**ADMISSION AND DISCHARGE PROCEDURE**

**Operational procedure linked to Leeds Transfer of care Policy**

The key messages the reader should note about this document are:

1. This procedure is intended to ensure that service users are admitted to and remain in hospital for no longer than they need by effectively managing the inpatient stay.
2. It ensures that people are cared for in the most appropriate environment and that care is planned to meet the needs and goals of the service user with their full involvement.
3. Planning patient’s service -users transfer/discharge from inpatient care should commence on or before the day of admission to hospital.
4. That joint working and the sharing of responsibility for transfer and discharge from hospital across the whole system is critical to a well-managed and delivered process
5. That all agencies involved in the service users care working collectively is key to reducing length of stay, delayed transfers of care and the likelihood of emergency readmissions.
6. The transfer of care process will focus on the persons needs and both they and their carers should be involved and kept informed of what is happening at all times.
7. That service users and carers expectations as to the purpose of inpatient care are well managed with regards to the options available to them.

**DOCUMENT SUMMARY SHEET**

ALL sections of this form must be completed.

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**1.** **THE PROCEDURE**

* 1. **Background**

The admission, transfer and discharge of a service user to and from inpatient services is a critical function of our services in delivering a needs based person-centred approach to care. Whilst we work to try to minimise the numbers of service users who will require inpatient care it is an important part of the care pathway for some service users. Ensuring people do not stay in hospital for longer than they need to is however an important issue in both promoting recovery and maintaining patient flow across the care pathway.

An inpatient admission is a multi-disciplinary and inter-agency collaboration to ensure that the needs of the service user are met as effectively and efficiently as possible. We aim to develop a care and treatment plan based on goals identified by service users and carers and delivered through collaboration between Trust staff, our partners and service users, their families, carers and significant others i.e. advocates.

By more effectively managing inpatient stays and reducing delays for service users we will improve our overall patient flow. This will in turn reduce the numbers of service users needing an out of area placement.

The Trust identified that delayed discharges as well as being undesirable from a patient perspective had a significant impact on its flow. As part of its required reporting against the NHS’s OPEL framework to the Leeds CCG the Trust reports its delayed transfers of care as a percentage of total bed availability per patient group. These are mapped to OPEL levels 1 to 3 escalating and attract a score when these levels are reached and there is an out of area placement for the same patient group, thereby recognising the linkage between delayed transfers and its impact on bed availability. This interrelationship has been recognised across the Leeds health care economy and hence this procedure as well as being in the best interests of patients will also have a beneficial impact on the Trust’s OPEL declarations.

**1.2 Purpose of the procedure**

The purpose of this procedure is to:

* Describe the minimum standards of practice to be followed to support service users through their admission to hospital to achieve a timely transfer or discharge.

# To ensure that transfers of care are managed using the principles described by the Department of Health high impact changes: managing transfers of care and NICE guidance on transition between inpatient hospital settings and community or care home settings for adults with social care needs

* Describe how we will measure the performance of the Trust and our partners against these standards
* Ensure that it is the agreed needs and goals of the service user which determine the service most appropriate to coordinate their care, and **not** age or diagnosis.
* Set out the overarching principles and standards to support local protocols
* Describe the process to follow to escalate disputes and issues related to transfer and discharge from inpatient care to achieve resolution of these.
* To inform the local working instructions of each ward

**1.3 Objectives of the Procedure**

The objectives of this procedure are:

* To reduce the numbers of service users whose transfer from hospital is delayed and to reduce the number of days that service users who are reported as delayed are awaiting transfer
* To reduce the overall length of stay for people admitted to hospital and to free capacity to eliminate the need for out of area placement
* That potential barriers to discharge are identified as soon as possible and that these are mitigated through effective care planning
* To ensure that care delivery is well designed, effective and efficient
* That service users and their carers are given timely and appropriate information to help them plan for discharge at the point of admission so there are no surprises when transfer or discharge takes place
* That service users are treated with respect and dignity throughout their inpatient stay
* That any areas where gaps in service provision across the care pathways which are creating delays can be identified and escalated appropriately

**Flowchart of procedure**

**1.3 Description of Procedure/Process**

**1.3.1 Roles and Responsibilities**

|  |
| --- |
| **Crisis Resolution Intensive Support Service (CRISS) working age. Intensive Home Treatment Service (IHTT) older peoples service – Triaging/gatekeeping bed management referrals.**   * As part of the CRISS/IHTT triaging assessment -identify goals expected from inpatient admission and the purpose of admission * Identify anticipated length of stay in hospital and communicate this with the service user, carer and ward team * Take lead in daily capacity conference call (OPS 10am ,WAA 10.15am)   **Bed Administrator**   * Participate in daily capacity conference call for both working age and older adult * Maintain list of available beds including out of area provision and update this with agreed discharges to give overview of capacity.   **Daily capacity calls (Leeds Care Group)**  Each day the adult acute and older people’s wards, CRISS (WAA) & IHTT (OPS) within the care group participate in the daily capacity call. PICU and rehabilitation and recovery join the call three times per week. The aim of the call is to ensure that:   * All parts of the inpatient pathway are aware of the demand for admission * All parts of the inpatient pathway are aware of the planned discharges * Wards can report availability of stable leave beds * Wards can escalate any issues arising following the PIPA meeting which is impacting on bed availability   **Care Coordinator**  All service users will either already have an identified care coordinator or will be allocated a care coordinator within 48 hours of admission. On admission to hospital, the Care Co-ordinator maintains the lead role.   * + Leads on discharge planning.   + Ensure that all service users have an agreed initial discharge plan within 72 hours   + Ensures that all required care documents are completed   + Liaise with ward to set preliminary discharge dates   + Attend Care Programme Approach reviews   + Develop plan of care for service user post discharge   + Communicate with service user, carers, other clinical teams and agencies regarding planned date of discharge   + Ensure crisis plans are up to date and that these include any relevant information related to hospital admission   If the Care Co-ordinator is not available at any point in this process, the appropriate duty worker must take over the duties of the care coordinator until they return. |

