local authority adult social care team, or NHS Trust, in order to receive advice and support in making an informed choice, and to develop a person centred care and support plan which focuses on the individual's needs and preferences. This should include a discussion of the option of a personal budget [see 4.22]. It is important to consider the principles of Home First to ensure every effort has been made to get the patient home if safe to do so.

2.20. The patient should be referred to Hampshire County Council or Portsmouth City Council for advice and information regarding advocacy, if required.[21]

2.21. If the patient is assessed to have care needs after discharge, the discharge coordinator will advise the patient at the earliest appropriate opportunity about currently available care providers that can meet their needs and are registered with the Care Quality Commission (CQC). In some cases it is possible that there may be only one appropriate option, and the rationale for this must be explained.

2.22. If it is known that the placement / package is to be funded or provided by the NHS, the IDS staff (normally form the Discharge Planners) will advise the patient of their right to look at alternatives that fall within the criteria set by the CCG, based on their individual needs.

2.23. If it is known that the placement / package is to be funded by social services, local authority staff from Hampshire County Council or Portsmouth City Council will advise the patient of their right to look at alternatives that fall within the criteria set by the local authority, based on their individual needs[22], and the option to top-up. Particular consideration should be given to the timings within this policy to prevent breaches of local authority duties relating to discharge[23].

2.24. If the patient is interested in taking up the offer of a personal budget (social care), personal health budgets (NHS) or integrated personal budgets, senior members of the PHT IDS, both health and social care staff, will advise them where to get information, who to contact locally and refer them appropriately.

2.25. Self-funders should be provided with the same level of information, advice and support as people whose care is being funded by the NHS or the local authority[24].

2.26. The discharge coordinator should discuss discharge plans with the patient regularly, in some cases this may be as often as daily conversations. The discharge coordinator will endeavour to meet the patient's wishes regarding specific concerns about the appropriateness of a temporary arrangement, if concerns are brought to their attention.

[20] Certain circumstances where the local authority should disregard a property from means testing for the first 12 weeks of being a permanent resident in a care home, when it is providing assistance with the placement
[21] Care Act 2014, s67 Involvement in Assessment, Plans etc.
[22] Care Act 2014 s4 and s30; Care and Support and After-care (Choice of Accommodation) Regulations 2014
[23] Care Act 2014 s3, and Care and Support (Discharge of Hospital Patients) Regulations 2014, SI 2014/2823
[24] Care Act 2014

2.27. Patients should be informed of the rights they have to complain and provided with details of how to do so.

2.28. In order to minimise the need for patients to have recourse to formal complaints procedures, statutory agencies should make every effort to ensure that patients are involved in all stages of decisions that affect them, and that their agreement to such decisions is obtained.

STEP 4 – FIVE DAY WINDOW

2.29. Once step 3 is completed by giving appropriate information on packages of care or placements, resolving any disputes and giving Letter B to the patient, the expectation set out is that the patient makes a decision about discharge within 5 consecutive days or firm arrangements are in place to leave the hospital.

2.30. There are particular circumstances, such as an out of area transfer or safeguarding concerns, where it is unreasonable to expect a decision to be made within five days. In those circumstances a longer period may be agreed for an individual. At Step 4 of this policy, this decision will be made by the Discharge Co-ordinator/Case Manager (supported by their respective IDS Lead) and the Matron and agreed with the relevant General Manager.

2.31. Step 3 should be completed well in advance of the EDD, where possible, to prevent avoidable delays to discharge occurring, and in these circumstances more than five days can be given as a timescale to people to make arrangements. This is particularly the case with people whose care will be funded by the local authority to prevent breaches of their responsibilities for discharge[25].

2.32. Patients do not have the right to remain in hospital longer than required[26]. However, they do have the right to respect for private life and not to be treated in an inhuman or degrading way. Therefore it is crucial for the hospital to ensure that the proposed transfer is appropriate and in line with human rights legislation.[27]

2.33. The discharge coordinator will advise the patient that the hospital will expect discharge to be achieved within the agreed timescale.

2.34. Implementation of this policy does not impact on the measurement of delayed transfers of care, which should continue to be reported against the guidance laid out by NHS England[28].

STEP 5 – INTERIM PACKAGES AND PLACEMENTS

4.36 An interim package of care or placement will be offered to a patient where a decision has not been made within five days of completion of step 3, available options have been declined, or where a decision has been made but the specific

[25] Care Act 2014 s3, and Care and Support (Discharge of Hospital Patients) Regulations 2014, SI 2014/2823

[26] Barnet PCT v X [2006] EWHC 787. Case law 'R (Burke) v GMC [2005] EWCA Civ 1003' states that patients have no right to insist on particular treatment which is not clinically indicated. This includes provision of an acute inpatient bed when medically fit for discharge.

[27] Human Rights Act 1998

[28] https://www.england.nhs.uk/statistics/wp-content/uploads/sites/2/2015/10/mnth-Sitreps-def-dtoc-v1.09.pdf

package, placement, or adaptation is not yet available. Patients do not have the right to remain in hospital to wait for their preferred option to become available.

4.37 The interim package or placement is distinct from intermediate care or reablement.

4.38 Where decision and/or discharge are not achieved within five consecutive days of completion of step 3, members of the MDT will liaise **within two working days**. The MDT will discuss and seek to agree the recommended interim package or placement with the patient. Consideration of interim arrangements must be accompanied by a risk assessment, including impact on any carers.

4.39 The MDT may then advise the patient that an interim package or placement, which meets their assessed needs, is being offered, the reasons why the offer is appropriate, and a proposed date for transfer.

