Barnet, Enfield and Haringey NHS
Mental Health NHS Trust

A University Teaching Trust

Discharge & Transfer policy

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EQUALITY STATEMENT

Barnet, Enfield and Haringey NHS Trust aims to design and implement services, policies and measures that meet the diverse needs of our service, population and workforce, ensuring that none are placed at a disadvantage over others. It takes into account its legal obligations under Equality Act 2010, the Human Rights Act 1998 and other relevant legislation.

This document has been assessed to ensure that no one affected will receive less favourable treatment on the basis of a protected characteristic - age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex (gender) and sexual orientation.

The Trust embraces the four staff pledges in the NHS Constitution and this policy is consistent with these pledges. The Trust is also committed to safeguarding and promoting the welfare of children, young people and vulnerable adults and expects all staff and volunteers to share this commitment.
The Trust will make accessible versions of this document available if requested by members of the public, service users or staff who have particular communications needs.

Trust Values

This Policy supports the BEHMHT Trust values of:

- **Compassion.**
- **Respect**
- **Working Together**
- **Being Positive**

“Discharge and transfer is an essential part of care management in any setting. It ensures that health and social care systems are proactive in supporting individuals and their families and carers to either return home to another setting” (DH2010).

Discharge and transfer is a coordinated, patient-focused, transparent process that starts either before admission or as soon after admission as appropriate.

Patients, family and carers are treated with dignity and respect, and encouraged to be actively involved in all plans and decisions about their future care.

Staff work together supportively and understand how their own role and that of others can support the patient’s discharge plans. Staff members know what they and others are responsible for doing and who to ask for help.

Assessment and plans consider health and social care as a joined-up service to help patients achieve their best outcome. Care provided follows a ‘whole system’ approach that helps local health and social care services reach the people who need them most.

Consultation Record

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Jonathon Stephen Barnet Enfield & Haringey Mental Health NHS Trust

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Suneel Christian Barnet Enfield & Haringey Mental Health NHS Trust

Theophilus Bello Barnet Enfield & Haringey Mental Health NHS Trust

Sean Edwards Barnet Enfield & Haringey Mental Health NHS Trust

Bernard Mensah Barnet Enfield & Haringey Mental Health NHS Trust

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Dr Khalid Aziz Barnet Enfield & Haringey Mental Health NHS Trust

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Dr Tristan McGeorge Barnet Enfield & Haringey Mental Health NHS Trust

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Carol Moyo Barnet Enfield & Haringey Mental Health NHS Trust

Dilek Hill Enfield CCG

Muhammad Jaunbocus Barnet Enfield & Haringey Mental Health NHS Trust

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Suchitra Bhandari Barnet Enfield & Haringey Mental Health NHS Trust

Nina Van Markwijk Barnet Enfield & Haringey Mental Health NHS Trust

Jabu Chikore Barnet Enfield & Haringey Mental Health NHS Trust

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Dr Gareth Jarvis Barnet Enfield & Haringey Mental Health NHS Trust

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1.0 INTRODUCTION

BEHMHT is committed to providing high quality, safe inpatient services that optimise the recovery process for patients whose health needs cannot be met in any other setting. As such, this policy aims to provide a robust framework based in the commitment that patients will go through a safe, coordinated and timely discharge process that avoids unnecessarily hospital stays. Usually this will be at home.

This policy is required to ensure that patients that do need hospital care have that care managed in a way that best suits their needs. This includes making appropriate alternative arrangements should the patient be unable to return home, has been made homeless since admission or requires additional support to return to the community.

The process of assessment and decision making will be patient-centred, placing the individual, their perception of their support needs and their preferred type of support at the heart of the process. Where consent of an adult cannot be obtained, decisions about their personal welfare, including discharge planning, will be determined in accordance with the Mental Capacity Act 2005 and the accompanying Code of Practice.

This policy recognises that the development and operational management of a robust discharge policy requires a close working partnership with other key stakeholders, including primary care, acute hospital services, Local Authorities, intermediate care services, voluntary services, Clinical Commissioning Groups and the independent sector.

All discharge planning will be approached using the following principles, therefore allowing for a seamless inpatient stay that eliminates delays and unnecessarily long stays;

- Discharge planning to start on or before an admission;
- Develop a clinical management plan within 72 hours of admission, as part of the Formulation Meeting; and identify which stakeholders will be needed to support effective discharge;
- Set an expected date of discharge within 72 hours of admission;
- Allocate a lead to coordinate the discharge process in the formulation meeting;
- Review clinical management plan daily.

The discharge policy will operate in conjunction with the Trust;

- Care Programme Approach (CPA) policy
- Acute ward operational policy
- Bed management policy

2.0 AIM/PURPOSE

The main aim of this policy is to endorse that inpatient services exist to manage acute episodes of mental illness. Therefore, it is crucial to ensure patients have access to planned, safe and timely discharge under a robust clinical framework, with processes in place to allow joint working arrangements. The Trust is required to ensure the commissioned Mental Health inpatient beds are used appropriately; The Trust must ensure that patients, who have achieved recovery of their mental health crisis, are not housed, inappropriately, in commissioned Mental Health Hospital Beds.

Discharge planning is a multi-agency, multi-professional activity in which all professions have a contribution to make. Multi-professional involvement prior to, or as soon as possible after admission, is the key to successful discharge planning. This will support relevant assessments and plans being delivered to ensure discharge and avoid unnecessary delays

All staff, carers and representatives are required to ensure the patient is supported to make as many decisions as possible for them and for the patient to be involved in discharge planning.

For patients with long term care requirements, the Trust aims to identify a suitable place of discharge that meets the expectations of the patient and their careers. The Trust will work with the patient and family to establish appropriate levels of expectation.

Patients who are assessed as having capacity and decline assistance in achieving an appropriate discharge address will not be permitted to remain in an acute Mental Health Hospital bed or a Mental Health Recovery House bed. This process will be driven and managed by the current responsible treating multidisciplinary team (MDT) with support from stakeholders. It is important to have open and transparent dialogue with all parties involved.

This discharge and transfer policy will apply to all patients who receive adult acute mental health inpatient services.

The discharge and transfer policy will apply to all patients who receive inpatient services from BEHMHT Child & Adolescent Mental Health Services, Adults and Older Adults inpatient mental health services. This policy does not apply to Enfield Community services

Discharges and transfers from The North London Forensic Service are managed separate to the Trust's Discharge Policy. The procedures for discharge from the Forensic services are documented within a designated protocol.

3.0 DISCHARGES FROM CHILDREN & ADOLESCENT MENTAL HEALTH (CAMHS)

The decision to discharge a young person from the inpatient service will usually be made by the multi-disciplinary team in collaboration. Treatment will usually be planned to a forecast discharge date. Therefore the decision to discharge from the treatment programme will usually be clear in advance of the discharge CPA meeting.

The decision to discharge will take account of the treatment goals negotiated at assessment and during treatment, and will be based on comprehensive multidisciplinary assessment, formulation, treatment monitoring and review.

In the event of premature self-discharge, local services will be informed and a discharge CPA convened immediately. Detailed multi-disciplinary discharge summaries will be provided. In the rare event of treatment needing to be provided in an alternative inpatient setting (e.g. higher secure or highly specialist treatment) this will be discussed with the young person, parents/carers' referrers and involved community services, and agreement from commissioners will be sought.

4.0 DISCHARGES FROM OLDER ADULT SERVICES

All patients will have an assessment started within 72 hours of admission, or when appropriate. Assessment findings will be recorded in the patients records (within the appropriate section of the clinical record in RiO). All assessments will be reviewed weekly and updated as deemed necessary within the care plan review.

Home visits and environmental assessments will be carried out by appropriate professionals as required in advance of any discharge CPA meeting or discharge planning meeting. Referrals to Social Services will be made at an appropriate time during the patient' stay in hospital, with MDT contribution to completing Continuing Healthcare needs checklist if appropriate.

The patient, family and carers will be made aware of the discharge policy from admission. The MDT will ensure that good communication and involvement is maintained throughout the process with all stakeholders and a discharge plan agreed.

Within the Mental Health setting the BEH community mental Health Teams are able to support and advise all hospital staff involved in the discharge of patients on all aspects of the discharge process. They will co-ordinate the timely transfer of patients with complex needs such as accommodation and nursing or residential placements. In cases where placements are temporary prior to discharge i.e. where a trial placement is commenced, the patient should not be returned to hospital if the placement is not satisfactory. CPA procedures must be in place, where appropriate,

and it should be agreed in advance with the placement that the patient remains there until an alternative suitable placement in found.