**Ward Team**

* Allocate named nurse and primary nursing team
* Participate in purposeful inpatient admission (PIPA) process working age
* Participate in multi-disciplinary team meetings
* Agree initial discharge date for service user
* With the service user and carers identify goals to be met through inpatient admission
* Deliver agreed interventions and review effectiveness of these
* Communicate with service user, carers, other clinical teams and agencies regarding planned date of discharge.
* Identify delayed transfers of care and record on Paris

**Consultant / Responsible Clinician**

* Participate in PIPA process
* Review care delivery with service user and ward team and amend as required to meet agreed goals for admission
* Receive and review weekly information reports for ward activity
* Consider ongoing needs of service user post discharge regarding legal status

**Discharge Support Team**

* Working age –Discharge support team- attend daily PIPA report out meetings across all 5 acute wards mon-fri.
* OPS Discharge support team -Attend Multi-disciplinary meetings on each ward throughout the week and record expected discharges.
* Undertake specific pieces of work to facilitate discharge for complex service users who require specialised activities to enable discharge
* Work with wards to set preliminary discharge dates for all service users
* Keep central records of expected discharges and demand for hospital admission.
* At report out /MDT meetings identify barriers to discharge and work with wards and other agencies involved to mitigate these.
* Maintain DToC report updating weekly to show latest position and actions taken to mitigate the delay.
* Record on PARIS transfer and discharge case-notes any updates regarding individual service users discharge plans and inform ward.
* OPS have weekly delayed transfer of care meetings with Adult Social care.
* Escalate issues related to Delayed transfers and discharges to Matrons and Senior Operational Managers which cannot be resolved by the ward teams.

**Discharge and Capacity lead - Discharge Support Team.**

* Discharge and Capacity Lead-Attends OPS Delayed transfer of care meetings weekly
* Attend Capacity & Dtoc care group meetings.
* Maintain Dtoc report updates.
* Ensure Discharge support team processes are followed
* Act as a point of contact for service-users/carers, other involved agencies and ward staff are aware of options for transfer/discharge from hospital. And discuss any concerns they may have.
* Attend CPA /professional meetings/complex case meetings when appropriate
* Act as point of contact for ward staff regarding recording delayed transfer of care process (see appendix )
* When service user/carer is informed they are medically optimised or fit for discharge to meet with service-user/carers within 5 working days to discuss discharge plans. (it may be appropriate that ward manager or keyworker have these discussions) A clear plan including next steps and timescales will be set with the service user and their carer and this will be recorded in the clinical record. Give letter 2 the letter will explain that although the Trust will attempt to have a mutually agreed plan for discharge there may be times when this cannot be achieved. In these cases the Trust may therefore need to facilitate discharge to an appropriate placement whilst the ultimate planned discharge destination becomes available.
* To escalate to senior operational managers/matrons complex barriers to transfer/discharge

**Ward Managers**

* Ensure that PIPA /MDT process is followed for all service users and that all service users have initial date of discharge agreed within 72 hours of admission
* Ensure that all service users have a discharge plan within 72 hours of admission
* Act as an initial point of contact for service users and carers to ensure that they are aware of options for discharge from hospital and discuss any concerns they may have with these.
* Receive and review weekly information reports for ward activity

**Matrons**

* Monitor use of the PIPA/MDT process and make changes to the design of the process as are required
* Be aware of the number of delayed transfers of care and assist the wards in care planning to facilitate discharge for these service users.
* Escalate issues related to Delayed transfers and discharges to Operational Service Managers and Clinical Directors which cannot be resolved.
* Meet with service users and relatives as part of the dispute resolution process and ensure that they are aware of the options available to them and what can be provided for after care.
* Receive and review weekly information reports for ward activity

**Operational Capacity and Flow Manager**

* To monitor overall capacity and demand for inpatient admission to adult acute and older people’s services
* To work with teams to instigate strategic review of service delivery and to make recommendations on how this can be improved
* To provide operational leadership in work related to bed management with the sustainability and transformation plan
* To lead work with colleagues to review barriers to discharge and to implement service wide changes to improve this.
* To lead daily demand and capacity calls with clinical teams

**Senior Operational Manager**

* Understand current bed pressures
* Ensure that PIPA process is implemented across the adult working age acute wards.
* Ensure Multi-disciplinary meetings are implemented across all acute older people’s acute wards.
* To provide operational overview of demand and capacity and facilitate discharge of service users where specialist input is required
* Understand patterns of bed pressure
* Undertake actions as required when escalation of complex individual cases is required.

**Deputy Chief Operating Officer**

* Chair the fortnightly care group capacity and delay meeting
* Most complex delays will inform the Chief Operating Operator and Trust solicitors.

Deputy Chief Operational Officer will recap all the steps which have been taken and the reason that the Trust is considering taking legal action. It should be made clear that the Trust is considering taking this action to safeguard the wellbeing of other service-user by ensuring that beds are available locally.

**Adult Social Care**

* Will undertake timely assessments within the Care Act framework of 28 days.
* Will attend discharge and or professionals meetings
* Will engage and liaise proactively with family members in order to formulate appropriate and responsive support plans
* Will work with multi-disciplinary team and family members plus advocates to achieve timely discharge
* Will identify appropriate services to meet eligible need and formulate requests to take to the relevant funding panels for approval.
* Where an individual is on the Delayed Transfers of Care list the Head of Service will review, edit and approve the relevant codes on behalf of the Director of Adult Social Services

**Steps of the process**

**1. Purposeful inpatient admission process**

The purposeful inpatient admission process aims to ensure that agreed activities are undertaken for service users in a planned and consistent way. Through this it is expected that potential barriers to discharge are more quickly understood and are eliminated. Through this the time service users spend in hospital is no longer than it needs to be. There is an expectation that all working age wards will hold daily PIPA meetings, older adult wards will hold weekly Multi-disciplinary review meetings -each service user will be reviewed as part of this process.