4.40 The interim package or placement will be confirmed with letter C (version dependent upon funding arrangements). Letter C will be prepared and given to the patient by the ward manager. It is important that the letter is addressed to the patient, is personalised to reflect their circumstances and that the process is also discussed with the patient.

4.41 The prepared letter will be signed by an available clinician so that the process is not delayed

4.42 The interim package / placement will allow further time for the choice of package / placement to be resolved outside of hospital. This interim option would normally be in one of the initial packages / placements offered, if still available.

4.43 Interim placements will be funded by the local authority or local Clinical Commissioning Groups for a maximum of 6 weeks[29] and this timescale will be clearly communicated to the patient from the outset.

4.44 Discussions regarding permanent options will continue throughout the interim placement with a designated person from the relevant organisation responsible for leading the discharge plans.

4.45 Self-funders will be required to fund their care in the interim package / placement, based on the outcome of their financial assessment. The exception to this is where the 12 week property disregard applies.

4.46 The relevant statutory organisation is responsible for funding the interim placement beyond the 6 week period if the ongoing placement/package is not yet available.

STEP 6 – ESCALATION PROCESS

4.47 If no agreement has been reached regarding discharge arrangements after steps 1-5, and transfer arrangements are challenged at any time by the patient, the CSC General Manager and/or Senior Lead Nurse/Matron, along with the patient's lead clinician will support the discharge coordinator to continue plans for transfer to

[29] Local organisations that have supported the development of this template policy recommend an interim funded placement of 3 weeks in order to ensure the policy works in practice and can be implemented easily by staff. This prevents multiple transfers in quick succession and enables time for full assessments to be completed well. This timescale is specifically for interim placements not intermediate care or reablement pathways.

an interim package or placement. This will involve support from the IDS Operational Lead and Organisational Lead from the respective service.

4.48 The patient will be provided with details of complaints and appeals procedures throughout the process.

4.49 A formal meeting will be arranged with the patient. The formal meeting enables all parties to discuss concerns and seek resolution. An interim option will be discussed at this meeting.

4.50 The Divisional Matron will send letter D following the formal meeting, summarising the discussion, including discussions around risks, and next steps.

4.51 Letter D should also be sent if the patient does not engage in the meeting, including details of the reasons why the patient did not engage.

4.52 The prepared letter will be signed by the lead clinician.

4.53 The discharge coordinator will continue to work with the patient throughout this process to try and understand and address barriers to a decision being made.

4.54 If the patient declines NHS treatment and a care or support package, they may be discharged from hospital[30]. In those circumstances they will be advised in advance of any discharge on the further NHS or social care support they may be able to access in the community and warned of the risks if they refuse such support.

4.55 Care should be taken to ensure that the Trust meets its duty [31] to serve an assessment notice and a discharge notice as appropriate on the local authority where it appears that the patient's discharge may be unsafe without the provision of appropriate care, and some cases may justify an adult safeguarding referral, including for cases which may amount to self-neglect[32].

4.56 The discharge coordinator will escalate to the PHT Discharge Lead who may in turn , supported by the local director or the patients Lead Clinician in the hospital consult local legal advisors and escalate as required to ensure discharge from hospital, in order to safeguard the health and wellbeing of the patient and other patients.

STEP 7 – LEGAL PROCESS

4.57. If no agreement has been reached regarding discharge arrangements after steps 1-6, and transfer arrangements are challenged by the patient, the patient's case will be handed over to the Executive Team and Legal Team by the PHT Discharge Lead

4.58 The patient will be provided with details of complaints and appeals procedures throughout the process.

[30] The duty on Trusts and Foundation Trusts to carry out their functions "effectively, efficiently and economically" under NHS Act 2006 (as amended) s26, 63; Criminal Justice and Immigration Act 2008, ss119-121, if the patient is no longer in need of inpatient treatment and their behaviour constitutes a nuisance or disturbance and NHS protect guidance on this provision

[31] Care Act Schedule 3

[32] Care Act statutory guidance chapter 14

4.59 The PHT Discharge Lead, discharge coordinator and ward will be kept informed by the executive and legal teams on the progress towards compulsory discharge being made by the Trust and wider health and social care systems.

3. MENTAL CAPACITY

5.1 All patients should be assumed to have mental capacity to make a decision about their ongoing care, including as regards discharge. A capacity assessment should be undertaken at any point during the process if their capacity, in relation to the discussions and decisions on discharge, is in doubt.

5.2 Appendix 2 sets out in detail how the application of this policy should be adapted for cases where the patient may lack capacity to make the relevant decisions at the appropriate time.

4. CONSULTATION AND APPROVAL PROCESS

6.1 This policy was developed by consolidating current policies both locally and from neighbouring hospitals in collaboration with all system partners and with input from people working across the health and social care system.

5. REVIEW, REVISION

7.1 This policy will be reviewed at least annually by the system-wide IDS Operational Lead in conjunction with service leads and local ratification procedures.

APPENDIX 1: GLOSSARY

Advocacy: a service to help people be involved in decisions, explore choices and options, defend their rights & responsibilities, and speak out about issues that matter to them.

CHC: NHS Continuing Healthcare is defined as a package of ongoing care for an individual aged 18 or over which is arranged and funded solely by the NHS where the individual has been found to have a 'primary health need'.

CCG: Clinical Commissioning Group

DOLs / Deprivation of liberty: when an individual without mental capacity to consent is under continuous supervision and control and is not free to leave, and this is imputable to the state. See Appendix 2.

Discharge coordinator: the named individual responsible for coordinating a patient's discharge. This could be a named nurse from the ward, a named social care professional from the local authority, the Case Manager from the IDS, an appropriate person from a voluntary sector organisation contracted to co-ordinate statutory services and act as patient advocate, or a named CHC health professional.