There are three criteria for making the decision to discharge. These are not separate or sequential stages; all three must be addressed at the same time. (1) A Clinical decision has been made that the patient is clinically fit for discharge/transfer, (2) an MDT decision has been made that the patient is ready for discharge/transfer and (3) the patient is safe to discharge/transfer. Safe to transfer or respite or step down indicates that the patient may be transferred to an interim setting whilst awaiting service provision of the required package of care of placement into nursing or residential care or other placements. The patient will need to be over the acute phase of their illness or treatment and no longer in need of an acute hospital bed (or rehabilitation / respite bed).

5.0 ROLES AND RESPONSIBILITIES

All BEH staff working in the inpatient services will:

- Record actions, referrals, discussions and assessments in the patient's electronic record.
- Encourage patients and carers to engage in the discharge process as equal partners, treating them with kindness, dignity and respect, and taking account of their needs, wishes and rights.
- Work collaboratively with multidisciplinary colleagues to provide information, medication, equipment or specialist input, being aware of how each person's role supports the patient, and how all parts work as a whole, to meet their needs.
- Ensure that other professionals including private and charity sector providers are involved as appropriate in collating information and planning discharges
- Ensure that patients' rights to advocacy, including Care Act advocacy, are complied with.
- Ensure that discharge is timely, as soon as the patient no longer requires inpatient investigation, treatment or therapy, and that the patient is medically fit and safe to be transferred to another setting.
- Ensure all discharge documentation is complete and filed in the patient's record in chronological order. Confirm that the professionals referred to are aware of the patient's Predicted Discharge Date (PDD) and can provide the required care.

The admitting nurse will:

- Start discharge planning within 24 hours of admission.
- Identify what services are currently provided, note contact details, and make initial contact to engage them in plans to support discharge. It is especially important in clarifying a patient's accommodation and residency status.

The ward nursing staff will:

- Ensure effective verbal and written hand-over of assessments and care plans, negotiate timely and appropriate decisions, coordinate discharge plans, and act as a point of contact for effective communication between all MDT members.
- Communicate with the patient and/or carers, including discussing the initial and reviewed PDD, provide advice and support when needed and ensure carers are informed of their right to an assessment of their own needs.
- Screen the patient for potential risks that may result in discharge delay, follow the appropriate complex discharge pathway if risks are apparent and refer to other professions/agencies as soon as it becomes clear they might need support.
- Work towards the PDD, doing everything possible to arrange a safe and effective discharge by ensuring all discharge requirements are complete, and that the patient, carers or independent advocates are involved with all decisions.
- Escalate complex issues to the ward manager, Discharge Intervention Team and delegates to other ward staff.

The ward manager will:

- Ensure their teams are aware of this procedure and that discharge planning practice complies with it. Decide the process for identifying a named nurse to coordinate discharge plans and inform ward staff of this.
- Ensure operational systems are in place to support timely and safe discharge of medically fit patients, and that their team work towards the PDD set by the MDT and record changes in both the patient's electronic record.
- Organise and coordinate multi-disciplinary meetings, escalate discharge concerns to line managers for support to ensure patient safety.
- Ensure discharge summaries are sent to General practitioners
- Ensure patients being discharged have a discharge care plan
- Ensure patients being discharged have a crisis/contingency plan

The inpatient team lead/Modern matron:

- Hold ultimate responsibility for ensuring operational systems are in place to support timely and safe discharge of medically fit patients and that discharge is implemented in a standard way right across their services.
- Support the ward managers to resolve issues at a local level.
- Delegate to the ward manager, escalate operational matters and clinical issues to line managers.
- Develop and review discharge processes, ensuring these comply with local and national guidance and remain responsive to the changing needs of the Trust. This will include maintaining and updating systems and tools to meet the needs of users, such as discharge planning leaflet or education.
- Provide day-to-day operational leadership and management of discharge services.
- Seek the views of patients, carers and partner organisations and promote collaborative working with these organisations, including social services, housing, independent mental capacity advocacy (IMCA), other hospitals, community health services, specialist nurses, care homes, support services and voluntary organisations.
- Develop quality assurance processes for any panel referrals.
- Receive information on adverse incidents or near misses relating to patient discharge and arrange for these to be acted on as required.
- Escalate unresolved operational issues and clinical issues to line managers. Delegate as appropriate to discharge services administrative and clinical staff.

Discharge intervention team

- To undertake a brief, informed assessment of health and social need for those people admitted to inpatient services. Providing practical support, information and advice, the post holder will facilitate move on from acute services into the community.
- To support processes to monitor the daily use of beds within the service line and to ensure this information is disseminated to the appropriate people, such as, Bed Management Team, CRHT's, Acute Care Services Team Leaders.
- To proactively challenge colleagues and MDT's to ensure all Trust capacity is utilised effectively to ensure BEH manage within its own bed capacity.
- To track any acute placement which has been made in the independent sector ensuring the service user is repatriated to Barnet, Enfield and Haringey as soon as possible and maintain regular reviews to get repatriated at the earliest opportunity.
- To focus on discharge planning and the provision of practical support and advice to service users/carers on meeting health and social needs. Signposting MDT's to appropriate discharge destinations based on patients' individual needs.

- To have daily involvement in inpatient morning review meetings to proactively address any inpatient delays and assist in identifying patients suitable for early discharge or recovery house placements.
- To have oversight of all local BEH in patient delay patients and to undertake as well as co-ordinate resources/actions to address barriers to discharge.
- To support inpatient staff in liaising and link with partner agencies particularly Housing/ Benefits/CAB/Asylum seekers/Home Office in helping to prevent loss of tenancy, address rent arrears, accessing housing benefit.
- To work closely with service users and their care coordinators in assessing the habitability of the home environment, initiating necessary repairs if deemed unsuitable so as to make it ready for discharge.
- When patients have their own accommodation (private rented or social landlord) to make sure there are no issues with the tenancy including rent arrears and eviction proceedings are in progress.
- To have a detailed understanding of BEH inpatient and external resources including flexibility of wards, recovery house processes and to also have an in-depth awareness of partnering agencies including housing associations, local council contacts.
- To provide regular and timely information to BEH line mangers on the use of acute in-patient and Psychiatric Intensive Care Unit beds.
- To troubleshoot and resolve problems and delays in discharge. To escalate issues to senior staff when necessary.
- To support sector/ward daily bed meetings.
- To contribute to the systems that are in place to monitor the use of acute and Psychiatric Intensive Care Unit (PICU) beds including participation in regular reviews providing updates with the aim to repatriate to a BEH bed at the earliest opportunity.
- To work at a clinical and operational level and support the undertaking of reviews of Barnet, Enfield and Haringey service users in the independent sector.
- To support the Delayed Transfer of Care (DToC) meetings.
- To enable all wards to work to their admission and discharge criteria. Please see appendix (1) for further tasks, duties and responsibilities of the Discharge Intervention Team.

Medical staff:

- Consider alternatives to hospital admission where appropriate.
- Assess the likely outcome of the admission, length of stay and support likely to be needed, working collaboratively towards safe and timely discharge.
- Set a discharge date on admission, discussing details and support required after discharge with patients/ carers at the earliest opportunity.

- The consultant delegates medical discharge issues as appropriate, holding regular MDT discussions to share progress reports and facilitate effective discharge planning.
- Records MDT decisions in the patient's records, such as when the patient has become medically ready for discharge, consulting colleagues as required.
- To ensure a flow of patients through the ward is possible, the discharge process needs to occur over seven days. On Thursday and Friday all medical teams when reviewing their patients should identify those who are likely to be ready for discharge over the weekend. A list of probable discharges should be provided by each medical team to the local discharge Intervention team by 3.30 pm on Friday. Discharge summaries and medication (To Take Away) should be written up before the weekend.

6.0 DAILY DISCHARGE MANAGEMENT - NON DELAYED DISCHARGES

All patients will be assessed at admission in order to establish a personal discharge pathway within a set PDD. This assessment acknowledges mental health, physical health, functional, housing and social care needs.

All patients will have a 72 hour formulation meeting. An example of a 72 hr formulation meeting is in Appendix (2). This will be coordinated by the Ward Manager who will ensure all relevant parties are invited to attend. Contributing stakeholders will be invited as is deemed appropriate by the Ward Team may include for example;

- Service user
- Carer
- Discharge worker
- Care Coordinator
- Allied Health Professional
- Occupational Therapy
- Psychology
- Home Treatment Team
- Complex Care Team
- Early Intervention Service
- Enablement Team
- Housing Officer
- Support agency etc. will be invited to attend

It is a priority for the care coordinator (if the patient has one) to attend and participate in the 72 hour formulation meeting. If there is no care coordinator or no named Community Mental Health Team and the patient may require follow up the most appropriate Community Mental Health Team will be invited to participate.