At admission it is expected that service users will have a discharge date set and will be told this provisional date. This will ensure that the service user, carers and colleagues have a shared understanding of the aims of the inpatient admission and how long this is likely to be. This will allow everyone to plan for discharge at the same level of intensity.

Purposeful inpatient admission will reduce length of stay for service users and provide a more consistent standard of care. It helps to meet the NICE guidance for transfer and discharge is met by ensuring that everyone holds a shared understanding of what actions need to be taken to facilitate discharge and that these can be communicated to all involved in the discharge planning process.

At admission a letter will be given to the service user and carers explaining how the Trust has a responsibility to avoid DToCs where possible. The purpose of the letter is to be clear from the outset what the offer from the Trust can be and that service users cannot expect to wait in hospital when they no longer require inpatient care.

**2. Assessment and Treatment.**

Initial discharge plan will be agreed by the MDT which is inclusive of Adult Social Care, all barriers to discharge will be identified and plans developed to mitigate these. An initial discharge date should be set and communicated to the service user and their carers.

Initial CPA meeting date set for 2 weeks from date of admission.teding standard pport

Information shared with patient and carer re discharge from hospital and options for care and treatment after discharge

Complete initial formulation and communicate this with the service users and others involved in their care

Give the service user and carers’ letters explaining the options which will available for discharge and the responsibilities of the multi-disciplinary team

All service-uses will be given an Estimated Date of Discharge (EDD) as soon as possible after admission by a member of the primary ward team.

Regular review and discussion about the EDD as part of daily PIPA report outs (working age and weekly Multi-disciplinary reviews will ensure all parties understand when support will be required to facilitate discharge.

Review formulation and care plan with the service –user and amend this as required, communicate this to others involved in their care

Ongoing review of service users progress to discharge, their needs and goals to be met during inpatient stay, has anything changed, have any barriers to discharge been identified and what actions are required to facilate transfer/discharge

Review planned date of discharge and amends this as required

Information continually shared and discussed with service user, community team, carers, adult social care and any other agencies identified and involved in the service user’s current or future care.

Decision patient is fit/safe/ready for discharge-inform service-user /carer and other agencies involved in transfer/discharge planning. Record in multi-disciplinary case-notes. And transfer and discharge planning case-notes

1st Letter given to service-user/carer to request they look for placements if appropriate by Multi-disciplinary team or Discharge and Capacity Lead.

**3. Discharge Planning**

The best discharge planning begins at admission. Understanding the purpose of admission helps to determine and set a likely initial date of discharge.

It is expected that most service-user will return to their previous accommodation with the correct support package in place when fit / safe / ready for discharge. A preliminary plan of discharge should be in place within 72 hours of admission and therefore where this is not expected to happen an alternative discharge plan should be developed. To reduce the amount of time the service user stays in hospital the ward team must ensure that all clinically appropriate internal assessments have been completed as soon as possible and that referrals for partners to undertake required assessments take place without delay. All assessments and referrals will be clearly recorded on Paris.

* Liaise with the Discharge support service and inform them of the discharge plan and date of discharge
* Community teams (CMHT and CRIS S)/IHTT/ICHT undertake regular in-reach to the wards to identify possible service users who could be given additional support to facilitate early discharge
* Where a Community Treatment Order (CTO) is required, then a referral for an Approved Mental Health Professional (AMHP) is made immediately, with details of discharge plans
* Involve the service user, carer and community teams including partners involved in their care in the discharge plan to and ensure any changes to this are widely communicated and explained.
* Communicate any use of leave with carers and other teams involved in the service user's care and any support needs with this
* Ensure that community follow up is planned within 3 days and that the service user, carer and provider where appropriate are aware of this
* Discharge summary sent to GP within 7 days of discharge

The principle to be followed in transfer planning is one of regular and candid discussions operating on a principle of no surprises for the service user and their carers. The transfer/discharge plan will be discussed with the service user and their carer and if there are any changes to this they should be informed. Throughout the planning process the views of the service user will always wherever possible be taken into account and acted upon. The outcome of all assessments should be explained to the service user and where there is disagreement this should be recorded in the clinical record.

It should be made clear from the outset what options are available to service users and also what options are not available and why. This will make clear the expectations from both the Trust and the service user and encourage flexibility with regards to transfer. It should be made clear that where a final outcome from the transfer cannot be immediately achieved, for example transfer to a care home near family or carers that this will remain the long term goal but in the short term a transfer to another placement may be required. In all cases it must be made clear that there is not an option for service users to remain on an acute inpatient ward once they are medically fit for discharge.

**Accommodation**

Discharge to stable accommodation is likely to improve someone’s recovery and reduce the chance of emergency readmission. It is therefore important that accommodation is considered very carefully as part of transfer/discharge. We must also however recognise that accommodation options are not limitless and there may be a need to compromise. The options which are available to service users should be explained to service users as soon as possible following admission.

Where accommodation has been identified as an issue for a service users a referral to the accommodation gateway (WAA) Discharge and Capacity lead should be made so that a more detailed assessment of the issues can be made. These services have a more detailed knowledge of the options available and the systems in place to assist service users to get accommodation /care home placement suitable for their needs. It should be discussed with the service user that there may be a need for them to move to available accommodation whilst they wait in the community for their preferred option.

In cases where service users are delayed awaiting accommodation their needs should always be raised with the accommodation gateway for review.

**Non UK nationals**

Non UK nationals may not be entitled to any support with regards to housing or benefits on transfer from hospital and this should be established as soon as possible following admission. The discharge facilitators will normally be able to help the ward staff in establishing an individual’s right to support.

Legal Status post discharge should be established and where necessary this should be checked with the border agency.

