Direction of Choice Policy – Handling Difficult or Reluctant Adult Discharges from Hospital Care	**Type: Policy** **Register No: 11038** **Status: Public once ratified**

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Consultees listed in Section 16		

Professional Approval:		
Mandy Woodley	**Associate director of operations**	**22.09.2017**

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Author/Contact for info	Beccy Carpenter Integrated Discharge Team Lead
Policy to be followed by	All Staff
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Document Review History

Version No	Reviewed by	Active Date
1.0	Russell Harrison	23rd June 2011
2.0	Sharon Salthouse	20th November 2004
3.0	Tracy Porter	1st October 2015
4.0	Beccy Carpenter Integrated Discharge Team Lead	30 January 2018

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Appendices

1.0 Purpose

The purpose of this Policy is:

- To outline the process to ensure that patients are supported when choosing future support arrangements so that they receive relevant health care and support in a setting appropriate to their needs
- To ensure the exercise of Choice is managed fairly throughout the discharge planning process
- To reduce risks associated with lengthy hospital stay eg hospital acquired infection, habitual dependence, loss of skills for daily living
- To support patient flow and maximise use of acute hospital beds available for people who require emergency or acute medical and MDT care
- To support safe and timely discharge from hospital
- To support people in exercising choice at the optimal point in their recovery
- To ensure that a clear resolution process is in place for patients who are reluctant to leave hospital when no longer clinically required
- To ensure that no discharge is delayed if there is an available, appropriate option

2.0 Scope

This policy outlines the direction of choice process for all adult in-patients (18+) being discharged from MEHT hospital Trust. However, it will particularly apply to patients who are unable to return to their usual place of residence and require discharge to a care home facility.

3.0 Introduction

3.1 The direction of Choice policy applies to all adult inpatients in a Mid Essex Hospital setting.

3.2 Direction of choice is an integral part of planning ongoing care for people who are leaving hospital.

3.3 Discharge planning will assume discharge home (or to original place of residence) unless this is deemed unsuitable due to a change in functional ability or recovery needs.

3.4 This policy particularly applies when a patient is medically fit for discharge and no longer needs the specialist interventions, care, and equipment provided in an acute hospital but is unable to return directly to their home due to ongoing care or health needs.

3.5 Arrangements should be made for transfer to a temporary place of care to aid recovery or receive ongoing rehabilitation until it is appropriate to discharge home or until a new permanent place of residence can be identified.

3.6 People should not occupy an NHS inpatient bed indefinitely when choosing or waiting for a vacancy in their preferred care home or community setting. However, they will be supported in an appropriate setting whilst choosing or waiting for a vacancy

4.0 Trust Policy

4.1 The process of offering choice of care provider and/or discharge destination will be followed in a fair and consistent way and recorded in the patient notes.

4.2 Patients will be discharged to the most appropriate available setting whilst being provided with information regarding patient choice over how their ongoing care and support needs will be met. Discharge planning will be carried out in accordance with the Trust Discharge Planning policy

4.3 Where a patient is unable to express a preference, but has mental capacity, an advocate will be offered. Where a person lacks capacity and has a Deputy for welfare, the exercise of choice and decisions about future support arrangements should be discussed with them and with the patient. Where a person lacks capacity and does not have a Deputy for welfare the provisions of the Mental Capacity Act must be followed.

4.4 The special needs of patients with learning disabilities must be considered. Staff must refer to Trust policy “Caring for Adult Patients with a Learning Disability” and the Reasonable Adjustments that are obligatory.

4.5 These discussions will be conducted in line with Annex G of the Care and Support Statutory Guidance 2014 and any agreements made between the parties to this policy pursuant to the Statutory Guidance. This applies irrespective of who is funding the care.

4.6 Where a patient or their Deputy for welfare declines to choose a support option that would allow the patient to be discharged Mid Essex Health and Essex County Council will follow the defined process set out in the procedural section of this document. The approach is applicable to all patients regardless of who is funding their care.

4.7 In cases of disagreement, patients must be provided with information in accordance with the Trusts complaints policy

5.0 Responsibilities

5.1 Chief Executive Officer

The Chief Executive is the Accountable Officer of the Trust and as such has overall accountability and responsibility for ensuring safe and effective systems are in place for patient discharge and that staff are fully informed and skilled to carry out their responsibilities

5.2 **Chief Operating Officer**

The Chief Operating Officer has accountability for the effective and appropriate management of patient discharge arrangements that follows the clinical decision to discharge

5.3 **Consultants**

The Consultant has overall responsibility for ensuring that the patient is medically fit for discharge. It is the responsibly of the doctor to specify when a patient is medically fit for discharge and this will be documented in the medical notes. The actual date of discharge will depend on this and other factors as determined by the Multidisciplinary Team. When confirmed, the actual date of discharge will be clearly documented in the patient's notes and on the Discharge Planning Documentation. This will be used in conjunction with this policy

5.4 **MDT (Multi-Disciplinary Team)**

The multi-disciplinary team is responsible for timely and appropriate referrals to other professionals, taking into account the predicted date of discharge and recognising relevant requirements of the process e.g. agreeing the patient is ready for transfer and that this is recorded in the medical notes as "Health Complete". This is statutory requirement under the Community Care (Delayed Discharges) Act 2003. This team will support the patient and family in following this Policy supporting them to make the transition out of hospital

5.5 **Matrons**

The appropriate Matron is responsible for ensuring that all procedures have been proactively applied and for escalating any situation that could lead to non-compliance with this policy and for reporting all breaches of this on a risk event form (DATIX)

5.6 **Sisters/Ward Managers**

Sisters are responsible for Discharge Planning on admission and ensuring that the patient and/or carer receive:

- Standard discharge information on admission
- Choice letters if relevant with the support of the Health and Social Care Team.

5.7 **Integrated Discharge Team Manager**

Is responsible for overall management of Complex discharges and the Integrated Discharge Team.

6.0 Stage 1 – Providing Standard Information and Support

6.1 Ward to provide EVERY patient with patient discharge information within 24 hours of admission. The discharge information leaflet (appendix 1) outlines expectations with regard to discharge. An easy read version will be available.

6.2 An expected date of discharge is set and shared with the patient and/or representative within 24 hours of admission.

6.3 Place of discharge will be assumed to be the patient's customary place of residence unless this is deemed unsuitable due to a change in functional ability or recovery needs.