The formulation meeting is required to ascertain eligibility and agree fact finding requirements around Patient's present / previous circumstances in relation to;

- Housing/accommodation status. This will include obligations under the Housing Reduction Act and duty to refer where someone is likely to be homeless and has a local connection within a borough
- Assessment completion barriers to discharge
    1) Care Act assessments
    2) Assessment of Daily Living Skills
    3) Human Rights Act
- Treatment barriers to discharge
- Care co-ordination engagement and mobilisation to support discharge
- Risk management barriers to discharge
- Commissioning Barriers to discharge
- Procurement Barriers to discharge
- Benefits barriers to discharge
- Family issues as barriers to discharge
- Safeguarding issues as barriers to discharge
- Identification issues such as passport, birth certificate
- Immigration status
- No Recourse to Public Funds

The 72 hr formulation meeting is the forum which BEHMHT will use to adopt a criteria-led discharge. This will assist discharge decisions within agreed clinical parameters being made to support patient discharge from hospital. This will allow a broad group of healthcare practitioners being able to undertake the discharge of patients within these agreed parameters. This will be led by the Responsible Consultant with a multi-/inter-disciplinary team and guided by evidence from national clinical guidelines and protocols.

Principles underpinning the process of criteria-led discharge are;

- A discharge policy must be in place to guide the implementation and governance of criteria led discharge.
- Patients should be identified 'as suitable' for criteria-led discharge on admission or as early as possible in their hospital stay; this will depend on their clinical stability and complexity of their clinical condition.
- Patients must be identified as suitable for criteria-led discharge through an agreed clinical process, to be determined locally within the clinical area.
- The handover of a patient's criteria-led discharge plan to a designated healthcare practitioner must be documented in the patient's medical records.
- A clear hand back process to the medical team must be agreed if the patient fails to meet the clinical criteria (is unwell) and a criteria-led discharge is not possible.

- The hand back of patients, if they become medically unstable or unsuitable for criteria-led discharge must be documented in the patient's medical records.
- Patients must be provided with information about criteria-led discharge and the care pathway.
- The criteria-led discharge process must include all instructions about post-discharge care/advice: to be given to the patient and/or carer with a full and comprehensive explanation.
- At all times there should be accurate and full documentation of the discharge process.
- An estimated length of stay or estimated date of discharge should be approximated and reviewed daily.
- Patient progress against the criteria and discharge plan should be monitored daily.
- Supporting documentation should include clear timing, sequence and who is responsible for the patient's discharge.
- In accordance with the discharge policy, criteria-led discharges will include as a minimum the discharge checklist, a discharge summary for the GP and tablets to take out.
- All staff undertaking criteria-led discharge should undergo appropriate training and a record will be held locally as evidence of training.

The daily management of discharges are supported by the 'Jonah Discharge Planning Tool' database is now used throughout the acute inpatient wards. This system supports ward teams to proactively manage the patient's discharge process by focusing on defining clear plans for the patient's say on the ward. Supported by daily MDT meetings any potential discharge problems are identified earlier in the process allowing time to resolve any issues and plan a smooth discharge for patients.

Identified needs in the 72 hr formulation are to be allocated as required to appropriate staff for action and follow up. These identified patient needs will be regularly reviewed by the ward team and care coordinator, during the patient's stay in hospital. As clinical signs of recovery are confirmed, an assessment of the patient's mental capacity will be undertaken. This assessment will confirm if the patient is able to make decisions about their personal welfare, including decisions relating to discharge planning, ability to be involved in the process and what support may be needed for them to be fully involved in the process.

Some patients will not require additional ongoing support from health or social care following discharge and so will follow a simple discharge pathway as set out in this policy. These are inpatient discharges requiring no additional health or social services support.

During the patients stay in hospital, any change in assessed housing needs and social needs will actioned as required when identified to ensure the person is

discharged as planned. The local Discharge Intervention Team will support MDT's in having care act assessments, referral paperwork and Activities of Daily Living assessments completed. Trust will act in accordance with the Homelessness Reduction Act and refer people suspected as being homeless within 56 days to the relevant Council Housing Department in order to prevent homelessness. It is imperative that this is done as early as possible so that actions can be undertaken in a timely and meaningful way.

7.0 DISCHARGES AGAINST MEDICAL ADVICE

A service user wishing to leave hospital without going through the proper discharge planning procedures should have their current mental state and mental capacity assessed. The Crisis Resolution & Home Treatment Team (CRHTT), care co-ordinator/Responsible Consultant (or deputy), team doctor or duty doctor must be contacted in order to assess the service user.

A nurse must explain to the service user that if discharge from hospital is to be beneficial, it is better to have made suitable plans after discussion with people at home, in the community and the team responsible for his/her care. Consent should be sought from the service user to liaise with the care co-ordinator, carer or a friend or neighbour who might be able to persuade the service user to stay in hospital and complete the planned discharge and to ensure that the service user reaches home safely.

If a service user who is obviously unwell insists on leaving hospital before seeing a doctor then, following a nursing assessment, a nurse authorised to do so, may detain the service user for up to 6 hours under Section 5(4) of the Mental Health Act.

If the result of the doctor's assessment is that the service user is not fit to leave, then the doctor must consider the use of Section 5(2) of the Mental Health Act 1983. If a Section 5(2) is implemented, ward staff must refer to Section 5.2 guidance.

If the service user does not meet the criteria for detention and insists on leaving, then every reasonable effort should be made to ensure that the service user reaches home safely. The CRHT will be pivotal here.

The following factors should be considered by the ward staff, Responsible Consultant or duty doctor when attempting to ensure the safety of the service user:

1) time of the day
2) weather conditions
3) carers contacted and informed of the situation
4) whether the service user has somewhere to go
5) Whether the service users have their keys
6) Have the support providers have been informed?

7) how the service user will get there
8) whether the service user has money and suitable clothing
9) whether the service user needs medication – an emergency supply will be issued if requested by the doctor via the pharmacy.

The ward manger or Senior Nurse should be notified and will offer support and assistance.

The service user should be asked to sign the form relating to 'Service user taking own Discharge.' An entry should be made in the nursing and medical notes that departure is against advice. If the service user declines to sign the form then the entry should reflect that.

When a service user discharges themselves from hospital against medical advice it is recognised that it may not be possible to follow the discharge procedure. The Named Nurse will inform the CRHT, care co-ordinator, or the relevant Community Mental Health and Social Care Team, Support Provider and GP immediately or, in out-of-hours situations, either the following morning or the Monday morning.

A discharge summary will be forwarded to the Care Co-ordinator and GP the next working day and recorded on the IT system.

The Care Co-ordinator or the relevant Community Mental Health and Social Care Team will instigate aftercare arrangements where practicable.

The Discharge against Medical Advice checklist must be completed.

8.0 COMPLEX DISCHARGES

The following groups of patients are considered to have complex discharge needs, though it should be noted that the identification of any patient group is not mutually exclusive:

- Patients with complex on going mental health and social care needs who are being discharged home with a package of care.
- Patients who have been detained under the Mental Health Act and require S117 aftercare.
- Patients who have no recourse to public funds.
- Patients who have a dual diagnosis, learning difficulties / mental health or substance misuse / mental health and physical health difficulties.
- Patients who are to be discharged to another care setting.
- Patients who lack capacity to make a decision about their long term care needs.
- Patients who are homeless upon admission, or have become homeless since admission.

- Patients where a safeguarding concern has been identified.

CHOICE DELAYS

In the absence of a Mental Health Choice Policy, currently in development, this procedure for Managing Choice on Hospital Discharge will be followed.

Principles of Choice:

- Patients should be moved to the right place for their care as soon as possible
- Patients are still given a choice of their long term care provision but the decision should not be made (wherever possible) whilst waiting in an acute or recovery house bed.
- Consistent approach with open and transparent conversations as it is important to manage people's expectations for example would be that most of the care and supported housing projects have shared housing and the move on prospects are likely to be in the private rented sector rather than access to social housing.
- Involving patients and carers in the process and final decision on long term destination.
- A patient does not have the right to occupy an acute hospital bed once they no longer need acute care and must move to a more appropriate location when ready, possibly to a temporary care home whilst they wait for a home of their choice.

A patient will usually be offered a choice of available suitable care options but if their needs can be met equally well through different options the commissioner can legitimately decline to fund more expensive options. Also there are often financial limits to how much care can be provided in a patient's own home, so commissioners may only offer funding for residential care.

If a patient or carer persistently refuses options offered, social services may inform them that it has fulfilled its duty and the patient or carers will need to make their own arrangements. However, the patient/carers can ask for an alternative option if the home offered would not meet the patient's physical or psychological needs.