**3 Day Follow Up**

It is considered best practice for all service users to receive contact post discharge within 3 days from the allocated care coordinator. If a service user is to be discharged to another area outside of Leeds and will be remaining there contact should be made with the local mental health provider and arrangements for follow up agreed.

Prior to discharge an up to date address and telephone number for the service users should be obtained and this recorded on the information system.

**NHS Continuing Care**

The NHS is required to assess a service-user’s needs utilising the National Framework for NHS continuing healthcare and NHS funded nursing care.

If the screening does not identify eligibility for a full assessment then the service-user must be informed of the outcome and the screening tool retained in the notes, dated and signed by the clinician who undertook the assessment

Where full assessment is indicated, the Continuing Care link worker will then contact the ward, patient and carer/significant other to arrange a full assessment of eligibility utilising the Decision Support Tool – This is not a decision tool, but provides documentary evidence that consideration has been given to eligibility in all 11 domains. This assessment will then be taken to Panel for a decision.

Communication relating to the continuity of medical care will follow the existing practice and procedures.

**4. Delayed Transfers of Care (DToC)**

A delayed transfer of care occurs when:

* The service user is deemed medical fit or medically optimised for transfer/discharge by the Multi-Disciplinary Team. In either the MDT review or a CPA meeting. The decision that the level of care being provided i.e. in an acute in-patient setting is no longer needed should be taken by the Multi-Disciplinary Team (MDT) and should be documented in the care record and fully explained to the individual and their carer
* The service-user / carer and other agencies involved have been informed and advised to look for placements and accommodation and none have yet been sourced or the relevant assessments from providers have not been undertaken.
* Support has been offered by either Adult Social Care or the Accommodation Gateway to source placements and there is currently no available provision to meet need.
* Letter B has been given to the service user and carer informing them to begin looking for placements/accommodation.
* All required referrals have been completed.
* Following a 14 working day period and no placement /accommodation has been found. MDT to record on PARIS the service-user as a delay reason why and agencies responsible.

All Service users transferring between wards providing the same level of care do not count as delayed transfers of care. For the transfer of care to be recorded as delayed the service user must be safe to transfer.

The service user and where appropriate their carers will be informed that continued inpatient care is no longer required and that they are now being reported as a delayed transfer of care. The service user and their carers will be informed by the ward team of the plan for transfer from inpatient care and given the opportunity to discuss this and any concerns that they might have. A clear plan including next steps and timescales will be set with the service user and their carer and this will be recorded in the clinical record.

In the majority of cases the delay in facilitating discharge will be frustrating for service users and their carers and the reasons for the delay and the actions being taken will be explained to them. Where actions are needed to be taken by the service user or their carers in conjunction with Trust teams this should be explained to them and the reasons for these actions need to be taken. These conversations will be recorded in the clinical record. Any difficulties that the service user or carers may have in undertaking any actions will be considered and where appropriate support put in place to help them with this. This may include support from ward and community staff as well as 3rd Sector partners, advocacy and Adult Social Care.

The ward and community teams will ensure that there are regular, at least weekly, updates given to the service user and the carers with regards to their transfer and the delay. These updates will focus on the actions that have been taken and will include an estimate of when transfer will happen. Any changes to the estimated date of transfer will be explained to the service user and the reasons for this.

Where a delay is due to the service user and / or carer disagreeing with the proposed plan and a mutually agreeable plan for transfer from inpatient care cannot be achieved this should be reported as a dispute and the escalation process instigated. The service user and carer will be informed that this will be escalated.

**4.3 How will DToCs be managed?**

The service user and their carers should be informed by the ward team of the plan for transfer from inpatient care and given the opportunity to discuss this and any concerns that they might have. The service users care coordinator and social worker will be involved in all discussions with the service user regarding plans for transfer and will support the service user and carers with transfer.

The Older People’s Services Discharge and Capacity lead and Discharge Lead Working Age Adults will maintain a list of all service users who are reported as a delayed transfer of care.

The report will detail the actions taken in the last week to facilitate the transfer of the service use from inpatient care and any identified barriers which are preventing this. The OPS Discharge and Capacity lead /Discharge Lead working age and discharge support service will review the actions which have been taken and give advice to the ward team on any other actions which could be considered.

Any barriers which have been identified will be discussed at the fortnightly delayed transfer of care group which will be attended by senior managers from the Trust and Adult Social Care. Terms of reference see appendix 2

**4.4 Working together to avoid DToCs**

The care coordinator, ward team, Discharge and Capacity Lead and the discharge support team will work constructively with colleagues from partner agencies to facilitate a smooth transfer of care for the service user. Understanding and identifying possible causes of delays is critical to avoiding these through appropriate care planning. In all cases the service user and carers should be involved in the care planning and the services need to be clear with regards to the expectations of the service user and what can be achieved during an inpatient admission.

Support for the service user with accommodation delays is available through the Accommodation Gateway workers. The gateway specialises in providing support for services to receive priority for housing, identify possible accommodation and support people with gaining bonds for private lets.

Where delays and blockages occur within our internal systems or between organisations these should in the first instance try to be resolved by the care coordinator and ward team. Where this is not possible escalation of the issues should be made through the management structure. (See flowchart). Prior to any escalation it will be expected that all possible solutions will have been explored and documented as to why they could not be implemented to remove the delay.

In some cases delays will occur because the service required by the service users to facilitate transfer is not available. Issues related to the commissioning of services should be immediately raised with the appropriate service manager for discussion with the Clinical Commissioning Group and Adult Social Care.

**4.5 DToC recording**

Once a DToC has been identified by the MDT this must be recorded on Paris using the agreed process. If a service user is not recorded as delayed on Paris this will not be reported as part of the Trust’s submission and will not be included as part of the Delayed transfer of care review process. For guidance on how to record DToCs on Paris staff can contact either the Paris team or the bed management team.