6.4 If more than one appropriate option is available, the MDT will offer to help the patient to choose.

6.5 The discharge plan must include all options and state the patient's choice. Explanations must be given to the patient and conversation documented if this preferred option is not possible.

6.6 The MDT will apply the Code of Practice that supports the Mental Capacity Act 2005 when planning discharge with patients and/or representatives or Deputy for Welfare. The MDT will identify when the patient no longer requires inpatient care at the current hospital and is medically fit for discharge, at which point the patient will be discharged to an appropriate location, with appropriate care if required.

7.0 Stage 2 – Assessing Need - Referral for service to support discharge

7.1 Patients will be referred to services to support discharge where appropriate. The organisation arranging care ensures the patient and/or their representative and the ward are informed of all currently available options.

7.2 Wards will manage simple discharges. The ward will refer to the integrated discharge team if a person has complex discharge needs. ie

- Discharge date and discharge destination not easily determined
- Significant services required to support the patient in the community
- Current condition hampers the patient's ability to return to their home

7.3 Those who need to be involved after discharge are contacted at the earliest opportunity to discuss the patient's needs and that responsibilities are transferred on discharge.

7.4 All parties will record plans, communication with the patient and/or representatives, referrals and actions in the patient's record.

7.5 All communications reinforce the expectation that patients will leave the hospital as soon as their need for inpatient treatment ends.

7.6 Whilst the patient is still undergoing hospital treatment, the discharge plan will include establishing care needs after discharge, and actively seeking available options from which the patient and/or representative can choose.

7.7 Options for discharge may include appropriate and reasonable interim placements suitable for the patient's needs.

7.8 If a patient seems eligible for care funded by CHC or their local authority, a referral will be made to the integrated discharge team to begin the process to identify and arrange appropriate, available support. They will give

consideration to all assessments and involve patients and/or representatives in decisions as appropriate, whilst taking account of quality, safety and financial sustainability.

7.9 If social services identify that the patient will 'self-fund' new care provision, the patient will be referred to a relevant agency eg Age UK who will offer to help the patient and/or representative find available option/s.

8.0 Stage 3 – Preparing for Discharge - Available care offered

8.1 Ward staff will manage simple discharges - advise patients of confirmed discharge date and support them to make their arrangements to return home.

8.2 The hospital and social care MDT, in consultation with the patient and/or representative, agree the patient's needs for discharge and what constitutes a suitable and appropriate option.

8.3 The relevant professional from the Integrated Discharge team will advise the ward, patient and/or their representative about currently available care providers, care homes or community inpatient beds that can meet their needs and any potential cost or contribution at the earliest appropriate stage.

8.4 It may be that there is only one care provider or community hospital that can currently meet the patient's needs, in which case transfer to this provider will be arranged as an interim arrangement on a temporary basis. A patient may not wait in an acute hospital bed for a preferred option to become available. The patient and/or representative will be supported to identify ongoing options to meet longer term needs.

8.5 If the time required to confirm funding or other arrangements for permanent/ long term care exceeds the patient's need for an acute hospital bed, arrangements will be made for transfer to a suitable interim placement whilst these issues are resolved or processes are completed.

9.0 Stage 4 – Available Care Declined- Seven day Window

9.1 Once clearly defined plan or options for discharge have been agreed, the patient and /or representative is expected to make a decision about discharge so that discharge has happened or arrangements are in place to do so

9.2 The patient and / or representative must be advised that the hospital will expect a decision about discharge within a 7 day window. A discharge support plan is sent with accompanying letter. (See appendix 3 for example letter)

9.3 If a patient and/or representative declines proposed arrangements to facilitate discharge, the ward and MDT members will discuss rationale and explain clearly that refusal to choose an available care provider or location will not prevent the discharge process proceeding.

9.4 If a patient and/or representative declines proposed date of discharge, the ward and MDT members will discuss rationale and explain clearly that the discharge date cannot be postponed if the patient is medically fit for discharge and needs can be met on proposed date.

9.5 If an informal or family carer is not available for the discharge date, it is the responsibility of the patient or representative to make alternative arrangements.

9.6 MDT members, Matrons and Associate Directors of Nursing will assist resolution of any potential barrier to discharge. The patient and/or representative is provided with details by the ward or directed to the patient advice and liaison service (PALS) for advice and information regarding advocacy if required.

10.0 Stage 5 – Interim packages and placements. Formal Choice Letter 1

10.1 If discharge arrangements are not agreed within 7 days due to available options being declined preferred option not available or no decision made, an interim package of care or placement is discussed and offered by the MDT with a proposed discharge date.

The ward escalates to the Associate Director of Nursing for the division. Formal Choice letter 1 is sent. See appendix 4

10.2 Where the need for an NHS CHC assessment has been identified in hospital, the individual should not be charged for their care during the period it takes to complete the NHS CHC assessment.

10.3 Where funding sources are clear, the relevant funding source will apply for the interim placement eg self-funders.

11.0 Stage 6 – Escalation following non-agreement at Stage 5

11.1 If no agreement for discharge has been reached and transfer arrangements are challenged, the Associate Director of Nursing for the division will support the discussions for discharge. The local process to escalate delayed transfers of care (DTOC) is followed throughout the Managing Choice process. All parties continue to encourage patients to make their own choices throughout this process.

11.2 The IDT lead and the Associate Director of Nursing for the division invite the patient and/or representative to a formal meeting, to discuss plans for discharge so that all parties can discuss and agree transfer to the most appropriate available care provider at least as an interim option.

11.3 If the patient / representative does not engage with discharge planning or are unable to attend a formal meeting this is held without them and a follow-up letter is sent afterwards summarising discussion and plans.

11.4 If it appears that there will be further delay, the Associate Director of Nursing for the division escalates to the Chief Operating Officer

11.5 If the patient has declined the offer of an available community hospital bed the patient will be advised that they are declining the offer of recommended NHS treatment, which is not in their best interest. If discussions do not resolve the issue, discharge from NHS care is discussed.

11.6 All staff will continue to support the patient and/or representative where possible to finalise plans for discharge and continue to search for available care options where relevant.

11.7 The MDT and IDT continue to work with the patient and/or representative to try and arrange an appropriate means of meeting the patient's care needs at the point of discharge on the agreed date.

11.8 The Associate Director of Operations (ADO) sends formal choice letter 2 to the patient and/or representative at or soon after the formal meeting. See appendix 5.

11.9 The IDT Manager, supported by the ADO consults local Trust advisors regarding legal proceedings and escalates as required to ensure discharge from hospital, in order to safeguard the health and wellbeing of this and other patients.