It would be useful to read the following guidance and framework below;

The NHS England on Delayed Transfers of Care Situation Report: Principles, Definitions and Guidance: https://www.england.nhs.uk/statistics/wp-content/uploads/sites/2/2018/11/Monthly-Delayed-Transfers-of-Care-Situation-Report-Principles-Definitions-and-Guidance.pdf. Specifically, G - Patient or Family choice 8.11 – 8.12.

9.0 PATIENT WHO IS MEDICALLY FIT, OFFERED OR IN RECEIPT OF SUITABLE ACCOMMODATION, BUT REFUSES TO LEAVE THE HOSPITAL.

- If a patient who has been medically assessed as being fit for discharge and is in receipt of, or has privately secured, suitable accommodation, but refuses to the leave the hospital, the patient will be issued with a letter. The letter will convey that following a clinical review meeting that a discharge date has been identified.
- It is not anticipated that such situations will be frequent, however, in order to ensure the most appropriate use of commissioned mental health facilities, the Trust reserves the right to issue a letter to affect an eviction following a risk assessment.
- Should it be considered necessary to issue a letter with a stated discharge date then the Discharge Team will establish a meeting with the patient / family member if applicable, Care Coordinator, Ward Manager and Consultant Psychiatrist well as relevant advocates as may be required.
- The meeting will be recorded on the patient's RiO electronic patient record.
- The Chair will ensure that considerations of any exceptional circumstances, which have caused or contributed to the delay in discharge, are duly considered.
- If the patient refuses to attend the meeting, the meeting will be undertaken in the patient's absence.
- If the meeting concludes that the patient is to be served notice of eviction, plans will be established to issue a letter to the patient, along with follow up and support plans.
- Any such letter may only be issued upon the written authorisation (email), of a member from the Trust Executive Management Team. This will normally be the Chief Operating Officer.
- On the rare occasion that it is necessary to evict a patient, the authorising member of the Trust Executive Management Team, will ensure they nominate a member of the Senior Management Team to oversee the process.
- The letter will formally give notice to the patient that they will be discharged and evicted from the Trust site. The letter will be hand delivered. If the patient refuses to accept the letter it will be placed on the patient's bed and appropriate records will be made.
- The letter will specify the time and date of eviction.
- Should the patient not leave the premises by the specified time they will be evicted from the site.
- Should it be necessary to carry out such an eviction notice, appropriate security or Police will be present at the time of eviction.

- Police support can be requested under 119 of the Police & Immigration Act 2008 states that Offence of causing nuisance or disturbance on NHS premises;

  (1)A person commits an offence if—

  (a)the person causes, without reasonable excuse and while on NHS premises, a nuisance or disturbance to an NHS staff member who is working there or is otherwise there in connection with work.

  (b) The person refuses, without reasonable excuse, to leave the NHS premises when asked to do so by a constable or an NHS staff member, and

  (c) The person is not on the NHS premises for the purpose of obtaining medical advice, treatment or care for himself or herself.

  (2)A person who commits an offence under this section is liable on summary conviction to a fine not exceeding level 3 on the standard scale.

  (3)For the purposes of this section—

  (a)a person ceases to be on NHS premises for the purpose of obtaining medical advice, treatment or care for himself or herself once the person has received the advice, treatment or care, and

  (b) A person is not on NHS premises for the purpose of obtaining medical advice, treatment or care for himself or herself if the person has been refused the advice, treatment or care during the last 8 hours.

10.0 LETTER CONTENT

- Standard letters referred to in this policy (appendix 3) should be relevant to the Patient's situation and must be checked, authorised and signed at Managing Director level.
- Where the patient lacks capacity, the letter will be issued to an authorised representative.
- Letters are to be hand delivered to patients or sent to relatives by recorded delivery. A copy of the letter must be kept in the patient's notes along with a written entry.

11.0 DISCHARGE PROCEDURE

Planning for discharge will begin at the point of admission/assessment. A 72 hour formulation meeting will take place; this will assist with planning and identifying any issues that may make discharge difficult. Initial risk assessment will also be completed at the point of admission. The Trust Discharge Intervention Team will be contacted identifying discharge barriers following the 72 hour formulation meeting. This would include supporting a patient being transferred from supported housing or

even housing to a more supported environment so that BEH staff work with the patient to agree to end any tenancies

The discharge destination should always be back to where the patient was admitted from, unless this is not possible. If there are issues relating to accommodation or if it is considered there may be a requirement for supported accommodation, the appropriate referral options and eligibility will be discussed with the patient or relative/carer. The ward team or Care Coordinator will make the appropriate referral to the Local Authority agency with support from the local Discharge Intervention Team. The actions required will be recorded on Jonah and in the patient's RIO notes.

All patients will have a comprehensive assessment including information about physical, psychological and social needs. Information will be recorded about financial and housing positions and will identify any carers.

12.0 PATIENTS WHO REQUIRE LOCAL AUTHORITY (LA) HOUSING FOR INDEPENDENT LIVING

Patients who require, and are thought to be eligible for emergency housing allocation, will be referred to the LA at the earliest possible date, as indicated by their Mental Health condition. This will be indicated when the crisis begins to subside and clinical assessment indicates the patient is expected to recover sufficiently to return to independent accommodation.

The Homelessness Reduction Act 2017 places a places a duty on hospital trusts, emergency departments and urgent treatment centres to refer people who are homeless, or at risk of becoming homeless within 56 days, to their local authority. Therefore, patients who are identified as homeless and/or at risk of homelessness need to be referred to the relevant Local authority following the 72 hour formulation meeting or at any other time during their admission.[1]

Delays that are due to social care/housing related issues will be escalated with BEH line mangers and within local CCGs and LA senior officers. The Care Act passed in April 2014 contains legislation around delayed transfers of care. The Act outlines requirements for Social Services. The Trust has a duty to notify social services of any patients requiring assessment and also of predicted discharge dates for those patients. Social services have a duty to assess in a timely manner and to meet the discharge date if appropriate notice has been given. Under the Act, the Trust has a duty to notify social services when a patient needs to be assessed and when they are going to be discharged. When making referrals to social services, Trust staff should not make definitive commitments to care that social services can provide until

[1] 190124 - GUIDANCE - Safe and effective discharge of homeless hospital patients.pdf

a full assessment by Trust services has been made with staff utilising the correct local brokerage and panel processes.

13.0 ESCALATION

Level of management support and involvement required increases as delay or complexity increases

NURSING RESPONSIBILITIES AND ESCALATION

Named nurse leads discharge planning throughout escalation process

- Ensure discharge plans are progressed from admission.
- Give patient/representative discharge planning leaflet, discuss discharge process, clearly define PDD and identify named nurse.
- Contact GP surgery on admission to liaise with those involved.
- Involve all MDT members in discharge plans and document input.
- Identify potential for DToC and follow appropriate pathway to manage any discharge dependencies proactively.
- Agree actions at discharge planning meetings – progressing, reviewing and updating actions between meetings.
- Liaise with allocated care coordinator or others throughout process.
- Access support from ward manager/Discharge Intervention team lead as soon as complexity is identified.
- Inform discharge Intervention team of potential DToC, who track through process.

Named nurse continues above actions -	**Ward manager supports named nurse with potential DToC**
	Ensure named nurse continues to follow and document actions above. Ensure required DOLS/ IMCA/ safeguarding referrals arranged in a timely manner. Contact, agree actions and continue to liaise as required with patient's consultant, GP, social services/CHC manager/ community hospital ward lead or others as appropriate. Arrange MDT meetings with patient, representatives and others as

	appropriate. Document specific actions agreed. Access support from line manager as soon as challenging situations or ongoing barriers to discharge (potential or actual DToC) identified. Consult discharge intervention lead for guidance as required.
Ward manager continues above actions -	**Inpatient team lead supports ward manager with complex discharge/ potential DToC** Ensure all actions above continue to be followed and documented. Contact, agree actions and continue to liaise as required with social service/CHC senior manager, community hospital matron or others as appropriate. Attend or ensure representation at discharge meetings. Access support from Divisional Director as soon as ongoing barriers to discharge are identified, if legal advice is required or if length of stay (LOS) is 30+ days. Consult discharge intervention team lead for guidance as required.
Inpatient team lead	**Service manager supports Inpatient team lead with on-going difficulties** Ensure responsible staff members as above continue to follow and document agreements and actions. Contact, agree actions and continue to liaise as required with senior manager or

director at relevant partner organisation.

Identify clear actions and hold individuals to account.

Implement Trust policies

Consult Trust legal advisor as necessary.

Ensure Trust policies are reviewed to negate future occurrences.

It is anticipated that almost all potential DTOC cases will be resolved within this process, however, individual cases that are not actively being resolved, will be escalated between the Trust and the identified LA or CCG (Stakeholder). This will be referred to as Escalation Level 1.