**4.6 Review of delayed transfers of care**

All delayed transfers of care will be reviewed daily on the working age wards as part of the PIPA process and weekly in MDT reviews on the older adult wards any actions which either need to be taken or have been taken to facilitate discharge should be agreed and a member of the ward or bed management team nominated to take action within an agreed timescale.

**4.7 When is a DToC Cancelled?**

A delayed transfer of care will be cancelled when one of the following occurs:

* The service user is transferred from inpatient care. Discharging a service user on Paris will automatically cancel the DToC however transfer of the service user to another ward within the Trust will require the DToC to be manually ended on Paris.
* The service user’s clinical presentation changes so that they are no longer considered to be medically fit for discharge. This must be agreed by the multi-disciplinary team and recorded in the service user’s clinical records. Paris should be completed giving the date that the DToC ceased.

Where the service users clinical presentation changes it is important that the care coordinator and others involved in their care are made aware of this. The service user and carers will be informed that they are no longer being recorded as a delay.

**Disputes and Escalations**

Whilst the majority of admissions will result in a smooth transfer of care from inpatient services there will be occasions when the ward team will require support in managing disputes. All efforts should be made at each level to achieve a mutually acceptable agreed outcome between the service user, the Trust and carers and for disputes to be avoided. On many occasions disputes are created by a mismatch of expectations and honest, good quality and regular communication can help to avoid this. Trust staff should be clear and open with service users and their carers with regards to their options for transfer and that remaining on the ward is not an option in most cases. Service users do not have a right to occupy an NHS bed for an indefinite period of time.

In its guidance ‘NHS responsibility for meeting continuing care needs’ the Department of Health states that:

‘Where a person has been assessed as needing care in a nursing home or residential care home arranged by a local authority, he or she has the right under the direction of control to choose within limits on cost and assessed needs which home he or she moves into. *Where however, a place in a particular home is unlikely to be available in the near future, it may be necessary for the patient to be discharged to another home until a place is available*.’

Before a dispute can be raised by the ward the following must have taken place:

* All necessary assessments have been completed by the multi-disciplinary team and copies shared with the service user and carer and prospective providers where appropriate
* Discharge to the service user’s own home has been fully explored and there is agreement that this is not appropriate
* Service users and carers have been provided with information to help them find a suitable placement
* Liaison with the service user and carers has taken place with a member of the nursing team
* Funding from the Local Authority and / or CCG (if the service user is not self-funding) has been confirmed.
* It has been confirmed that the service user remains medically fit or medically optimised for discharge

Where a dispute regarding transfers from inpatient care has been identified the ward team will organise a meeting with the service user and where appropriate carer or advocate to discuss their options. The meeting should involve appropriate professionals. The ward manager will confirm the following with the service user:

* That all information has been provided to the service user and carers
* The reason for the dispute
* The options for discharge and possible destinations
* That a further 7 days will be allowed to arrange transfer of care from inpatient services.

The ward manager will ensure that all those at the meeting are given the opportunity to speak and will where possible answer any questions in an open and honest way. The ward manager will ensure that the discussion is recorded and any actions agreed are allocated with a timescale for completion.

If after 7 days the service user has not been transferred from the inpatient ward and transfer is not imminent then the Discharge and Capacity lead older peoples service and acute Discharge and capacity Lead working age should escalate to the Operational Service Manager and head of service (adult social care)are made aware of the dispute. Prior to this the Discharge and Capacity lead (OPS) Discharge and capacity Lead (WAA) will ensure that all risks have been considered and reviewed, that the service user remains medically fit for discharge, confirms all available options for discharge and that all reasonable steps have been taken to resolve the dispute. The Operational Service Manager will arrange a meeting with the service user and carer. If following the meeting a reasonable discharge date cannot be mutually agreed then the Operational Service manager will escalate to the Deputy Chief Operational Officer who if required agrees that legal proceedings should be instigated then a meeting with the service users and carers should be organised to discuss this within 5 days. At this point the Deputy Chief Operational Officer should inform the Chief Operating Operator and Trust solicitors.

## At the final review meeting the Deputy Chief Operational Officer should recap all the steps which have been taken and the reason that the Trust is considering taking legal action. It should be made clear that the Trust is considering taking this action to safeguard the wellbeing of other service-user by ensuring that beds are available locally. All reasonable steps should be taken to resolve the dispute and the date that the service user must be by should be confirmed with the service user and carers. All discussions and actions will be recorded.

## ****Escalation flow chart****

Steps 1 - Providing standard information and support

**Where a dispute regarding transfers from inpatient care has been identified the ward team will organise a meeting with the service user and where appropriate carer or advocate to discuss their options. The meeting should involve appropriate professionals. The ward manager will confirm the following with the service user:**

* **That all information has been provided to the service user and carers**
* **The reason for the dispute**
* **The options for discharge and possible destinations**
* **That a further 7 days will be allowed to arrange transfer of care from inpatient services.**

**The ward manager will ensure that all those at the meeting are given the opportunity to speak and will where possible answer any questions in an open and honest way. The ward manager will ensure that the discussion is recorded and any actions agreed are allocated with a timescale for completion.**

Steps 1 - Providing standard information and support

**If after 7 days the service user has not been transferred from the inpatient ward and transfer is not imminent then the Discharge and capacity Lead working age should escalate to the Operational Service Manager and head of service (adult social care) are made aware of the dispute. Prior to this the Discharge and capacity Lead will ensure that all risks have been considered and reviewed, that the service user remains medically fit for discharge, confirms all available options for discharge and that all reasonable steps have been taken to resolve the dispute.**

**The Operational Service Manager will arrange a meeting with the service user and carer. If following the meeting a reasonable discharge date cannot be mutually agreed then the Operational Service manager will escalate to the Deputy Chief Operational Officer who if required agrees that legal proceedings should be instigated then a meeting with the service users and carers should be organised to discuss this within 5 days. At this point the Deputy Chief Operational Officer should inform the Chief Operating Operator and Trust solicitors.**