EDD: Estimated or expected date of discharge. This means when the patient is clinically assessed as ready for discharge. The EDD is initially based on average length-of-stay data and may change several times in response to the patient's specific needs.

IDS: Integrated Discharge Service

Independent Mental Capacity Advocate (IMCA): will represent patients assessed as lacking capacity under the Mental Capacity Act 2005 to make important decisions, such as change of accommodation, and who have no family and friends to consult.

Interim care: A provisional placement that is suitable and able to meet the patient's assessed needs whilst they wait for their preferred option.

Intermediate care: Short-term care provided free of charge by the NHS for people who no longer need to be in hospital but may need extra support to help them recover. It lasts for a maximum of six weeks and can be in the patient's home or in a residential setting.

MDT: Multidisciplinary team of health and social care professionals involved in the care and assessment of patients.

Medically fit for discharge: Further inpatient medical care or treatment is no longer necessary, appropriate or offered. Any further care needs can more appropriately be met in other settings, without the need for an acute inpatient hospital bed.

Mental capacity: Being able to make a specific decision at a specific time (see Appendix 2).

PHT: Portsmouth Hospital Trust

Patient: The individual receiving treatment.

Reablement: Reablement services are meant to help people adapt to a recent illness or disability by learning or relearning the skills necessary for independent daily living at home. Reablement should be provided free of charge by the local authority for up to six weeks. It can be extended at the local authority's discretion.

Self-funder: A person who financially meets the full cost of their social care needs (apart from reablement care and the 12 week property disregard), because their financial capital exceeds the threshold for adult services funding, their level of need is not deemed to be high enough for local authority funding, or because they or a representative choose to pay for their care.

APPENDIX 2: HOSPITAL DISCHARGE AND MENTAL CAPACITY ISSUES

All staff must follow the five guiding principles of the Mental Capacity Act 2005 ("MCA").

- Presume that adults (from 16 years of age) are mentally capable of making their own decisions;
- Do not determine the person lacks capacity until all practicable steps to support them have been taken without success;
- Do not consider someone to lack capacity because they make a decision we consider to be unwise;
- When the patient is assessed to lack capacity we must act in their best interests;
- Before taking any action or decision on their behalf we must consider if it can be achieved in a less restrictive way.

Capacity is specific to the decision that must be made, at the relevant time, and so it is possible that a patient who has been assessed as having capacity to consent to or refuse the treatment they have had as an inpatient may lack capacity to make decisions around discharge and care planning (and vice versa). Where there is a reason to doubt capacity for a particular decision, it must be specifically assessed, in accordance with the MCA, the MCA Code of Practice, relevant case law and documented appropriately.

All practicable steps must be taken to support the patient to make the decision before concluding that they are unable to make it themselves. This might involve taking a number of steps such as a providing information in a different format or breaking information down into smaller chunks.

If a person is assessed to lack capacity this means that staff have tested whether they can:

- Understand the information relevant to the decision,
- Retain the information long enough to make a decision,
- Use and weigh the information as part of the decision making process and
- Communicate the decision they want to make.

In the context of a discharge decision, the information relevant to the decision will include an understanding of their care needs on discharge, the process and outcome of the assessment of needs, offers of care and options available, with the person being given concrete information to consider, not starting with a blank sheet approach.

Options which are not available (e.g. placements which are not available, care which is not considered clinically appropriate, or care which will not be funded) should not be considered in either capacity assessments or in best interest decision-making. A patient with capacity cannot insist on staying in hospital after they are medically fit for discharge and so neither is it an option for a patient who lacks capacity for the discharge decision.

Where a patient, despite all reasonable efforts to support them, lacks capacity for discharge decisions, the decision must be made in their best interests (see MCA s4).

It is important to identify who the decision maker is as it could be a number of different people. The decision maker may be an attorney (if a health and welfare Lasting Power of Attorney has been granted, and is valid, applicable and registered) or a Deputy (if a health and welfare Deputy has been appointed by the Court). If neither of these is appointed then it will be the health or care professional who needs to make the decision in question. The wishes and feelings of the patient are paramount, but this does not mean they will always get what they want, any more than a patient with capacity would.

"Best interests" is interpreted widely, and goes beyond medical risk and benefit to include social, psychological and emotional factors. Before making a best interest decision, it should be tested by asking whether the patient's best interests can be achieved in a way which is less restrictive of their rights and freedoms.

A patient is entitled to an Independent Mental Capacity Advocate (IMCA) where it is proposed that an NHS body or a local authority provides accommodation in a care home for 8 weeks or longer unless there is someone to consult about their best interests other than a paid professional (MCA s38-39).

If the proposed placement or care package on discharge puts a patient without capacity to consent to it at risk of being deprived of liberty (Article 5, European Convention of Human Rights), currently as interpreted by the Supreme Court in Cheshire West [2014] UKSC 19 to mean "under continuous supervision and control and not free to leave" then additional safeguards are required to ensure that the deprivation is lawful.

Where the proposed deprivation of liberty is in a hospital or a registered care home, a referral must be made for a standard authorisation under the Deprivation of Liberty Safeguards (DoLS). However, DoLS do not extend to other placements, such as supported living or domiciliary care and so any proposed deprivation of liberty there can only be authorised by the Court of Protection. [In either case, case law has found that it is preferable for any proposed deprivation of liberty to be authorised in advance by a prior referral to DoLS or Court application – see for example Re AJ (DoLS) [2015] EWCOP 5, or Re AG [2015] EWCOP 78]

[It may be appropriate to seek legal advice on cases where deprivation of liberty after discharge appears to be an issue.]