Escalation Level 1 will be time limited and will take place within 72 hours of a potential DToC being identified. The Trust borough Managing Director (MD) will take responsibility for determining the urgency of escalation based on the presenting situation and impact on patients and Trust resources. The Trust borough based MD will liaise directly with the stakeholder MD confirming escalation to Level 1. This conversation, confirmed by email, will establish any outstanding actions required to be completed within the following a 72 hour period. These actions will be designed to facilitate a safe discharge within the stated 72 hour Escalation Level 1 period. Should this fail, or the time limited period of 72 hours expire, the Trust will invoke Escalation Level 2.

In the event that Escalation level 1 fails to facilitate a discharge within 72 hours or agree a plan and timetable for discharge, the case will be further escalated to Escalation Level 2. This escalation process is time limited for a period of 72 hours.

BEH Chief Operating Officer will contact the Director of Commissioning, or equivalent (CCG) and Director of Social Services, or equivalent, (LA). This escalation is designed to facilitate senior level brokerage, so establishing a definitive decision of liability and action. The outcome of the escalation will provide a directive for specified actions to be implemented within 72 hours, so affording a safe discharge.

Should Escalation Level 2 not secure a safe discharge, the Trust will agree a process with both Commissioners and local authority to resolve any issues outside of this policy.

14.0 Delayed Transfer of Care (DToC)

Why not home? Why not today?

Behind every delayed transfer of care from hospital to home, there is a person, in the wrong place at the wrong time

Introduction

Identifying and counting DTOCs helps whole systems to understand unmet need and identify bottlenecks and ensures that pathways through the system are patient-oriented rather than organisation or service-centred. Further, it supports partners across the local health economy are aware of and are taking equal responsibility for timely and person centred discharges for patients who are using inpatient services for a brief intervention.

Principles

The most recent national DTOC guidance has identified the following principles underpinning the counting and collecting of DTOCs data as:

- Improve services for patients by reducing situations where people are in hospital longer than they need to be, which has a detrimental effect on their recovery, rehabilitation and long-term health and well-being; this may be particularly problematic for people who are frail or have long-term care and support needs.
- Encourage system-wide investment in services and support which can reduce and prevent the likelihood of delays occurring in the first place.
- Reinforce the importance of integrated and partnership working between acute, mental health and community trusts, intermediate and rehabilitation services, social care, service providers and primary care, to meet the needs of patients and their carer's at the right time in the right setting.
- Ensure discharge systems are integrated, so that planning is proactive and undertaken in parallel, rather than reactive and undertaken sequentially, which will contribute to improved flow.
- Develop a fair and consistent system of notification for alerting community and social services to the likely need for assessment and services post-discharge and to promote forward planning for discharge by communicating clear proposed patient discharge dates.

Definition of a Delayed Transfer of Care (DTOC)

A delayed transfer of care (DTOC) from NHS-funded acute or non-acute care occurs when an adult (18+ years) patient is ready to go home and is still occupying a bed.

A patient is ready to go home when **all of the following three conditions are met**:

1. A clinical decision has been made that the patient is ready for Discharge AND
2. A multidisciplinary team (MDT) decision has been made that the patient is ready for Discharge AND
3. The patient is considered to be safe to discharged.

1. **Clinical Decision**
   - A clinical decision in an acute setting means a consultant-led medical decision.
   - The clinical decision, that a patient is medically optimised, is the point at which **care and assessment could be continued at home or in a non-acute setting or the patient is ready to go home**.
   - A patient being classified as medically optimised **does not equate to them becoming a DTOC and is not sufficient for any delay to be reportable as a DTOC**.

2. **Multidisciplinary team (MDT)**

Clinically optimised means professionals asking themselves the following questions (where relevant):

- Does the patient's care need to be continued in the current clinical setting?
- Are the needs of the patient better met in a different care setting?
- If the support and services required, to meet the assessed need at home, were available at this moment, would the MDT in the hospital confirm that the patient could now go?
- If I saw the patient today in outpatients, or in the Emergency Department, would I admit them or would I try to get them straight home again with any additional support they needed?

Clinically optimised for discharge decision making process:

- **Does not** mean whether all the assessments have been completed and all equipment delivered.
- **Is not** dependent upon whether or not the patient is back to a baseline level of function.
- **It is date and time specific** and as such should be acted upon in a timely manner otherwise the clinical decision may need to be reassessed.

   - A multidisciplinary team (MDT) in this context should involve people from all the relevant professional groups and support providers who have knowledge of the patient and the support they will need in their home setting. Where consent has been given by a patient, then consideration should always be given to involving family members, paid carers, unpaid carers or volunteers.
   - The role of the MDT is to balance the acute health care requirements of the patient, the desire of patients to return to their home environment as soon as

possible, the potential harms associated with staying in hospital and the risks of being discharged home too early, which could result in a re- admission.

- Non-participation by parties external to the trust reporting the delay, including family members and patient advocates, in the requirements of the MDT, does not represent a valid reason to prevent a delay being recorded as a DTOC

3. Safe

Safe to discharge means asking the question "if what the patient needs were available now, are they safe to go home?" A delay in an assessment, or the lack of provision to meet a need, does not necessarily mean it is unsafe to discharge someone.

- Concerns about safety on discharge should be identified and addressed through early discharge planning, so they do not contribute unnecessarily to delays.
- Where there are general concerns about safety on discharge, the views of the patient or their advocate/representative must be sought about these concerns. This should also include what, if anything, they wish to happen in relation to these concerns. The views of any carers in their own right should also be sought.
- If there are concerns that a patient will be at risk of **abuse or neglect on discharge**, their views must be sought about that risk and to where they will be discharged. A decision should be made about whether to raise a safeguarding concern with the Local Authority, in line with the policies and procedures of the local Safeguarding Adults Board.

<u>Counting Delays</u>

The monthly SitRep (MSitDT) return captures delays for patients awaiting lower levels of care, either a discharge home or a transfer to a non-acute bed for intermediate or interim care, irrespective of whether these beds are within the same or a different care provider. Patients may spend longer in NHS-funded care than is necessary because of delays caused by internal systems within the reporting trust. Although good practice means these delays should be addressed as part of normal internal business improvement practices**, internal delays do NOT equate to a delayed transfer of care** (DTOC) and must NOT be reported in the monthly SitRep (MSitDT) return.

Delays caused by external systems, which are outside of the control of the care provider, **DO equate to a DTOC and must be reported** in the monthly SitRep (MSitDT) return.

Internal delays include:

- Lack of MDT engagement by members internal to the reporting trust.
- Lack of Patient Transport Service (PTS) availability.
- Unavailability of CRHT to take out and/or medication.
- Unavailability of Assessments to be undertaken by a member of staff funded by the reporting trust.
- Unavailability of Tests or Procedures.

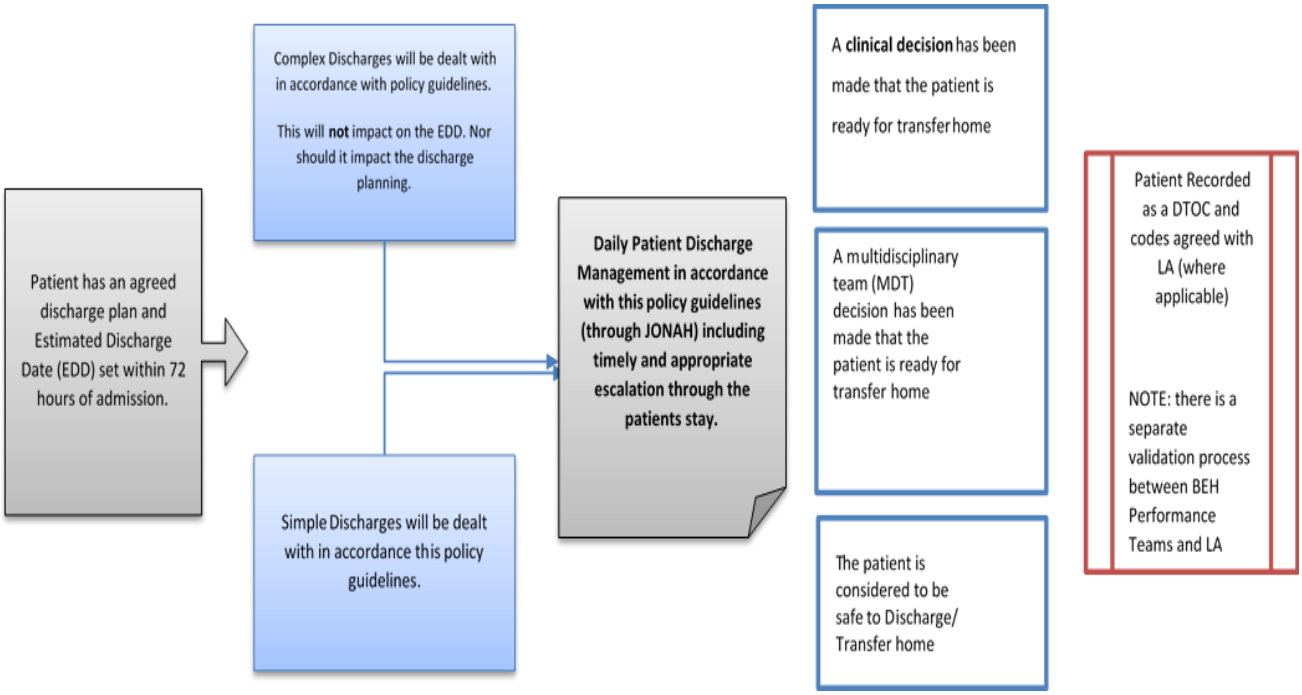
Patients that are in a BEH Bed but are the responsibility of a different Local Authority (not Barnet Enfield or Haringey) are not to be attributed as a delay to the Local Authority that is hosting them.