**At the final review meeting the Deputy Chief Operational Officer should recap all the steps which have been taken and the reason that the Trust is considering taking legal action. It should be made clear that the Trust is considering taking this action to safeguard the wellbeing of other service-user by ensuring that beds are available locally. All reasonable steps should be taken to resolve the dispute and the date that the service user must be transferred by should be confirmed with the service user and carers. All discussions and actions will be recorded.**

* 1. meeting, appendix 1 – Sample letter to service user on admission

Appendix I sample letter Admission letter Older Adult

Dear

Our goal is to provide very good care in every aspect of your hospital stay. Our staffs are committed to working together as a team to coordinate your care and provide as much information as you need about your care. Your named nurse will review your care needs on a daily basis with the rest of the ward team to put in place a plan to transfer your care to right service to support your ongoing recovery.

We need your help to make sure that your stay in hospital is no longer than is needed. We aim to minimise your dependence on the ward and in so doing possibly increase demand on social and community care. We will also be able to make sure that we will always have capacity for people who need the level of care that can only our wards can offer.

When you are ready for discharge or transfer the ward will have already considered your on-going care provision and will have discussed this with you and your community care coordinator. Between the ward and your community care coordinator we will have undertaken all the required assessments to plan your future care and will be able to tell you the options that are available to you.

If your preferred choice is not available at the pint you are ready for discharge we will offer an alternative location or care provider whilst you await availability of their first choice. The ward tem, adult social care and our others partners will continue to support you in the community to offer support.

If you have any concerns with this please discuss these with your named nurse or care coordinator or in your ward review.

Yours sincerely

Operational Service Manager

Inpatient services

Appendix 1 Sample Admission Letter working age Adult

Dear

During your inpatient admission our goal is to provide very good care in every aspect of your hospital stay. Our staff is committed to working together, as a team, to coordinate your care and provide as much information as you need about your treatment and care needs. Your Primary Nurse will review your treatment plan with you, other members of the ward team and our community colleagues on a regular basis so that we can put in place a plan to transfer your care to right service to support your ongoing recovery upon discharge from hospital.

In order to do this, we need your help to make sure that your stay in hospital is no longer than is needed. There are two reasons for this: 1. We know that the vast majority of people make the best recovery at home supported by family, friends and professional community mental health staff once the acute phase of an illness is brought under control; 2. Hospital beds need to be available for those who are in greatest need. Creating capacity by transferring people home when they are well enough helps us to ensure that a local bed is always available when it is required.

Discharge planning takes place upon your admission and is kept under consideration throughout your treatment in hospital; you will always be included in this process. Your ward Consultant, Primary Nurse, Occupational Therapist (if appropriate) and Community Care Coordinator will help you by paying close attention to any matters that might affect your discharge so that everything possible can be done to prevent these being a barrier to you leaving hospital at the right time. *For some people having accommodation to go to may be an issue. If you think this may be a problem for you, please ensure that you discuss it with a member of staff at the earliest opportunity. We will do all that we can to assist you to have settled accommodation by the time of discharge and your cooperation with this process is very important. Of course, we always hope that your accommodation needs are in place by the time you are ready for leaving hospital but if this is not the case, then you will need to be discharged from hospital to present at Leeds City Council Housing Options Team who may, after assessment, assist you to find emergency accommodation and continue to support you to find permanent accommodation*. ***If you have accommodation when you come into hospital you should not give this up during your admission without first discussing it with a member of the team***.

Before you are discharged you will have a clear plan of the arrangements for your ongoing treatment and how to make contact should you need any urgent support.

If you have any concerns about any of the matters contained in this letter then please discuss it with your Primary Nurse or Care Coordinator or in your ward review.

Yours sincerely

Operational Service Manager

Inpatient services

Appendix 1 – Sample letter for discharge meeting

Date

Dear

Following the telephone conversation on the XXXX OR> we have been unable to contact you by telephone on the XXX, XXX, and XXX so in order to facilitate your relatives discharge. I am writing to invite you to a meeting at (TIME) on (DATE) in (LOCATION).

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

It is hoped that you will have made some progress in identifying discharge options. You may have already found a suitable residential or nursing home care provider. If so, please continue discussions with them and allocated social worker the Ward Manager or Matron. Please bring details of any placements and/or questions you may have to our meeting. If you are unable to attend the meeting please contact me on the telephone number above to discuss an alternative time.

Every effort will be made to arrange a convenient date for all parties to meet within the constraints of this busy unit and to be flexible in the light of your domestic arrangements. It is important that we hear from you as soon as possible in order to arrange a date for a safe discharge from the Hospital. If you are unable to meet for any reason please contact thenamed person above. In the meantime the clinical will continue to work with you/ you’re relative to facilitate discharge. (If no contact by telephone)

Please can you confirm attendance at the above meeting? If you have not contacted us the meeting will proceed to discuss the discharge plan. If you have any queries, or concerns, please do not hesitate to contact us on XXX contact name XXXX

Yours sincerely

Ward Manager/Discharge and Capacity lead

Appendix 1 Sample letter 3

Date

Dear

The meeting today was to discuss the need for you/person’s name to be discharged now that inpatient hospital care is no longer required. I am sorry you were unable to attend. All required assessments of [your/person’s name] needs are now complete and you/he/she is ready for discharge.