11.10 Depending on legal advice, the patient is escorted from the premises to the discharge destination by relevant staff. Security is called to assist if there is risk of harm to the patient or staff during this process

12.0 Escalation Process

12.1 Responsibility for the discharge process in relation to patients will remain with the Nurse in Charge on the ward. They will undertake or delegate as appropriate the task of gathering MDT assessments to inform decisions about needs on discharge. They will work in liaison with the IDT.

12.2 The IDT will offer the appropriate level of guidance and support and will consult the Nurse in Charge as needed. All staff will proactively chase progress with the discharge.

12.3 The MDT will aim to undertake considerable discussion with the patient and/or representative prior to initiating formal 'managing choice' meetings. Emphasis in discussions will be placed on accessing available support, clarification of the process and the need to transfer to an interim placement or alternative provision if the preferred option is not available.

13.0 Incident reporting

In the event of the second formal choice letter being issued, an incident will be reported on the trust incident reporting system by the associate director of operations

14.0 Auditing and Monitoring

14.1 This policy will be monitored by an on-going programme of weekly validation of Delayed Transfers of Care (DTOC). This process is undertaken within the IDT team for all patients identified as being delayed during the week. All patients delayed due to 'awaiting placement in care home' or 'patient or family choice' will be reviewed and the IDT Manager will identify any patients for further review.

15.0 Communication of this Policy

15.1 This policy will be available on the intranet and on the website

15.2 Associate Director of Nursing for each division will ensure that all staff who will be practically responsible for working to this policy have copies of this document.

16. Document Consultation

Consulted with:	Post/Committee/Group	Date
Lisa Hunt	Managing director	22.09.2017
Peter Fry	Chief Operating Officer	22.09.2017
James Day	Trust Board Secretary	22.09.2017
Clive Gibson	Elderly Assessment Team	22.09.2017
Mandy Woodley, Louise Jones, Nicola Cottington, Kathleen Hawkins, Michelle O'Donnell,	Associate directors of operations	22.09.2017
Lyn Hinton	Director of Nursing	22.09.2017
Hilary Bowring, Jo Myers, Angela Wade	Associate directors of nursing	22.09.2017
Liz Stewart	Public Information Manager	22.09.2017
Aisling Bowman	Deputy chief operating officer	22.09.2017
Lisa Seaman, Lindsay Youngs and IDT team	IDT team managers	22.09.2017
Doug Smale	Accredited security management specialist, Emergency planning officer	29.11.2017
Sandra Moreton-Nance	Learning Disability Specialist Practitioner	29.11.2017
Matrons	MEHT lead nurse	22.09.2017
Brid Boraks	Service Manager ECC	22.09.2017
Simon Froud	Director for local delivery, ECC	22.09.2017
Rachel Hearn	Mid Essex CCG	22.09.2017
Jane Corser	Exec clinical and operations director, Provide	22.09.2017
	Mid Essex Urgent Care Project Group	07.09.2017
	MEHT patient flow meeting	18.10.2017
Michelle Stapleton	Group Director – Integrated Care Operations	22.09.2017

17.0 References

ECC and Mid Essex 2010 Equality Act
2012 The National Framework for NHS Continuing Care and NHS-Funded Nursing Care
Human Rights Act 1998
Care Act 2014
The Care and Support (Discharge of Hospital Patients) Regulations 2014

The Care and Support Statutory Guidance 2014
Guidance on Continuing Care HSG
Care and Support Act
CCG Threshold Policy

Appendix 1: Discharge information leaflet

Patient Information
Planning your discharge from hospital
Welcome to Broomfield Hospital

We understand that coming to hospital can be a worrying experience but we hope to make your stay as pleasant as possible. The ward staff are here to help so please feel free to ask any questions.

Hospital beds are for people who are very unwell. Once your doctor has decided that you are well enough and no longer need acute hospital care, you will be discharged home or transferred out of hospital to a more appropriate environment.

The length of time you spend in hospital will depend on your condition and on discharge arrangements.

An expected date of discharge will be discussed with you when you are admitted to hospital, and we will let you know if there is any change.

We place a lot of importance on planning for your care after you leave the hospital, this is known as discharge planning.

We will involve you and your relatives/carers in planning for your safe discharge so please feel free to ask any questions.

What do we need to know?

As soon as possible during your hospital stay, please let us know the following:

- Please tell us if you were already receiving help before you came into hospital, so that arrangements can be made ready for when you leave.
- If you are not returning to your own address, please tell your nurse where you will be staying. This is important as there may be adjustments that need to be made.
- Please let us know if you have any special medication requirements, e.g. a medicine list or dossett box.

Please ensure you have your key available for when you return home

Please make sure you have someone to take you home when you are ready to leave

This will help us to make sure that delays are prevented so your stay in hospital is as short as possible.

Why do we try to make your stay as short as possible?

- Patients who remain in hospital for a long time are more likely to develop an infection or complications.
- People waiting for surgery or a procedure may have this cancelled if there is no bed available.

It is not appropriate for you to remain in Broomfield Hospital once your doctor has decided that you are medically fit for discharge and no longer need acute hospital care.

- People will generally be discharged back to their own home or return to their care home.

- You may be transferred to a different ward once you are medically fit, but still need occupational therapy, physiotherapy or social service input.
- It may be best for you to be transferred to an 'intermediate care centre', not necessarily local to you where you will continue to receive nursing and therapy support to enable you to return home.
- You may be moved to a residential or nursing home for a short length of time that can meet your individual needs.

What will happen on the day I am discharged?

On the day you are discharged you will be asked to vacate your bed before 10am. Please make sure you have all your belongings including any valuables from the hospital safe. Have a bag, your key and suitable outdoor wear ready to go home.

If you

- cannot be collected until later in the day or are waiting for transport
- arrangements will then be made for you to wait in the discharge lounge where you will be looked after by nurses until you are ready to leave the hospital.

The discharge lounge is located on AMU (A204). The staff here will ensure your discharge documentation and medication is available and completed.

You will be able to:

- Watch television
- Read newspapers
- Have refreshments and snacks (provided)

If you have any questions or concerns about your hospital stay, please discuss them with a member of staff before leaving the hospital.

Medical certificates

If you require a medical certificate, please let your named nurse know as soon as possible before your discharge date.

Follow up appointments

If you need a follow-up appointment, this will be forwarded to you in the post.