Principles behind attributing delayed transfers of care (DTOCs) to Local Authorities

- The Care Act (2014) and the Care and Support (Discharge of Hospital Patients) Regulations (2014) set out the arrangements for discharging people from acute care, where they are likely to have ongoing social care and support needs; in particular they set out the process and timings for issuing assessment and discharge notices which must be applied to NHS patients in receipt of acute care.

- DTOC attribution is by ordinary residence. Irrespective of who is responsible for the delay, it is always counted under the Local Authority of ordinary residence, even where a patient is awaiting out of area services. DTOC attribution helps to understand where patients are experiencing unnecessary delays and not to apportion blame.

DTOC PROCESS



MHSDS v2 Reason Code		Unify Reason Code		Possible Attributions in Unify collection
A2	Awaiting care coordinator allocation	O	Other	NHS
B1	Awaiting public funding	B	Public funding	NHS/ social care/ both
C1	Awaiting further non-acute (including community and mental health) NHS care (including intermediate care, rehabilitation services etc.)	C	Further non acute NHS care (including intermediate care, rehabilitation etc.)	NHS
D1	Awaiting Care Home Without Nursing placement or availability	Di	Care home placement - residential home	NHS/ social care
D2	Awaiting Care Home With Nursing placement or availability	Dii	Care home placement - nursing home	NHS/ social care/ both
E1	Awaiting care package in own home	E	Care package in own home	NHS/ social care/ both
F2	Awaiting community equipment, telecare and/or adaptations	F	Community equipment/adaptions	NHS/ social care/ both
G2	Patient or Family choice (reason not stated by patient or family)	G	Patient or Family Choice	NHS/ social care

G3	Patient or Family choice - Non-acute (including community and mental health) NHS care (including intermediate care, rehabilitation services etc.)			
G4	Patient or Family choice - Care Home Without Nursing placement			
G5	Patient or Family choice - Care Home With Nursing placement			
G6	Patient or Family choice - Care package in own home			
G7	Patient or Family choice - Community equipment, telecare and/or adaptations			
G8	Patient or Family Choice - general needs housing/private landlord acceptance as patient NOT covered by Housing Act/Care Act			
G9	Patient or Family choice - Supported accommodation			
G10	Patient or Family choice - Emergency accommodation from the Local Authority under the Housing Act			
G11	Patient or Family choice - Child or young person awaiting social care or family placement			
G12	Patient or Family choice - Ministry of Justice agreement/permission of proposed placement			
H1	Disputes	H	Disputes	NHS/ social care
I2	Housing - Awaiting availability of general needs housing/private	I	Housing - patients not covered by Care Act	NHS/ social care

	landlord accommodation acceptance as patient NOT covered by Housing Act and/or Care Act		NHS
I3	Housing - Single homeless patients or asylum seekers NOT covered by Care Act		NHS/ social care
J2	Housing - Awaiting supported accommodation		Social care
K2	Housing - Awaiting emergency accommodation from the Local Authority under the Housing Act		
L1	Child or young person awaiting social care or family placement	O Other	NHS/ social care
M1	Awaiting Ministry of Justice agreement/permission of proposed placement	O Other	NHS
N1	Awaiting outcome of legal requirements (mental capacity/mental health legislation)	O Other	NHS/ social care

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15.0 NO RECOURSE TO PUBLIC FUNDS

On occasions patients who have no recourse to public funds (NRPF) will present to the Trust in crisis. Many of these patients will be confirmed as having a lifelong enduring mental problem. Such patients will often be subject to detention under Section 3 of the mental Health Act, and will subsequently be subject to Section 117 of the Mental Health Act. The Trust Discharge Intervention Team will be contacted identifying discharge barriers following the 72 hour formulation meeting.

Such patients will be provided with a Mental Health service, equal in every way, to service provision afforded to all presenting patients.

When providing care to patients with NRPF. The Trust will ensure that all previously stated processes - 5.0 to 8.5 - are followed.

The borough Managing Director will notify both the LA and CCG when a patient with NRPF is identified. This will be confirmed in writing to the appropriate Senior Officers following the 72 hour formulation meeting.

This letter acts to both notify stakeholders of shared responsibility and to request that a NRPF stakeholder meeting, between the Trust, Local Authority and CCG, takes place within one week of the issue date. The Managing Director in the borough of origin (or nominated deputy) will chair and co-ordinate the meeting.

The borough based Managing Director will work collaboratively and actively to share the responsibility of care and to facilitate the sharing of all relevant information.

The stakeholder meeting will aim to establish all possible options of care provision that will facilitate a safe discharge plan. Representatives will be asked to consider their responsibility as set out in the 1948 National Assistance Act, the Human Rights Act and the Mental Health Act with specific reference to Section 117 Duty of After Care. Representatives will often need to seek further evidence and /or request legal advice. Stakeholders are requested to ensure that attending representatives are afforded a sufficient level of seniority, to act as decision makers during the meeting.

If representatives of stakeholders are not of such seniority that they can act as decisions makers, it will be the responsibility of the stakeholder representative to escalate the case appropriately, ensuring detailed hand over of the case, within their specific organisation.

Should this be necessary, the stakeholder Senior Officer who has received the escalation will contact the Chair within 2 working days, confirming their decision-making and action.

Should the stakeholder decision makers be unable to agree a safe discharge pathway for the patient, and the patient subsequently recover and be clinically

assessed as being fit for discharge with the only remaining deficit identified as the provision of a safe place of discharge, as dictated by the Mental Health Act Section 117 aftercare responsibility, Human Rights Act and the 1948 National Act Assistance Act, the Trust and stakeholders will agree a process to resolve issues outside of this policy.

What is the assessment process?

An assessment is how a local authority decides whether a person needs care and support to help them live their day-to-day life.

The assessment (Appendix 2) must be carried out by an appropriately trained assessor, for instance a social worker, who will consider a number of factors, such as:

•the person's needs and how they impact on their wellbeing – for instance, a need for help with getting dressed or support to get to work

•the outcomes that matter to the person – for example, whether they are lonely and want to make new friends

•the person's other circumstances - for example, whether they live alone or whether someone supports them

The aim is to get a full picture of the person and what needs and goals they may have. After carrying out the assessment, the local authority will then consider whether any of the needs identified are eligible for support.

Because not all care needs are met by the State, the local authority uses an eligibility framework to decide which needs are eligible to be met by public care and support.

16.0 SOCIAL SERVICES SUPPORT FOR PEOPLE WITH NRPF

Assistance provided by social services is not a public fund, so a person with NRPF is not prevented from getting help from their local authority's social services department, and should not be refused support because they have NRPF.

•When can housing and financial support be provided?

•Is the person in a group excluded from social services support?

•What does the exclusion mean in practice?

•What if the exclusion does not apply?

•What support will social services provide?

When can housing and financial support be provided?

There are provisions which require local authorities to provide some people with NRPF with housing and/or financial support in order to prevent homelessness or destitution. Such assistance can be provided to:

Families, where there is a child in need (for example, because the child is homeless or the parent cannot afford to meet the family's basic living needs)

•Young people who were formerly looked after by a local authority, for example, because they were an unaccompanied asylum seeking child (UASC), or other separated migrant child

•Adults requiring care and support due to a disability, illness or mental health condition

To establish eligibility for assistance, the local authority will undertake the following assessments:

•Families - a child in need assessment

•Adults with care needs - a needs assessment

People requesting help from social services should provide as much evidence as possible to confirm their circumstances, for example, an eviction notice or letter from the person who has been accommodating them explaining why they are no longer able to assist. It is very important that the person provides all information that they are asked for, and if they cannot do so, explain why this is not possible. Social services cannot legally refuse to provide support without making sufficient enquiries to be able to reach such a decision. If a person or family is in urgent need, then emergency assistance can be provided whilst this information is being gathered and assessments are being undertaken.