APPENDIX 3: SUMMARY OF LEGAL RESPONSIBILITIES AND RIGHTS

This appendix includes a brief summary of selected key legal responsibilities held by participating organisations and the rights that patients have in relation to the specific topic of this policy, with references to specific legislation and case law.

This list does not cover all of the legal complexities in relation to this issue – it is only provided as a guide to the people reading this policy and should not be used in place of legal advice.

	Responsibility or right in relation to choice at discharge	**Relevant legislation / case law**
Hospital (NHS Trust)	No clinician or Trust is obliged to offer anything which is not clinically indicated. This includes provision of an acute inpatient bed.	R (Burke) v GMC [2005] EWCA Civ 1003; Aintree University Hospitals NHS FT v James [2013] UKSC 67
	A Trust is obliged to carry out its functions "effectively, efficiently and economically", which is not consistent with prolonged occupation of inpatient beds by patients who are medically fit for discharge	NHS Act 2006 (as amended) s26, 63
	In some cases, where the patient's refusal to leave hospital when medically fit for discharge constitutes a nuisance or disturbance, an offence may be committed and there is a power to remove the patient	Criminal Justice and Immigration Act 2008, ss119-121 [and see NHS Protect guidance]
	Alternatively, other remedies may be available to Trusts under property law	Barnet PCT v X [2006] EWHC 787
	Where appropriate, where the Trust considers it will not be safe to discharge a patient unless arrangements for care and support are in place it must give notice to local authority, including provision in some circumstances for a financial remedy against the local authority where discharge is delayed as a result of failure to meet needs	Care Act 2014, Schedule 3, Care and Support (Discharge of Hospital Patients) Regulations 2012, and Delayed Discharge (Continuing Healthcare) Directions 2013
	Responsibility to seek authorisation for any deprivation of liberty occurring in the hospital	MCA Schedule A1, paras 1-3 , 24 and 76
Local Authority	Responsibility to assess a patient's needs for care and support where it appears to the local authority that the patient may have such needs	Care Act 2014 s9
	Responsibility to assess a carer's needs for support and choice about caring	Care Act 2014 s10

	Responsibility to provide patient's choice of accommodation in care home / shared lives / supported living, where this is to be arranged by the local authority, in some circumstances	Care Act 2014 s30, Care and Support and After-care (Choice of Accommodation) Regulations 2014
	Responsibility to provide information and support on choices	Care Act 2014 s4
	Responsibility to offer choices / involve the patient in preparation of a care and support plan	Care Act 2014 s25
	Responsibility to provide a Care Act advocate if a patient would experience substantial difficulty in participating in the assessment of need or care planning process unless there is another (unpaid) appropriate person to fill this role	Care Act 2014, s67
	Responsibility to authorise deprivation of liberty in care homes and hospitals	MCA Schedule A1 paras 21, 50
Clinical Commissioning Group [and NHS England]	Responsibility to ensure an assessment for eligibility for NHS funded Continuing Healthcare where it appears that there may be a need for such care. [This is the responsibility for NHS England for military personnel and prisoners]	NHS Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) Regulations 2012, reg 21
Patient	Right to assessment for care and support by local authority and for NHS Continuing Healthcare as appropriate	Care Act 2014, s9 and NHS Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) Regulations 2012, reg 21
	No right to insist on particular treatment which is not clinically indicated, including provision of an acute inpatient bed when medically fit for discharge	Barnet PCT v X [2006] EWHC 787; R (Burke) v GMC [2005] EWCA Civ 1003
	Right to be involved in decision making about care	NHS Constitution
	Right to choice of accommodation in care home / shared lives / supported living, where this is to be arranged by the local authority, in some circumstances (but no right to remain in hospital when medically fit for discharge while preferred choice is awaited)	Care Act 2014 s30, Care and Support and After-care (Choice of Accommodation) Regulations 2014

	Right to respect for family life and to not be treated in an 'inhuman or degrading' way	Human Rights Act 1998 s6 in relation to Articles 3 and 8 of the European Convention of Human Rights
Carer	Right to carer's assessment / support and choice about caring i.e. willingness to provide care	Care Act 2014 s10

APPENDIX 4: PATIENT INFORMATION LEAFLET REGARDING DISCHARGE PROCESS

Discharge leaflet 18 2927.pdf

CHOICE LETTER B1

Date: ……

Dear

You now need to choose a care package at home

In order for you to receive the right on-going care we request that you take the following actions:

1. Consider the care at home options currently available to you;
2. Choose one of these care at home options;
   OR
   Advise us of an alternative option that you have arranged.

We request that you make your decision within 5 days of receiving this letter {or insert a longer timeframe if letter is sent more than 5 days before the EDD}. We will arrange for a temporary package of care or accommodation to be made available to you if you need longer than 5 days to make your decision, or need to wait for your preferred care provider.

Additional information to help you

The recent assessment looked at your care needs and wellbeing and showed that you will need a care package at home following discharge on {*insert estimated discharge date*}.

We want to help you leave this hospital as soon as possible because home is the best place for you to recuperate, and will give you more independence than being on a hospital ward.

To support you at this time we will ensure that:

- You now have all of the information about the choices currently available to you, including details of any costs, and you have spoken about this with a member of the team;
- You have access to further high quality information, advice and support to make your decisions [*include details of where this can be accessed*];
- This includes [*include details of support service*] and the option to involve your family, friends and carers to support you, as you wish.
- You can make a complaint or appeal at any stage of the discharge process by contacting the Patient Advice and Liaison Service on pht.pals@porthosp.nhs.uk. You can also call us on 0800 917 6039

Please do not hesitate to ask one of the nurses on your ward, or any member of the team caring for you, if you have any questions or if you would like a copy of this letter to be given to someone else.