Medicines

We will confirm whether you need any medications to take home and provide supplies if needed. We will explain your medications to you, identify potential side effects and discuss with you how to obtain further supplies.

If you have any queries about your medication when you leave hospital you can contact our medicines helpline on **01245 514822**,
Monday-Friday, 9-4pm.

Signs of being unwell
When you leave hospital it is important to know the signs and symptoms of the following:

Sepsis
Sepsis was previously known as septicaemia or blood poisoning. Sepsis is the body's reaction to an infection. If you develop any of the symptoms described below following discharge home, please seek medical advice **immediately**:

- feeling very cold and shivery
- feeling very hot and looking flushed
- high temperature
- aching muscles
- feeling very tired
- sickness and/or diarrhoea (upset stomach)
- not feeling like eating
- feeling confused or have slurred speech

Blood clots
A hospital-acquired blood clot can occur in patients while in hospital or up to 90 days after you go home. There are two kinds:

- **Deep vein thrombosis (DVT)**

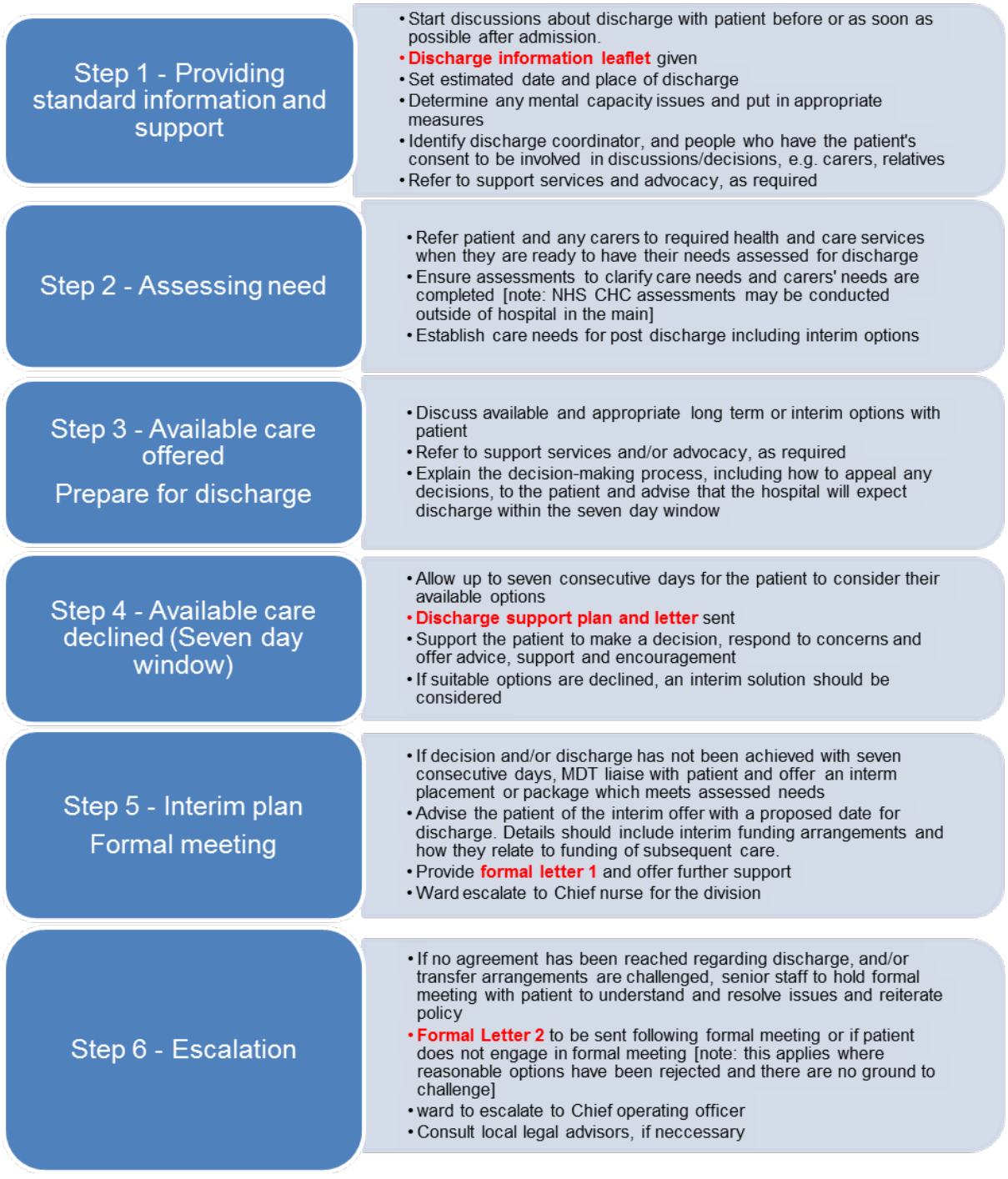
  A DVT is a blood clot (also known as a thrombosis) that forms in a deep vein, most commonly in your leg or pelvis. It may also cause no symptoms at all or cause swelling, redness and pain.

- **Pulmonary embolism (PE)**

  A PE is when a clot becomes dislodged, passes through your blood vessels and enters your lungs. Symptoms include coughing (with blood-stained phlegm), chest pain and breathlessness. Health professionals use the term venous thromboembolism (VTE) to cover both DVT and PE.

If you develop any of these symptoms in hospital or after you go home, please get medical advice **immediately**. Call either **111** or your GP (Call 111 when you need medical help fast but it's not a 999 emergency).

Appendix 2 Choice policy flowchart



Appendix 3 Discharge support plan Letter

DIRECTION OF CHOICE LETTER

Date: ……

Dear <*Name*>

Arrangements for leaving hospital

Following your admission to this hospital we have been planning the arrangements for your safe discharge with the right level of care.

Members of the team have discussed the advice and options to support you when you leave this hospital. You have been advised to choose one of these or to arrange an alternative option that is available at this time.

In order for you to receive the right on-going care we request that you consider the options available to you OR Advise us of an alternative option that you have arranged.

We request that you make your decision within 7 days of receiving this letter so that we can help to plan your discharge. We will arrange for a temporary package of care or accommodation to be made available to you if you need longer than 7 days to make your decision, or need to wait for your preferred care provider.

Additional information to help you with your decision

Staff at the hospital will support you to make a decision and to leave this hospital as soon as possible.