In discussion with the multi-disciplinary team it has been agreed that your/person’s name needs would be best met by returning home with appropriate domiciliary care moving into a to a care home with/without nursing adapt as appropriate. The following actions were agreed at the meeting: All agreements to funding for social/health care needs require approval by the Local Authority/\Clinical Commissioning group and will normally be based on the rate which the Local Authority/Clinical Commissioning Group expect to pay for this type of care support and your allocated Social Care representative/NHS Continuing Healthcare Nurse will supply/have supplied you with options available within this range. If you are unable to identify any available care option that you consider meets your/person’s name requirements or your preferred option is not currently available, you/person’s name may need to temporarily accept an interim care home/care provider whilst you wait for your preferred choice. A Social Care representative will support you. We have made arrangements to meet with you again on [Date,

Yours sincerely,

Ward Manager /Discharge and Capacity lead [Trust Name] Tel: direct line

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

**Appendix 2**

**Capacity and Delayed Transfer of Care Group**

**Terms of Reference**

1. **NAME OF GROUP / COMMITTEE**

Capacity and Delayed Transfer of Care Group

**2** **COMPOSITION OF THE GROUP / COMMITTEE**

**Members: full rights**

|  |  |
| --- | --- |
| Title | Role in the group / committee |
| Deputy Chief Operating Officer | Chair |
| Clinical services Manager (Acute and Older Peoples services) | Deputy Chair |
| Lead Clinicians Community and Inpatient | Member |
| Clinical Operational managers ICS/Inpatient | Member |
| Care Navigator OPS | Member |
| Crisis Assessment staff | Member |
| Performance and Capacity Manager | Member |
| Head of Service Adult Social Care | Member |
| Service Manager Adult social care | Member |
| Clinical Commissioning group manager | Member |
| Accommodation gateway manager. | Member |
| Out of area clinician | Member |
| Deputy Associate Director  Specialist & Learning disability services. | Member |

**In attendance: in an advisory capacity**

In addition to anyone listed above as a member, at the discretion of the chair of the group the group may also request individuals to attend on an ad-hoc basis to provide advice and support for specific items from its work plan when these are discussed in the meetings.

**3** **QUORACY**

**Number:** The minimum number of members for a meeting to be quorate is 6 including Chair or Deputy Chair and representatives from each of the service areas (community teams, ICS and inpatients). Operational managers may represent more than one service area for which they have operational responsibility. Attendees do not count towards quoracy. If the chair is unable to attend the meeting, and if otherwise quorate, the meeting will be chaired by The Service manager/Lead clinician.

**Deputies:** Where appropriate members may nominate deputies to represent them at a meeting. Deputies do not count towards the calculation of whether the meeting is quorate except if the deputy is representing the member under formal “acting up” arrangements. In this case the deputy will be deemed a full member of the group / committee.

It may also be appropriate for attendees to nominate a deputy to attend in their absence.

A schedule of deputies, attached at appendix 1, should be reviewed at least annually to ensure adequate cover exists.

**Non-quorate meeting:** Non-quorate meetings may go ahead unless the chair decides not to proceed. Any decisions made by the non-quorate meeting must be reviewed at the next quorate meeting.

**Alternate chair:** Service Manager

**4 MEETINGS OF THE COMMITTEE**

**Frequency:** Two weekly.

**Urgent meeting**: Any member of the group / committee member may request an urgent meeting. The chair will normally agree to call an urgent meeting to discuss the specific matter, unless the opportunity exists to discuss the matter in a more expedient manner.

**Minutes:**

* Minutes will be taken by a nominated Care Group administrator
* Minutes will be produced within 5 days of the meeting
* Chair and Deputy chair will agree the minutes.

**5 AUTHORITY**

**Establishment**: The Group has been formed by the Deputy Chief Operating officer

**Powers**: The group has delegated authority from the Operational delivery group to make decision related to the Capacity and flow on inpatient services and issues related to patient flow across all service areas. The group will monitor the work plan relating to the elimination of out of area placements and Dtoc action plans. The group will report to the Operational delivery group and the relevant care group governance meetings.

**Cessation:** The group will be wound up by the care group management committee once it has achieved its objectives or following relevant changes to the structure of the care group making the group no longer operationally necessary.

1. **ROLE OF THE COMMITTEE**

**6.1 Purpose of the Committee**

The purpose of the group will be to deliver the reduction and overall elimination of out of area placements and to sustain this position. The group will achieve this through agreeing actions required to improve service user flow, reduce admissions to hospital and lengths of stay in hospital. The group will monitor the delivery and impact of these actions and to Manage any delays in transfers of care. The group will ensure that safety and responsiveness of services are equally considered in decision taking.

|  |  |
| --- | --- |
| **Objective** | **How the group / committee will meet this objective** |
| Responsive | Improve service user flow and decrease delays in transfer of care through the care pathway. This aim is to ensure that service users receive the right level of care at the right time in the right place to meet their assessed needs. |
| Caring | That services continue to meet privacy and dignity standards for service users and that people are valued and treated as partners in care. |
| Safe | To ensure that safety performance is not compromised in achieving the group’s overall aim. |
| Well Led | The group will provide clinical and managerial leadership and support teams through any changes required |
| Effective | The group will ensure that service users continue to achieve good outcomes through their contact with services. |

**6.2** **Guiding principles for members (and attendees) when carrying out the duties of the group / committee**

In carrying out their duties members of the group / committee and any attendees of the group / committee must ensure that they act in accordance with the values of the Trust, which are:

* We have integrity
* We are caring
* We keep it simple.

**6.3 Duties of the group / committee**

* The group will review key performance data related to service user flow through the inpatient services to understand the impact of clinical practice on this.
* The group will identify areas which are adversely impacting on patient flow
* The group will monitor the actions from the weekly delayed transfers list to ensure actions are appropriate and carried out.
* The group will identify areas of good practice which are improving patient flow
* The group will formulate actions to increase and spread the use of good practice and to eliminate or minimise the impact of practice adversely impacting on performance.
* To develop ways of working that takes into account human factors to minimise unnecessary variation and delayed transfers.
* To develop ways of working which continuously improve the flow through the inpatient wards and to the community
* To review information related to bed use and advise on whether bed numbers can be safely flexed to meet need and demand.
* To develop ways of working that improve the quality and consistency of the data collected
* To work with partners in developing initiatives across the Leeds system to encourage flow and create capacity for all partners.