Yours sincerely,

CLINICIAN

CHOICE LETTER B2

Date: ……

Dear

You now need to choose a care home.

In order for you to receive the right on-going care we request that you take the following actions:

1. Consider the care home options currently available to you, including visiting any care homes;
2. Choose one of these care homes;
   OR
   Advise us of an alternative option that you have arranged.

We request that you make this decision within 5 days of receiving this letter {or insert a longer timeframe if letter is sent more than 5 days before the EDD}. We will arrange for temporary accommodation to be made available to you if you need longer than 5 days to make your decision, or need to wait for your preferred choice if it has no current vacancies.

Additional information to help you

The recent assessment looked at your needs and wellbeing and showed that you will need to be discharged to a care home {insert for how long if a temporary placement} on {insert estimated discharge date}.

We want to help you leave this hospital as soon as possible because a care home is the best place for you to recuperate, and will give you more independence than being on a hospital ward.

To support you at this time we will ensure that:

- You now have all of the information about the choices currently available to you including details of any costs, and you have spoken about this with a member of the team;
- You have access to further high quality information, advice and support to make your decisions [include details of where this can be accessed];
- This includes [include details of support service] and the option to involve your family, friends and carers to support you, as you wish.
- You can make a complaint or appeal at any stage of the discharge process by contacting the Patient Advice and Liaison Service on pht.pals@porthosp.nhs.uk. You can also call us on 0800 917 6039

Please do not hesitate to ask one of the nurses on your ward, or any member of the team caring for you, if you have any questions or if you would like a copy of this letter to be given to someone else.

Yours sincerely,

CLINICIAN

CHOICE LETTER B3

Date: ……

Dear

You now need to choose an available housing option.

In order for you to receive the right on-going care we request that you take the following actions: 1. Consider housing support options currently available to you, including undertaking any visits; 2. Choose or agree to one of these housing support options; OR Advise us of an alternative option that you have arranged.

We request that you make this decision within 5 days of receiving this letter {or insert a longer timeframe if letter is sent more than 5 days before the EDD}. We will arrange for temporary accommodation to be made available to you if you need longer than 5 days to make your decision, or need to wait for your preferred choice if it has no current vacancies.

Additional information to help you

Your recent assessment looked at your care needs and wellbeing. It showed that you will need support from housing support services before being discharged on {insert estimated discharge date}.

We want to help you leave this hospital as soon as possible because supported housing is the best place for you to recuperate, and will give you more independence than being on a hospital ward.

To support you at this time we will ensure that:

- You now have all of the information about the choices currently available to you, including details of any costs, and you have spoken about this with a member of the team;
- You have access to further high quality information, advice and support to make your decisions [include details of where this can be accessed];
- This includes [include details of support service] and the option to involve your family, friends and carers to support you, as you wish.
- You can make a complaint or appeal at any stage of the discharge process by contacting the Patient Advice and Liaison Service on pht.pals@porthosp.nhs.uk. You can also call us on 0800 917 6039
  .

Please do not hesitate to ask one of the nurses on your ward, or to any member of the team caring for you, if you have any questions or if you would like a copy of this letter to be given to someone else.

Yours sincerely,

CLINICIAN

CHOICE LETTER B4

Date: ……

Dear

You now need to choose an available rehabilitation option.

In order for you to receive the right on-going care we request that you take the following actions:

1. Consider the rehabilitation options currently available to you,
2. Choose or agree to one of these rehabilitation options;
   OR
   Advise us of an alternative option that you have arranged.

We request that you make this decision within 5 days of receiving this letter {or insert a longer timeframe if letter is sent more than 5 days before the EDD}. We will arrange for temporary accommodation to be made available to you if you need longer than 5 days to make your decision, this may be in an available rehabilitation bed or nursing home whilst you wait for your preferred choice if it has no current vacancies.

Additional information to help you

Your recent assessment looked at your care needs and wellbeing. It showed that you will need support from rehabilitation services before being discharged on {insert estimated discharge date}.

We want to help you leave this hospital as soon as possible because receiving rehabilitation out of acute hospital is the best place for you to recuperate, and will give you more independence than being on an acute hospital ward.

To support you at this time we will ensure that:

- You now have all of the information about the choices currently available to you, including details of any costs, and you have spoken about this with a member of the team;
- You have access to further high quality information, advice and support to make your decisions [include details of where this can be accessed];
- This includes [include details of support service] and the option to involve your family, friends and carers to support you, as you wish.
- You can make a complaint or appeal at any stage of the discharge process by contacting the Patient Advice and Liaison Service on pht.pals@porthosp.nhs.uk. You can also call us on 0800 917 6039

Please do not hesitate to ask one of the nurses on your ward, or to any member of the team caring for you, if you have any questions or if you would like a copy of this letter to be given to someone else.

Yours sincerely,

CLINICIAN

CHOICE LETTER C1

Date: ……

Dear

Notification of plan to transfer to interim care whilst waiting for a preferred home

We understand that you are well enough to leave hospital and move to a care home, but <you have not yet found one that you like> OR <the one you prefer is not able to offer you a room at this time>.

We do not wish to cause you or your family anxiety, but unfortunately you will not be able to stay at this hospital whilst you continue to <search> OR <wait> for a care home.

- Staying in a care home will allow you to recuperate and give you more independence than being on a hospital ward;
- A care home is the best place for you to continue your recovery once your acute illness is over;
- Severely ill patients may be unable to access services, if beds in this hospital are occupied with patients who are medically fit for discharge.

As it has taken longer than 5 days to organise your discharge, we are now offering to transfer you to temporary accommodation in the following location, which has been assessed as suitable to meet your short-term needs because . This will be funded by for weeks[33]. Beyond weeks the costs of this care will need to be met by .