Find what social services will consider when a family requests help by completing our web tool - support for migrant families.

Although people with NRPF are able to receive help from social services, some people can only receive support if this is necessary to prevent a breach of their human rights. This is because exclusion applies to some people depending on their nationality and immigration status.

17.0 IS THE PERSON IN A GROUP EXCLUDED FROM SOCIAL SERVICES SUPPORT?

When a person or parent is in a group excluded from social services support, this means that social services can only provide housing and financial support when this is necessary to prevent a breach of the person or family's human rights or rights under the European treaties.

When the exclusion applies, social services will need to carry out a human rights assessment as well as a needs assessment to establish whether help can be given.

The five groups are:

•European Economic Area (EEA) nationals (not British citizens)

•People who are unlawfully present in the UK (including: visa over stayers; illegal entrants and refused asylum seekers who claimed asylum in-country, rather than at port of entry)

•People with refugee status that has been granted by an EEA country

•Refused asylum seekers who have failed to comply with removal directions

•Refused asylum seeking families that the Home Office has issued with certification confirming that they have failed to take steps to leave the UK voluntarily

The exclusion only applies to help from social services which are provided under the legislation listed in the table above. Any other assistance from social services must be provided to people who are eligible, regardless of their nationality, immigration status or whether they have NRPF.

The exclusion is set out in Schedule 3 of the Nationality, Immigration and Asylum Act 2002 and also applies to the dependants of the people above.

The exclusion does not apply to children, but when a parent is in an excluded group, the whole family may be prevented from receiving housing and financial support.

The exclusion does not mean that a person or family can automatically be refused assistance, and in practice, there will be often be a reason why support can be provided

What does the exclusion mean in practice?

When people with NRPF do approach social services for assistance, the Local Authority will check their immigration status with the Home Office in order to establish whether exclusion applies. Local councils are required by law to inform the Home Office of anyone presenting who is unlawfully present, a refused asylum seeker who has failed to cooperate with removal directions, or a refused asylum seeking family certified by the Home Office as having not taken steps to leave the UK.

If a person requesting assistance is in an excluded group, social services will undertake a human rights assessment, and will firstly consider whether the person or family can freely return to their country of origin.

Things that prevent this include:

•A pending human rights application made to the Home Office or a subsequent appeal

•Inability to travel due to illness or medical condition

•Lack of travel or identity documents

If there is such a barrier in place preventing the person from returning to their country of origin, then it is likely that the local authority will be required to provide assistance when the person or family meets the relevant eligibility criteria, i.e. to a family with a child in need or an adult who has eligible care needs. Social services will regularly review the status of the barrier.

It will be unlawful for a local authority to refuse to assist a person who is in an excluded group without undertaking a human rights assessment.

If it appears that there is no legal or practical reason preventing the person from returning to their country of origin, then the local authority will need to fully consider the person's or family's circumstances in the UK and their country of origin.

Social services will need to establish what assistance is necessary to prevent a breach of human rights or European treaty rights. When the person or family is assessed as being able to freely return to their country of origin then the local authority may offer to provide assistance with travel to that country, and only provide housing and financial support whilst this is being arranged.

What if the exclusion does not apply?

The exclusion only applies to people who are in one of the five excluded groups.

People will not be excluded from social services' support when they have the following types of immigration status:

•Leave to enter or remain with NRPF

•European right to reside as the primary carer of a British or EEA national child,

•European right to reside as the primary carer of a child (in education) of a former EEA worker

•Asylum seeker (a person who has claimed asylum and has a pending asylum application/appeal)

•Refused asylum seeker who claimed asylum at port of entry rather than in-country (unless they have failed to cooperate with removal directions or are a family certified as not having taken steps to leave the UK voluntarily)

If the person presenting is not in an excluded group then social services would need to provide assistance if they meet the relevant eligibility criteria, i.e. to a family with a child in need or an adult who has eligible care needs.

What support will social services provide?

Social services can provide housing and/ or financial support to a person or family that have been assessed as being eligible for support, or when emergency assistance is needed whilst assessments are being carried out.

Housing

Types of temporary accommodation offered by the council could include a B&B's, hostel or private rented accommodation. It is possible that social services will provide accommodation outside of the council's area, which could be in a different region of the country. Services will explore supported accommodation and how to access the pathway. This may also include floating support assistance in someone's own home.

Subsistence (financial support)

There are no standard rates of financial support that a council is required to pay, so what is provided will be different in each area. For families, social services must determine how much to pay based on the needs of the child. They may decide what to pay on a case-by-case basis, or with reference to internal guidance or to other statutory support rates, for example, DWP benefits or Home Office asylum support, so long as the council is flexible and prepared to vary the rate depending on the child's assessed needs.

Subsistence may be paid in cash, by vouchers or on pre-paid cards. Using a bank account enables people to have more control over their finances, however, it is no longer possible for a person with no valid immigration permission (for example, a visa over stayer), to open a bank account, so this method of paying subsistence will not always be appropriate.

If a person believes they are not receiving sufficient financial support from social services, then they can speak to their social worker to request that the amount is reviewed. If the matter is not resolved to their satisfaction, they would need to seek legal advice.

Emergency support

Social services have the power to provide emergency support (housing and financial assistance) before an assessment is undertaken or completed. If an adult, or family with children under 18, presents as destitute and has no alternative accommodation or support available, then the provision of emergency support should be considered.

18.0 UNPLACED PATIENTS WHO REQUIRE SUPPORTED HOUSING OR RESIDENTIAL CARE

If there is dispute between stakeholders with regard to securing a suitable discharge destination providing supported accommodation, or if the need is not disputed but the stakeholder confirms that such accommodation is not available, the Care Coordinator and Ward Manager will work collaboratively to identify alternative discharge arrangements. At this point the Discharge Intervention Team will be contacted identifying discharge barriers.

An appropriate letter of notice will be drafted by the discharge planning team, approved by the Managing Director and issued to the stakeholder.

19.0 TRANSFERS

Safe and effective transfer of care should be undertaken with minimal disruption and risk. All transfers will be planned and managed in a sensitive way ensuring all communication is clear to the patient, relative/carer and receiving service. The patient should be fully informed and if able to do so give agreement to the transfer prior to the transfer taking place. This must be documented in the patient's record.

Following a decision to transfer a patient, the decision should be documented in the patient records with the rationale and decision to transfer. The transferring team/clinician must ascertain who will take medical responsibility.

The patient will be identified as medically and mentally (where applicable) well/fit for transfer by the medical team with recognised authority to do this.

The ward qualified staff must ensure that all medication dispensed for that patient accompany the patient to the new ward/team/department. This should also include any medication that had been brought into the ward by the patient on admission where appropriate

The transferring team must ensure a risk assessment is completed prior to every patient transfer to determine the appropriate mode of transport required e.g. secure vehicle, ambulance, taxi. The risk assessment must include number of staff required for escort and band to effectively and safely carry out the role of escort.

Adequate information from the transfer/transport risk assessment must be communicated to the transport provider so they can fulfil their duties under H&S legislation and ensure safety of all parties involved.

Verbal and written communication between the ward, department or receiving team/service is necessary so that information may be shared regarding specific requirements: falls risk; mental health risks (including mental capacity); infections; any special equipment required and resuscitation status.

The staff member accepting the patient must ensure that they have all the necessary information to care for the patient safely and correctly.

If a patient has or is suspected of having an infection risk the receiving ward/department must be notified in advance of the transfer and the transferring staff member must complete the inter-healthcare infection control transfer form for all patients.

The time of transfer will be agreed with the receiving ward/team/department where possible avoiding out of hours transfers.

The patient's property will be checked and accounted for, returning any valuables which have been held in welfare for safe keeping.

In the majority of cases the decisions regarding the transfer of patients between wards will occur with the involvement of the ward MDT, the patient and those involved in their care such as bed management. Patients will be provided with a nurse escort in line with their identified need to ensure that their transfer occurs safely.