1. **RELATIONSHIP WITH OTHER GROUPS AND COMMITTEES**

The group will report to the Operational delivery group meeting and will work closely with the care group governance meetings.

**8 DUTIES OF THE CHAIRPERSON**

The chair of the group / committee shall be responsible for:

* Agreeing the agenda
* Directing the meeting ensuring it operates in accordance with the Trust’s values
* Giving direction to the minute taker
* Ensuring everyone at the meeting has a reasonable chance to contribute to the discussion
* Ensuring discussions are productive, and when they are not productive they are efficiently brought to a conclusion
* Deciding when it is beneficial to vote on a motion or decision
* Checking the minutes
* Ensuring sufficient information is presented to the care group management meeting in respect of the work of the group / committee.

It will be the responsibility of the chair of the group / committee to ensure that it (or any group / committee that reports to it) carries out an assessment of effectiveness annually, and ensure the outcome is reported to the care group management meeting along with any remedial action to address weaknesses. The chair will also be responsible for ensuring that the actions to address any areas of weakness are completed.

In the event of there being a dispute between any group / committees in the meeting structure it will be for the chairs of those groups / committees to ensure there is an agreed process for resolution; that the dispute is reported to the groups / committees concerned and brought to the attention of the care group management meeting and that when a resolution is proposed that the outcome is reported back to the all groups / committees concerned for agreement.

**9 REVIEW OF THE TERMS OF REFERENCE AND EFFECTIVENESS**

The terms of reference shall be reviewed in February by the committee at least annually, and be presented to the care group management meeting for ratification, where there has been a change.

In addition to this the chair must ensure the committee carries out an annual assessment in [month] of how effectively it is carrying out its duties and make a report to the care group management meeting including any recommendations for improvement.

Appendix 2

**Schedule of deputies**

It may not be necessary or appropriate for all members (or attendees) to have a deputy attend in their absence. If this is the case please state below “no deputy required”.

|  |  |
| --- | --- |
| **Full member (by job title)** | **Deputy (by job title)** |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |

|  |  |
| --- | --- |
| **Attendee (by job title)** | **Deputy (by job title)** |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |

**PART B**

**3 IDENTIFICATION OF STAKEHOLDERS**

The table below should be used as a summary. List those involved in development, consultation, approval and ratification processes.

|  |  |
| --- | --- |
| **Stakeholder** | **Level of involvement** |
| Leeds Care Group clinical governance council |  |
| Leeds Care Group Management meeting |  |
| System Resilience & assurance Board | Signed off by CEO |
| Operational delivery Group | Discussion with stakeholders |
| Inpatient services | Discussion with Stakeholders |
| Community services | Discussion with stakeholders |
| Adult Social care | Discussion with stakeholders Amended and added comments |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |

**4 REFERENCES, EVIDENCE BASE**

**5 ASSOCIATED DOCUMENTATION (if relevant)**

**6 STANDARDS/KEY PERFORMANCE INDICATORS (if relevant)**

**7. EQUALITY IMPACT**

The Trust has a duty under the Equality Act 2010 to have due regard to the need to eliminate unlawful discrimination, advance equality of opportunity and foster good relations between people from different groups. Consideration must be given to any potential impacts that the application of this policy/procedure might have on these requirements and on the nine protected groups identified by the Act (age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, gender and sexual orientation).

Declaration: The potential impacts on the application of this policy/procedure have been fully considered for all nine protected groups. Through this process I have/have not\* identified any potential negative impacts for any of the nine protected groups.

Print name: pp Eddie Devine

Job title: Interim Associate Director

Date: 02/05/2019

If any potential negative impacts are identified the Diversity Team must be contacted for advice and guidance: email; [diversity.lypft@nhs.net](mailto:diversity.lypft@nhs.net).

\*delete as appropriate

**CHECKLIST**

To be completed and attached to any draft version of a procedural document when submitted to the appropriate group/committee to support its consideration and approval/ratification of the procedural document.

This is a checklist and is part of the working papers. It does not form part of the final version of the procedural document to be uploaded to staff net.

|  | **Title of document being newly created / reviewed:** | **Yes / No/** |
| --- | --- | --- |
| **1.** | **Title** |  |
|  | Is the title clear and unambiguous? | *yes* |
|  | Is the procedural document in the correct format and style? | *yes* |
| **2.** | **Development Process** |  |
|  | Is there evidence of reasonable attempts to ensure relevant expertise has been used? | *yes* |
| **3.** | **Content** |  |
|  | Is the Purpose of the document clear? | *yes* |
| **5.** | **Approval** |  |
|  | Does the document identify which committee/group will approve it? | *yes* |
| **6.** | **Equality Impact Assessment** |  |
|  | Has the declaration been completed? |  |
| **7.** | **Review Date** |  |
|  | Is the review date identified? | *yes* |
|  | Is the frequency of review identified and acceptable? |  |
| **8.** | **Overall Responsibility for the Document** |  |
|  | Is it clear who will be responsible for co-ordinating the dissemination, implementation and review of the document? | *yes* |

|  |  |  |  |
| --- | --- | --- | --- |
| **Name of the Chair of the Committee / Group approving** | | | |
| If you are assured this document meets requirements and that it will provide an essential element in ensuring a safe and effective workforce, please sign and date below and forward to the chair of the committee/group where it will be ratified. | | | |
| Name | *Eve Townsley, Maureen Cushley Eddie Devine* | Date | *2/05/2019* |
| **Name of the chair of the Group/Committee ratifying** | | | |
| If you are assured that the group or committee approving this procedural document have fulfilled its obligation please sign and date it and return to the procedural document author who will ensure the document is disseminated and uploaded onto Staff net. | | | |

|  |  |  |  |
| --- | --- | --- | --- |
| Name | *Cath Hill* | Date | *12 June 2019* |