Discharge destination:	
Address:	
Tel number:	
Proposed date of transfer/discharge:	

You will be offered further support there with any decisions you need to make and you can wait there until transfer to a preferred home can be arranged.

Please discuss discharge plans with . You will need to either transfer to the temporary accommodation outlined above or inform us of an alternative arrangement to leave the hospital without further delay.

If you would like a copy of this letter to be given to someone else or you have any questions please speak to one of the people below or any member of the team caring for you.

If you would like to make a complaint or appeal against this decision then please contact the Patient Advice and Liaison Service on pht.pals@porthosp.nhs.uk. You can also call us on 0800 917 6039

Please do not hesitate to ask if you have any questions.

Yours sincerely

CLINICIAN

[33] *Local organisations that have supported the development of this template policy recommend a funded placement of 3 weeks in order to ensure the policy works in practice and can be implemented easily by staff. This prevents multiple transfers in quick succession and enables time for full assessments to be completed well.*

CHOICE LETTER C2

Date: ……

Dear

Notification of plan to transfer to interim care whilst waiting for preferred care at home services

We understand that you are well enough to leave hospital with care at home but <you have not yet found a care service that you like> OR <the care service you prefer is not able to accommodate you at this time>.

We do not wish to cause you or your family anxiety but unfortunately you will not be able to stay at this hospital whilst you continue to <search> OR <wait> for a care at home package.

- Leaving hospital will allow you to recuperate and give you more independence than being on a ward;
- Severely ill patients may be unable to access services, if beds in this hospital are occupied with patients who are medically fit for discharge.

As it has taken longer than 5 days to organise your discharge, we are now offering to transfer you to temporary accommodation in the following location, which has been assessed as suitable to meet your short-term needs because . This will be funded by for weeks[34]. Beyond weeks the costs of this care will need to be met by .

Discharge destination:	
Address:	
Tel number:	
Proposed date of transfer/discharge:	

You will be offered further support there with any decisions you need to make and you can wait there until your preferred care at home package can begin.

Please discuss discharge plans with . You will need to either transfer to the temporary accommodation outlined above or inform us of an alternative arrangement to leave the hospital without further delay.

If you would like a copy of this letter to be given to someone else or you have any questions please speak to one of the people below or any member of the team caring for you.

If you would like to make a complaint or appeal against this decision then please contact the Patient Advice and Liaison Service on pht.pals@porthosp.nhs.uk. You can also call us on 0800 917 6039

Please do not hesitate to ask if you have any questions.

Yours sincerely,

CLINICIAN

[34] *Local organisations that have supported the development of this template policy recommend a funded placement of 3 weeks in order to ensure the policy works in practice and can be implemented easily by staff. This prevents multiple transfers in quick succession and enables time for full assessments to be completed well.*

CHOICE LETTER C3

Date: ……

Dear

Notification of plan to transfer to interim care whilst waiting for housing support services

We understand that you are now well enough to leave hospital but require housing support services *<that are not yet completed> OR <that you have not yet decided upon>.*

- We do not wish to cause you or your family anxiety but unfortunately you will not be able to stay at this hospital whilst you continue to *<wait> OR <decide>* upon housing support services.
- Leaving hospital will allow you to recuperate and give you more independence than being on a ward;
- Severely ill patients may be unable to access services, if beds in this hospital are occupied with patients who are medically fit for discharge.

As it has taken longer than 5 days to organise your discharge, we are now offering to transfer you to temporary accommodation in the following location, which has been assessed as suitable to meet your short-term needs because . This will be funded by for weeks [35] . Beyond weeks the costs of this care will need to be met by .

Discharge destination:	
Address:	
Tel number:	
Proposed date of transfer/discharge:	

You will be offered further support there with any decisions you need to make and you can wait there until the housing support services *<are completed> OR <are available>.*

Please discuss discharge plans with .You will need to either transfer to the temporary accommodation outlined above or inform us of an alternative arrangement to leave the hospital without further delay.

If you would like a copy of this letter to be given to someone else or you have any questions please speak to one of the people below or any member of the team caring for you.

If you would like to make a complaint or appeal then please contact the Patient Advice and Liaison Service on pht.pals@porthosp.nhs.uk. You can also call us on 0800 917 6039

Please do not hesitate to ask if you have any questions.

Yours sincerely

CLINICIAN

[35] *Local organisations that have supported the development of this template policy recommend an interim funded placement of 3 weeks in order to ensure the policy works in practice and can be implemented easily by staff. This prevents multiple transfers in quick succession and enables time for full assessments to be completed well. This timescale is specifically for interim placements not intermediate care or reablement pathways.*

CHOICE LETTER C4

Date: ……

Dear

Notification of plan to transfer to interim care whilst waiting for rehabilitation services

We understand that you are now well enough to leave hospital but require rehabilitation services *<that are not yet completed> OR <that you have not yet decided upon>.*

- We do not wish to cause you or your family anxiety but unfortunately you will not be able to stay at this hospital whilst you continue to *<wait> OR <decide>* upon rehabilitation services.
- Leaving hospital will allow you to recuperate and give you more independence than being on a ward;
- Severely ill patients may be unable to access services, if beds in this hospital are occupied with patients who are medically fit for discharge.

As it has taken longer than 5 days to organise your discharge, we are now offering to transfer you to temporary accommodation in the following location, which has been assessed as suitable to meet your short-term needs because . This will be funded by for weeks[36]. Beyond weeks the costs of this care will need to be met by .

Discharge destination:	
Address:	
Tel number:	
Proposed date of transfer/discharge:	

You will be offered further support there with any decisions you need to make and you can wait there until the rehabilitation services *<are completed> OR <are available>.*

Please discuss discharge plans with . You will need to either transfer to the temporary accommodation outlined above or inform us of an alternative arrangement to leave the hospital without further delay.