You should have been provided with information about the choices currently available to you, including details of any costs, and the opportunity to speak about this with a member of the team and family, friends or carers as you wish

Although we aim to assist as far as possible, you can make a complaint at any stage of the discharge process.

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

Yours sincerely,

Appendix 4 Formal Choice Letter 1

Dear Sir or Madam

Following your admission to this hospital we have been planning the arrangements for your safe discharge with the right level of care.

Members of the team have discussed the advice and options to support you when you leave this hospital. You have been advised to choose one of these or to arrange an alternative option that is available at this time.

However, as you have not yet been able to make a decision you will be asked to move to or to accept a temporary option that is available. This may be so that you can have more time to make a decision or to wait for your preferred choice, if your first choice of care home or community hospital has no current vacancies or capacity. This is not permanent and you will still be supported to transfer to your preferred place of care as it becomes available.

It is not possible for you to remain at this hospital when you are ready for discharge or transfer. This would increase your risk of catching a hospital acquired infection and of becoming increasingly less independent. Please discuss transfer plans with the nurse in charge of your ward so that we can help make arrangements for your discharge as soon as a suitable option is available.

In 7 days from the date of this letter you will be expected to leave the hospital. If you have not found an alternative location you will still be required to leave the premises. Should you decline to leave, we will be required to assist your departure

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

Yours sincerely

Appendix 5 Formal Choice Letter 2
Date:

Dear Sir or Madam

Confirmation of discharge plans

I am writing further to the letter you were recently sent regarding arrangements for you to leave this hospital and the formal meeting to discuss these arrangements.

The meeting discussed the following points:

The meeting agreed the following discharge plans:

This hospital has offered you all the necessary support and guidance to enable your safe and appropriate discharge. You have been informed of your responsibility to finalise other arrangements if you would prefer not to accept what has been proposed.

We will now make arrangements to transfer you to the available location, which is most suitable to meet your needs. Should you refuse a reasonable option, the hospital will need to consult our legal advisers about the situation and how we can arrange a safe discharge. You also have the right to consult your own legal advisers.

Although we hope to reach a mutually agreeable solution, I also remind you of your right to make a complaint at any point in the process.

Please contact me if you have any questions or if I can help further

Yours sincerely

Director of Operations On behalf of NHS and local authority services in Mid Essex

Appendix 6 Equality Impact Assessment (EIA)

Equality or human rights concern.	Does this item have any differential impact on the equality groups listed? Brief description of impact.	How is this impact being addressed?
Gender	This policy applies equally to all patients in the hospital.	
Race and ethnicity	This policy applies equally to all patients in the hospital.	Where there language barriers the hospital will appoint an interpreter to ensure that the process is clearly communicated.
Disability	This policy applies equally to all patients in the hospital.	Patients' disabilities are taken into account when assessing needs, recommending discharge destination and requesting funding or equipment where appropriate. All patients will be encouraged to be actively involved in choosing their destination on discharge and to appoint someone assist them or to act as their representative if this is appropriate. If a patient appears to lack capacity to make decisions, an assessment of capacity, and a best interest decision if required will be undertaken, in line with the Mental Capacity Act (2005).
Religion, faith and belief	This policy applies equally to all patients in the hospital	
Sexual orientation	This policy applies equally to all patients in the hospital	
Age	This policy applies equally to all adult patients in the hospital. Children are discharged into the care of their parents /guardians	Although most patients who need care on discharge are older people, this policy is likely to promote equality amongst this group.
Transgender people	This policy applies equally to all patients in the hospital	
Social class	This policy applies equally to all patients in the hospital	
Carers	This policy applies equally to all patients in the hospital	
	Date of assessment:	20.09.17
	Names of Assessor (s	Beccy Carpenter

Appendix 7

Annex G: The process for managing transfers of care from hospital for patients with care and support needs

1. The Care and Support (Discharge of Hospital Patients) Regulations 2014 set out:
• the details of what the NHS body responsible for a relevant patient must include in the assessment notice that it issues, so that the local authority can then comply with its requirements to undertake assessments and put in place any arrangements necessary for meeting any of the patient's care and support needs or where applicable the carer's needs;
• the minimum period that the local authority has to undertake the assessment;
• the details of what must be included in the discharge notice;
• the minimum period of notice that the NHS must give the local authority in terms of a relevant patient's discharge;
• the circumstances when an assessment notice and a discharge notice must be withdrawn;
• the period and amount of any reimbursement liability which a local authority may be required to pay the NHS for any delayed discharge. 458 Care and Support Statutory Guidance

2. The regulations also set out what is to happen when a local authority disputes that the patient is ordinarily resident in its area and to recover expenditure incurred as a result.

Legibility of notices

3. All notices issued by the relevant NHS body must be provided in writing to Local Authorities. This means that each notice (whether an assessment notice, discharge notice or withdrawal notice) must be in a legible form capable of being reproduced (e.g. capable of being photocopied, emailed or faxed). Any notice which is not reasonably legible would therefore not be valid. In order to ensure the legibility of all notification notices, the NHS body who issues the notice should type or print the notices and use a digital format wherever possible. This ensures that the receiving local authority can read the information it requires to comply with its duties and helps to prove that a notice has been issued if ever this was disputed.

4. However, while it is important to establish an audit trail, the system which NHS bodies and local authorities set up around issuing notices should not impede good working practice. Where hospitals and local authorities are already operating joint discharge teams, which are often co-located in the same office with access to a shared database, an update to the database may be all that is required.

Assessment notices

5. The NHS is required to issue a notice to the local authority where they consider that an NHS hospital patient in receipt of acute care may need care and support as part of supporting a transfer from an acute setting regardless of whether they intend to claim reimbursement. The relevant local authority who the NHS must notify is the one in which the patient is ordinarily resident or, if it is not possible to determine ordinary residence, the local authority area in which the hospital is situated.

6. Not everyone who is admitted to hospital will need care and support after discharge. Indeed, for the majority of hospital discharges, this will not be the case and it is important within this context that NHS organisations do not issue assessment notices in a precautionary and/or routine way without having satisfied itself that there is a reasonable prospect that there may be a need for care and support for which arrangements may need to be made in order to ensure a safe discharge.

7. A locally agreed protocol between the NHS and local authorities which allows NHS staff to identify those likely to need care and support on discharge will provide help and advice as to when a patient should be considered to have possible care and support needs, in order to ensure the NHS issue assessment notices appropriately.