EMERGENCY AND OUT OF HOURS TRANSFERS

It may be in the best interest of a service user to be transferred for urgent treatment without delay and proper arrangements and documentation cannot be developed or put in place. In these instances the following must be considered and any action taken in relation must be documented in clinical records:

- Arrangements regarding medication
- Information for informing relatives, carers, care coordinator and any other external agencies that need to be informed
- Information to be provided to service user if appropriate regarding arrangements for care
- Any identified risk, including need for observation and/or escorts for example

If the service user is subject to detention in hospital under the Mental Health Act 1983 as amended by the Mental Health Act 2007, all decisions about their care must be made in light of Statement of Guiding Principles (Mental Health Act 1983 as amended by Mental Health Act 2007 s118) for further information refer to Code of Practice: Mental Health Act revised 2008 (Please click link below)

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/435512/MHA_Code_of_Practice.PDF

Appendix 1

Discharge Intervention team roles and responsibilities.

Attend the Jonah Meetings for each ward daily.

Escalate to CC/Managers any actions from the Jonah Meetings (including when CC fails to attend meetings/72hour formulation).

Attend Daily Borough Bed Management Meeting with Ward Managers and Acute Team Lead.

Attend the Daily Bed Conferences at 12pm and 3:30pm.

Throughout the day, working with the ward managers, consultants and bed managers to ensure plans are carried out, and secondary plans are made should issues arise.

Make any referrals to recovery house that have been discussed.

Liaise with the private sector and ELFT regarding patients in their care- and participate in their ward rounds by phone. This is to ensure their swift repatriation to a BEH bed or discharge to a recovery house, handing over to the CRHTT.

Liaise with embassies and relatives for patients from overseas that are willing to return to their countries of origin to ensure their safe return.

Weekly meetings with the resettlement officer from the Recovery House- to prevent delays from pts in Recovery House beds.

Work closely with Discharge Social Workers (x2) for Enfield to prevent delays for patient with social issues and no cc allocation.

Liaise with Housing and Housing Association, in order to escalate any issues pertaining to pts accommodation - ensuring that these habitable and facilitate discharge.

Track any placements in the female PICU to ensure that these pts can be repatriated as soon as they are well enough to step down.

Attend the weekly Borough DTOC meeting, with a focus in discharge planning and provision and practical support.

Meet with patients and relatives to gain collateral information that will support an early discharge.

Meet with patients on the ward to explain procedures and the need when being repatriated to their respective boroughs or to another ward- additionally liaising with the relatives for these patients to provide relevant information and reassurance.

Work closely with the Home Treatment Team (CHRTT) to assess patients to aid facilitating safe decisions for discharge or leave.

Liaise with other trusts to acquire relevant information for patients who are admitted from other boroughs.

Prioritise a monthly meeting with the DIT team members from the other boroughs with the aim to improve the service we provide.

To ensure that all relevant information is documented accurately on RiO regarding patient care and plans for discharge.

Upload clinical notes received from the private sector or ELFT to patient's electronic files on RiO.

Be willing to escort patient on home visits to ensure property is habitable- when needed liaise with cc or enablement team to facilitate a deep clean.

Be willing to support when patients express anxiety about leaving the recovery house or the wards, to ensure they fully understand. This can involve accompanying them to their new placement.

Facilitate travel arrangements for patients being repatriated to other parts of the UK or abroad.

Appendix 2

RiO 72 hour formulation meeting standard format

Name of service user:

Date of admission:

Status

Date of 72 hours formulation meeting (& reasons for any delay):

Members present (name & role):

Background information (including presenting problems, reason for admission, predisposing, precipitating, perpetuating & protective factors):

Current medication:

Service user perspective (e.g. views on admission, medication etc.):

Mental state examination:

Capacity and Consent:

- Admission.
- Treatment

Risks identified (including accidental or intentional risk to self-others):

Risk to self:

Risk to others:

Plan for managing identified risk (e.g. level of observation, leave arrangement etc.):

Carer's perspective:

Accommodation needs:

Barriers to Home Treatment:

Care plan:

Members identified to feed back to service user: Present during the review

Appendix 3

1)

Dear Patient

From the time you come into hospital, your doctor and other members of the care team will be planning your discharge. This will include notifying you of your estimated date of discharge. Most people admitted to hospital complete their care and treatment here and are discharged home or to their normal place of residence. If you are not able to return directly home, or it is not possible to return to your usual place of residence, we will discuss with you transfer to an appropriate, alternative care setting.

If it is assessed that you require additional support to enable you to return home, we will work with you to establish your needs and a suitable package or care.

If whilst you are in the hospital, the decision is made that you will need help to enable you to continue living at home, or that medium to long term care, or supported accommodation is needed, we may transfer you out of hospital, to a

temporary, but appropriate setting, whilst the Local Authority or Clinical Commissioning Group secure the required package of care / accommodation.

Occasionally such a transfer will need to take place at short notice to ensure that we have enough available beds in this hospital to admit and care for acutely ill patients.

It is important that you, your family and friends understand that you may not be able to stay in hospital whilst waiting for longer term arrangements to be made. We will work closely with you and ensure you are kept fully informed.

We would like to assure you of our commitment to provide you with a high standard or care that will facilitate your recovery.

Please do not hesitate to speak to the ward manager or your care coordinator if you require further details.

Yours sincerely

2)

Dear … (Borough LA Senior Housing Officer, as nominated by LA)

RE – Impending DTOC due to absence of housing

I am writing to notify you that a patient presently hospitalised, who has previously been referred for assessment of their housing needs, has been medically assessed as being clinically fit for discharge.

Patient details xxxxxxx

Date initial referral was made to the housing service xxxx

The patient will be discharged from a hospital bed in 48 hours, on xxxx

I would like to request an appointment for the patient to present once discharged.

The discharged patient will be assisted to present at the LA emergency Housing department. The Trust will ensure their staff assists the discharged patient in every possible way, so to provide reassurance.

The Trust will not be in a position to readmit the discharged patient due to the LA not allocating emergency housing. Should the LA emergency housing team be unable to accept the discharged patient, the Trust will work collaboratively with the LA by securing temporary Bed & Breakfast accommodation and invoicing the LA at cost.

Yours sincerely

Managing Director

Barnet Enfield & Haringey Mental Health Trust

(Add Borough, address and tel no)

3)

Dear xxCCG & XXLA

Notice of Patient with No Recourse to Public Funds

I am writing to confirm that Barnet Enfield & Haringey Mental Health Trust have admitted a patient from Barnet / Enfield / Haringey who has been identified as having no recourse to public funds.

The patient was admitted on xxxx and a 72 hour formulation meeting took place on xxxxx.

At this meeting opinion was given that the patients potential discharge date is xxxxx

I would like to request a case meeting to discuss shared responsibility between the Trust, Local Authority and CCG, takes place within one week of the issue date.

The Trust will work collaboratively and actively to share the responsibility of care and to facilitate the sharing of all relevant information.

The stakeholder meeting will aim to establish all possible options of care provision that will facilitate a safe discharge plan. Representatives will be asked to consider their responsibility as set out in the 1948 National Assistance Act, the Human Rights Act and the Mental Health Act with specific reference to Section 117 Duty of after Care.

Proposed meeting xxxxxxx (within 1 working week)

Yours sincerely

Service Manager

(Add Borough, address and tel no)

4)

Dear (LA / CCG / Joint Commissioner)

RE – Impending DTOC due to absence of supported housing / Residential Home

I am writing to notify you that a patient presently hospitalised, who has previously been referred and accepted for assessment of their housing needs, and has been approved at panel, was medically assessed as being clinically fit for discharge on xxxxxx.

Patient details xxxxxxx

Date case presented at Panel xxxx

Date initial referral was made to the housing service xxxx

The patient will be discharged from a hospital bed in 5 working days, on xxxx

I would like to request confirmation of placement for this patient.

The Trust will not be in a position to maintain this patient in an acute mental health bed beyond xxxxxx

The Trust will continue to work collaboratively with the LA and CCG. Should no placement be confirmed by the notice date, the Trust will seek to place the discharged patient in the private sector and invoice the LA / CCG accordingly.

Please don't hesitate to contact me if I can assist you with resolving this case.

Yours sincerely

Managing Director

Barnet Enfield & Haringey Mental Health Trust

(Add Borough, address and tel no)

PRIVATE AND CONFIDENTIAL

5)

Dear xxx

RE: Your discharge from hospital

I am aware that you were advised on [insert date] that it is necessary for your discharge to be expedited as it is no longer appropriate for your care to be provided in a hospital environment. Staffs have confirmed that you have allocated accommodation which we have asked you to return to following a clinical review meeting held on xxxxx Barnet Enfield and Haringey Mental Health Trust will be discharging you on xxxxxx at xxxx to your home address

I would like to assure you that the Care Coordination support previously explained to you remains in place and your care will be transferred to your GP.

It is necessary for me to inform you that should you not vacate Trust premises at xxxx on xxxxx, the Trust will affect your eviction with immediate effect.

Yours sincerely

Managing Director

Barnet Enfield & Haringey Mental Health Trust

(Add Borough, address and tel no)