If you would like a copy of this letter to be given to someone else or you have any questions please speak to one of the people below or any member of the team caring for you.

If you would like to make a complaint or appeal then please contact the Patient Advice and Liaison Service on pht.pals@porthosp.nhs.uk. You can also call us on 0800 917 6039

Please do not hesitate to ask if you have any questions.

Yours sincerely,

Senior Clinician

[36] *Local organisations that have supported the development of this template policy recommend an interim funded placement of 3 weeks in order to ensure the policy works in practice and can be implemented easily by staff. This prevents multiple transfers in quick succession and enables time for full assessments to be completed well. This timescale is specifically for interim placements not intermediate care or reablement pathways.*

CHOICE LETTER Da

Date: ……

Dear

Confirmation of discharge plans following formal meeting

Thank you for meeting with us on to discuss your discharge arrangements from this hospital and on-going care requirements.

Discharge options discussion
We want to help you leave this hospital as soon as possible now you no longer need hospital care. A hospital ward is not the best place for you to continue your recovery and other types of services are now better equipped to support your needs. In addition we have a responsibility to make sure that beds on our wards are available for people who need treatment that can only be provided in a hospital.

At the meeting we discussed the following points:

Discharge plan discussion
The following discharge plan was agreed:

The risks of you refusing the care options provided after being discharged from NHS hospital care were also discussed and identified:

We will continue to work with you to try to come to a mutually agreeable solution. However, in the meantime the hospital will now need to consult our legal advisors about your situation and how we can arrange for you to be safely discharged from this hospital as soon as possible. We have a responsibility to consider and to ensure your health and wellbeing throughout this process. You also have the right to consult with your own legal advisors.

If you would like a copy of this letter to be given to someone else or you have any questions please speak to one of the people below or any member of the team caring for you.

If you would like to make a complaint or appeal against any part of the discharge process then please .

Please do not hesitate to ask if you have any questions.

Yours sincerely,

SENIOR CLINICIAN

CHOICE LETTER Db

Date: ……

Dear

Confirmation of discharge plans following formal meeting

Dr and the discharge team met in your absence on to discuss your discharge arrangements from this hospital and on-going care requirements.

Discharge options discussion
We want to help you leave this hospital as soon as possible now you no longer need hospital care. A hospital ward is not the best place for you to continue your recovery and other types of services are now better equipped to support your needs. In addition we have a responsibility to make sure that beds on our wards are available for people who need treatment that can only be provided in a hospital.

We discussed the following options to enable the discharge process to proceed:

Discharge plan discussion
The following discharge plan was agreed:

The risks of you refusing the care options provided after being discharged from NHS hospital care were also discussed and identified:

We will continue to work with you to try to come to a mutually agreeable solution. However, in the meantime the hospital will now need to consult our legal advisors about your situation and how we can arrange for you to be safely discharged from this hospital as soon as possible. We have a responsibility to consider and to ensure your health and wellbeing throughout this process. You also have the right to consult with your own legal advisors.

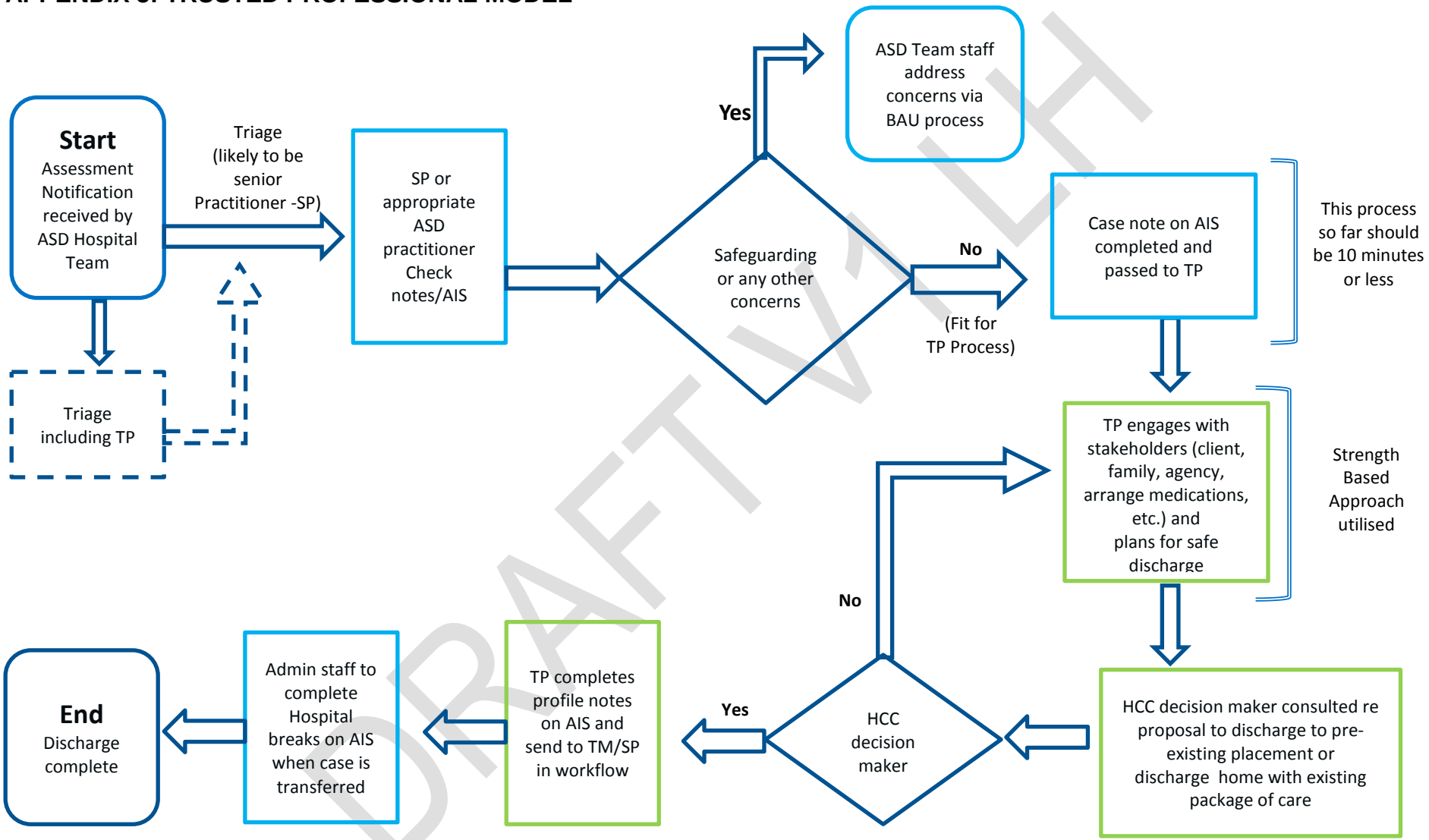
If you would like a copy of this letter to be given to someone else or you have any questions please speak to one of the people below or any member of the team caring for you.