8. However, the relevant NHS body must issue an assessment notice where it considers that a patient may require care and support on discharge and the local authority must or may be required to meet such needs. Before issuing any assessment notice, the NHS must consult with the patient and, where applicable, the carer. This is to avoid unnecessary assessments where, for example, the patient wishes to make private arrangements for care and support without the involvement of the local authority. Before issuing an assessment notice, the NHS body must have also completed any assessment of the potential Continuing Health Care needs of the patient and if applicable made a decision on what services the NHS will be providing. Timescales for NHS to issue an assessment notice

9. In general, the NHS should seek to give the local authority as much notice as possible of a patient's impending discharge. This is so the local authority has as much notice as possible of its duty to undertake a needs and (where applicable) carer's assessment.

10.However, an assessment notice must not be issued more than 7 days before the patient is expected to be admitted into hospital. This is so the notice is not provided too far in advance of admission to avoid the risk of wasting preliminary planning in the event that the patient's condition changes. A balance should be struck between giving the local authority early notice of the need to undertake an assessment of the patient and the risk that the patient's condition may change significantly such that any early planning needs to be reviewed.

11.Accordingly, if the NHS is able either to issue an assessment notice up to seven days before the date of the patient's admission into hospital and/or have a good indication of the likely proposed discharge date which is unlikely to change, then the NHS should issue the assessment notice as soon as possible.

Content of assessment notice

12.The information contained in an assessment notification is intended to be minimal, both to reflect patient confidentiality requirements and to minimise bureaucracy – it is only the trigger for assessment and care planning.

13.The assessment notice must state that it is an assessment notice given under paragraph1 (1) of Schedule 3 to the Care Act. This is so the local authority is aware

of the consequences that could flow from the receipt of the assessment notice (i.e. that it has to take steps to assess the patient and (where applicable) the patient's carer and put in place any arrangements to meet those needs it proposes to meet. Ultimately if the local authority fails to carry out such steps then the local authority may, in certain circumstances, be liable to pay the NHS for any delayed discharge period.

14.The assessment notice must include the following:
• the name of the patient;
• the patient's NHS number;
• if given before the patient's admission, the expected date of admission and the name of the hospital in which the patient is being accommodated;
• an indication of the patient's discharge date, if known
• a statement:

a. that the NHS body by whom the assessment notice has been given ("the NHS body") has complied with the requirement to consult the patient and, where feasible, any carer the patient has;
b. that the NHS body has considered whether or not to provide the patient with NHS continuing health care and the result of that consideration. So, where the NHS considers that the patient may have needs for continuing health care to be met by the NHS after discharge, then it must have (i) carried out a continuing health care assessment first 460 Care and Support Statutory Guidance and (ii) made a decision as to what (if any) services the NHS is to provide to the patient after discharge and (iii) informed the local authority of these details.
c. as to whether the patient or carer has objected to the giving of the notice;
d. the name and contact details of the person at the hospital who will be responsible for liaising with the local authority in relation to the patient's discharge from that hospital. This must be one or a combination of the person's telephone number and/or their work based E-mail address.

15.The requirements above are intended to make the assessment notice process work more effectively, including the requirements to include the patient's NHS number and also the contact details of the person at the hospital who will be responsible for liaising with the local authority in relation to the patient's discharge from that hospital.

16.These requirements may be built on at a local level to produce a form that meets the agreed needs of the NHS and local authority. Although not exhaustive, local systems might also want to include on the assessment notice the patient's address and the lead clinician's details. The following template provides a model that the NHS might want to use:
NOTICE OF REQUEST FOR Assessment under
The Care and Support (Discharge of Hospital
Patients) Regulations 2014
Name
Date of Birth
Address*
NHS Number
Expected Date Of Admission (where known)

Name and contact details of the carer (where applicable)*
Name and contact details of the person at the hospital liaising with the local authority
Patient's Lead clinician at hospital*
Please confirm the following
The patient has been consulted with regarding the assessment
(Where applicable and feasible) carer has been consulted regarding the assessment
An assessment of their continuing health care needs has been completed and a decision made
The patient has not objected to the giving of the assessment notice
The carer has not objected to the giving of the assessment notice
Those marked with an * are not legal requirements but should be included where known as a matter of good practice.
Timescales for local authorities' responsibilities to carry out assessments

17.On receiving an assessment notice, the local authority must carry out a need assessment of the patient and (where applicable) a carer's assessment so as to determine, in the first place, whether it considers that the patient and where applicable, carer has needs. If so, the local authority must then determine whether any of these identified needs meet the eligibility criteria and if so, then how it proposes to meet any (if at all) of those needs. The local authority must inform the NHS of the outcome of its assessment and decisions.
18.To avoid any risk of reimbursement liability, the local authority must carry out a needs assessment and put in place any arrangements for meeting such needs that it proposes to meet in relation to a patient and, where applicable, carer, before "the relevant day". The relevant day is either the date upon which the NHS proposes to discharge the patient (as contained in the discharge notice – see below) or the minimum period, whichever is the later.

19.The minimum period is 2 days after the local authority has received an assessment notice or is treated as having received an assessment notice.

20.Any assessment notice which is given after 2pm on any day is treated as being given on the following day.
21.Examples of how these timescales work are set out below:

Scenario 1
• The NHS issue an assessment notice to the local authority at 1pm on Monday. The assessment notice must specify the date of the proposed discharge date. The earliest date which would be permitted is 2 days after the date the assessment notice is given (although a later proposed discharge date could be set out in the discharge notice.) This means that in order to avoid any risk of reimbursement liability, Wednesday would be the earliest day by which the local authority would need to have carried out the assessment and put in place any care and support services and, where applicable, carers' services that it proposes to meet.
Scenario 2
• The NHS issue an assessment notice to the local authority at 3pm on Monday. The assessment notice is treated as having been given on the following day, Tuesday. This would mean that if no later discharge notice were given in the assessment notice, then Thursday would be the earliest day by which the local authority would need to have carried out the assessment and put in place any care and support

services and, where applicable, carers' services that it proposes to meet if it were to avoid the risk of any reimbursement liability. Again, the assessment notice and later the discharge notice (see below) could set out a proposed discharge date after Thursday, in which case this would be the actual deadline by which the local authority would be required to have carried out the assessment and put in place any care and support and carers' service that is proposes to meet in order to avoid the risk of incurring any reimbursement liability.

Assessment notice withdrawal

22.The NHS body which issued the assessment notice may withdraw that assessment notice at any time. Once an assessment notice has been withdrawn by the NHS, this means that the local authority that has been given the assessment notice is no longer required to comply with the requirements to assess or, where an assessment has been carried out, to put in place arrangements to meet some or all of the patient's care and support needs. Once an assessment notice is withdrawn no liability to the local authority can accrue after that date. This is even if a discharge notice has been subsequently issued. But any liability which may have accrued before the withdrawal of the assessment notice is unaffected.

23.There are a number of circumstances when the NHS must withdraw an assessment notice. These are where:

• the NHS body considers that it is likely to be safe to discharge the patient without arrangements being put in place for the meeting of the patient's needs for care and support or (where applicable) the carer's needs for support;

• the NHS body considers that the patient's on-going need is for NHS Continuing Health Care;

• Following the decision as to which (if any) services the relevant local authority will make available to the patient or (where applicable) carer, the NHS body still considers that it is unlikely to be safe to discharge the patient from hospital unless further arrangements are put in place

• for the meeting of the patient's care and support needs or (where applicable) the carer's needs for support;

• The patient's proposed treatment is cancelled or postponed;

• The NHS body has become aware that the relevant authority is not required to carry out any assessment because the patient has refused a needs assessment or (where applicable) the carer has refused a carer's assessment;

• The NHS body becomes aware that either:

• the patient's ordinary residence has changed since the assessment notice was given; or

• the notice was given to a local authority other than the one in whose area the patient is ordinarily resident.

24.The regulations do not prescribe what a withdrawal notice must contain. However, it must be in writing, and local systems should be established to ensure that the withdrawal notice provides sufficient information for both the NHS and local authority to be clear as to which patient and assessment notice the withdrawal notice refers to, and the reason(s) as to why the assessment notice is being withdrawn. In the context of identifying the person, mirroring either in full or part what is required for the assessment notice itself should be considered.

Discharge notices

25.Patients and carers should be informed of the discharge date at the same time as or before the local authority. In addition, hospital staff may give the local authority an early indication of when discharge is likely as part of helping their planning.

26.Where the NHS has issued an assessment notice to a local authority (so as to require the local authority to assess a patient's care and support needs to facilitate a transfer of care), it must also give written notice to the local authority of the proposed date of the patient's discharge notwithstanding that it included the proposed discharge date in the assessment notice. This is known as a discharge notice and its purpose is to confirm the discharge date as it either may not have been previously known at the time of the issue of the assessment notice or may have subsequently changed since the assessment notice was issued.
27.The NHS could not seek to recover any reimbursement from the local authority in respect of a patient's delayed transfer of care unless it has first issued both an assessment notice and a discharge notice.
Content of a discharge notice

28.A discharge notice must contain:
• The name of the patient;
• The patient's NHS number;
• The name of the hospital in which the patient is being accommodated;
• The name and contact details (telephone and/or email) of the person at the hospital who is responsible for liaising with the relevant authority in relation to the patient's discharge from hospital;
• the date on which it is proposed that the patient be discharged;
• A statement confirming that the patient and, where appropriate, the carer has been informed of the date on which it is proposed that the patient be discharged;
• A statement that the discharge notice is given under paragraph 2(1) (b) of Schedule 3 to the Act. This is to make it clear that the notice is a formal "discharge notice" for the purposes of the Discharge of Hospital Patient provisions.
Timing of discharge notice
29.To ensure that a local authority receives fair advance warning of the discharge, the NHS body must issue a discharge notice indicating the date of the patient's proposed discharge. The minimum discharge notification allowed is at least one day before the proposed discharge date. Again, where the discharge notice is issued after 2pm, it will not be treated as having been served until the next day.

30.Taking the examples above:
Scenario 1
• The NHS issue an assessment notice to the local authority at 1pm on Monday. The assessment notice must specify the date of the proposed discharge date where known. The earliest discharge date which would be permitted to be specified is 2 days after the date the assessment notice is given (although the proposed discharge date can be later than this) i.e. Wednesday. This means that where the minimum period was to apply the discharge notice must be issued no later than Tuesday.
Scenario 2
• The NHS issue an assessment notice to the local authority at 3pm on Monday. The assessment notice is treated as having been given on the following day, Tuesday. This would mean that if the minimum period were to apply then Thursday would be the earliest date by which the local authority would need to have carried out the

assessment and put in place any care and support services and, where applicable, carers' services that it proposes to meet if it were to avoid any risk of reimbursement liability. So, this means the discharge notice must be issued no later than Wednesday.

31.The NHS body can issue the discharge notification with a much longer period of advance warning if appropriate and it should continue to seek to provide the local authority with as much notice of the proposed discharge date as possible. However, it will need to consider the likelihood of such a date being inaccurate and then the potential need to withdraw and reissue the discharge notification in the event the patient's condition changes in the meantime.

32.The NHS body is required to inform the local authority, by way of a withdrawal notice withdrawing the discharge notice, when it considers that it is no longer likely to be safe to discharge the patient on the proposed discharge date for any reason other than the fact that it would be likely to be unsafe to discharge the patient because the local authority has not taken the require steps. So, for example, the NHS must inform the local authority of changes in circumstances affecting the discharge date, for instance if the patient's medical condition changes or the patient dies.
33.The NHS should also consider the appropriateness of issuing the assessment and discharge notices too closely together, as this may result in extremely short time frames for local authorities to put in place what may be complex and comprehensive packages of care, which will also need to be subject to discussion with the patient and/or their carer. This potentially could lead to decisions being made, which while supporting a safe discharge may not be in the best long-term interests of the patient.
Withdrawal of discharge notice

34.The NHS body which issued the discharge notice to a local authority may withdraw that discharge notice at any time. Such a withdrawal must also be in writing. It is important that the NHS body informs the local authority as soon as possible of a withdrawal of a discharge notice so that the local authority is not unnecessarily expending resources arranging a discharge on a date, which is no longer correct.

35.A discharge notice must be withdrawn where the NHS body considers that it is no longer likely to be safe to discharge the patient from hospital on the proposed discharge date.

36.However, this does not apply where the reasons for withdrawal are that the local authority has not taken the steps required to inform the NHS body of the outcome of the assessment the needs of the patient (and the carer, where applicable), and whether it Intends to put in place care and support to meet any eligible needs.

37.Local systems should be established to ensure that the withdrawal notice provides sufficient information for both the NHS and local authority to be clear who the person is that the notice refers to, and the reason(s) as to why it is being withdrawn. In the context of identifying the patient, mirroring either in full or part what is required for the discharge notice itself should be considered.
38.Once a discharge notice is withdrawn, no further liability for the local authority to pay the NHS for any delayed transfer of care arises.