If you would like to make a complaint or appeal against any part of the discharge process then please

Please do not hesitate to ask if you have any questions.
Yours sincerely,

SENIOR CLINICIAN

APPENDIX 5: TRUSTED PROFESSIONAL MODEL



APPENDIX 6: HOME FIRST

Portsmouth and South East Hampshire Healthcare System

Home First – Why not Home Why Not Today
So what will we be doing differently?

Earlier identification of patients with complex support needs once they are 'assessment fit' (we need your support with this)

'Home' should be the default discharge destination

We should ask of every patient at every Board Round - Why Not Home Why Not Today

We 're going to stop 'assessing to discharge' and instead 'discharge to assess' so that we stop prescribing long term care needs during an acute stay

APPENDIX 7: MANAGING DISCHARGE – SIMPLE STEPS FOR WARD USE

Step 1: Providing standard info and support (Ward and Discharge Teams)

- Start discussions about discharge with patient before or as soon as possible after admission
- Determine whether the patient has mental capacity and if not, put in place appropriate measures
- Identify **discharge coordinator**, and other people who have the patient's consent to be involved in discussions and decisions, e.g. carers, relatives
- Provide patient information letter regarding discharge process to every patient on admission

Step 2: Assessing need (Ward team and IDS)

- Refer patient and any carers to required health and care services when they are ready to have their needs assessed for discharge (access this via the Integrated Discharge Service (IDS))
- Ensure assessments to clarify care needs and carers' needs are completed

Step 3: Preparing for discharge (Ward Teams and IDS)

- Discuss available and appropriate options with patient
- Refer to support services and/or advocacy, as required
- Explain to the patient the decision-making process, including how to appeal any decisions, and advise that the hospital will expect discharge within the five day window
- **Provide relevant Letter B** (pages 25-28 in the policy) and tailored information on options which are suitable to meet assessed needs and available funding

Step 4 - Five day window (Ward Manager/Matron, IDS)

- **Initiates upon provision of Letter B** and information on choices to patient, in advance of the estimated discharge date
- Allow up to five consecutive days for the patient to consider their available options
- Support the patient to make a decision, respond to concerns and offer advice, support and encouragement

Step 5 - Interim placements and packages (Case Manager from IDS, Ward Team)

- If decision and/or discharge has not been achieved with five consecutive days, IDS to liaise with patient and arrange the offer of an interm placement or package which meets assessed needs
- Advise the patient that an interim arrangement **for a given length of time** is offered with a proposed date for discharge. Details should be provided of how interim funding arrangements relate to funding of subsequent care
- Give appropriate **version of Letter C (page 29 of policy)** and offer further support

Step 6 - Escalation

(Case Manager, IDS Organisational Lead, CSC General Manager/Head of Nursing, Clinical Lead, Matron)

- If no agreement has been reached regarding discharge, and/or transfer arrangements are challenged, senior staff to hold formal meeting **(step 6 mtg)** with patient to understand and resolve issues and reiterate policy
- **Letter D** to be sent following formal meeting or if patient does not engage in formal meeting [note: this applies where reasonable options have been rejected and there are no ground to challenge]
- Consult local legal advisors, if necessary

Step 7 - Legal
(Executive team and Legal)

If no agreement after formal meeting; case is handed to Executive and Legal teams to progress compulsory discharge, provide necessary correspondence and liaison with patient

EQUALITY IMPACT SCREENING TOOL

To be completed and attached to any procedural document when submitted to the appropriate committee for consideration and approval for service and policy changes/amendments

Stage 1 - Screening			
Title of Procedural Document: Managing Hospital Discharge Policy			
Date of Assessment	25/04/18	**Responsible Department**	Corporate Functions
Name of person completing assessment	M Roland	**Job Title**	Associate Medical Director – Operations
Does the policy/function affect one group less or more favourably than another on the basis of :			
	Yes/No	**Comments**	
• Age	No		
• Disability	No		
• Gender reassignment	No		
• Pregnancy and Maternity	No		
• Race	No		
• Sex	No		
• Religion or Belief	No		
• Sexual Orientation	No		
• Marriage or Civil Partnership	No		
If the answer to all of the above questions is NO, the EIA is complete. If YES, a full impact assessment is required: go on to stage 2, page 2			