Delayed discharge reimbursement

39.While reimbursement remains available for use by the NHS body, they and local authorities are encouraged to use the provisions on the discharge of hospital patients (such as the issue of assessment and discharge notices) to seek to focus on effective joint working so as to improve the care of those people whose needs span both NHS and local authority care settings. While reimbursement is a potential way of exposing local difficulties in the relationship between the NHS body and the local authority, NHS bodies should not use reimbursement as the first approach to address any local difficulties around delayed transfers of care.

40.The NHS will only be able to seek any reimbursement from the local authority arising from a delayed transfer of care, if the NHS has first sent both an assessment notice and a discharge notice to the local authority, but the local authority has then either not carried out an assessment or put arrangements in place for the meeting of care and support and, where applicable, carer's needs which it proposes to meet by the end of the relevant day (i.e. the proposed delayed discharge date in the discharge notice or the minimum period and it is for this reason alone that there has been a delay in the patient's delayed transfer of care.
41.In these circumstances, it is then in the NHS's discretion whether to recover payments for reimbursable delayed discharge days. In terms of the level of reimbursement, the regulations provide that:
• for local authorities outside London, the penalty amount per day will be £130 and;
• for London authorities, the penalty amount per day will be £155.

42.The amounts above have risen in line with the CPI measure of inflation since 2003, and the higher rate only applies to local authorities in London.

43.The period for which liability can be sought, if the NHS so chooses, starts on the day after the relevant day i.e. after the date of the proposed discharge date contained in the discharge notice or the minimum period which is, at the earliest, 2 days after the assessment notice is given.

44.It then ends on the earliest date as to when any of the following occurs:
• the NHS withdraws either the assessment notice or the discharge notice;
• the local authority notifies the NHS that it has now carried out the assessment and put in place arrangements for meeting any of the needs it proposes to meet in respect of that patient or where applicable carer;
• the local authority is no longer required to put arrangements in place either because the patient informs the local authority that they have made alternative arrangements for care and support and ,where applicable, the carer informs the local authority that they have made alternative arrangements for their support;
• the patient discharges themselves;
• the NHS decided that the patient now needs to remain in hospital for a further course of treatment; or the patient dies.
Days exempt from payment liability

45.It is intended that both the NHS and local authorities should have established systems in place by April 2015 that provide for seven-day coverage. Accordingly, the exemptions that previously existed for weekends and Bank Holidays are no longer to

apply and as such all days become potentially reimbursable. However, a day is not to be treated as a day for which a local authority could be liable for reimbursement when the local authority has by 11am that day put in place arrangements for meeting some or all of the needs that it proposes to meet in relation to the patient and, where applicable, the carer.

46.Also, no liability will arise for any day where the NHS considers that the patient is not able to be discharged because they have suffered a deterioration in their condition on that date so that it would not be safe to discharge them even if the local authority had put in place arrangements for meeting the patient's care and support and, where applicable, the carer's needs.

47.If the patient's deterioration becomes more established such that the patient requires a further course of treatment in hospital, and it would be unsafe to discharge the patient then the NHS body must withdraw the discharge notice and should consider withdrawing the assessment notice.

Ordinary residence

48.The NHS should serve the assessment notice on the local authority where the patient is ordinarily resident or where the patient has no settled address, the local authority in which the hospital is located. Where a local authority disputes the assertion that they are responsible for that individual based on ordinary residence, they must in the period of dispute still comply with the requirements of the Regulations in terms of providing an assessment and any care and support provision which is identified as being needed to secure a safe transfer from one care setting to another.

Dispute resolution

49.Where any dispute arises because a local authority disputes that the patient is ordinarily resident in its area (so that it should not be the local authority to whom an assessment notice is given), then that local authority must accept provisional responsibility and undertake the steps required under the discharge of hospital patient provisions. If no agreement can be reached on ordinary residence, it must then seek a determination as the patient's ordinary residence from the Secretary of State or an appointed representative. Further information on this process can be found within the Ordinary Residence Regulations, which have also been established as part of the Care Act 2014.

50.All other disputes in relation to delayed discharge payments (e.g. whether to seek reimbursement, whether the day should be counted as a day of delayed discharge period etc.) should be resolved between the NHS body and local authority. Where they cannot be resolved then resolution would have to be way of an application for judicial review to the High Court.

Sign-off of data between the NHS and local authority

51.As set out in existing guidance, the NHS organisation must ensure that before reporting days attributable to care and support that it has verified their accuracy with the local authority, irrespective of whether the NHS body is seeking reimbursement or not. This should happen in advance of them being reported into the formal system so that any errors can be identified and addressed. The system by which this

happens is for local determination, although it is expected that it would be the relevant Director of Adult Social Services or their nominated representative who would be the local authority point of contact for this.

Reporting of all DTOC days

52.Irrespective of whether the delayed days fall into the reimbursement category or not, they must be reported by the relevant NHS body, this is reflected in the NHS Operational Guidance delivered via SitRep. These days include any person with a delayed discharge at any point in the given month, as well as that those patients who meet the DTOC definition on the last Thursday of each month. In terms of definition, Delayed Transfers of Care (DTOC) mean that individuals are in a setting that is recognised as not being appropriate for the care they need. This potentially contributes to worse outcomes for the individual, particularly in the context of their quality of life, as well as placing additional and sometimes costly burdens on the NHS and local government.

The definition of a DTOC provided for within SitRep is when a patient is ready for transfer after being in receipt of acute care, when:

• clinical decision has been made that a patient is ready for transfer; AND
• A multi-disciplinary team decision (involving the NHS body and the local authority) has been made that a patient is ready for transfer; AND
• The patient is safe to discharge/transfer; YET
• The patient is still occupying a bed.

Data and information

53.The exchange of data needed for the purposes of NHS bodies and local authorities carrying out their respective functions is allowed in accordance with the common laws of confidentiality and data protection legislation. It is the responsibility of the individual bodies to ensure they have robust data protection safeguards in place to ensure a patient's personal data is kept secure and only used for the purposes that it is required (i.e. seen by those it needs to be seen by on a needs to know basis).

Patient and carer involvement

54.It is fundamental that both the NHS body and the local authority involve the patient and, if appropriate, their carer about their current and ongoing care and support needs. In doing this, it should have already undertaken an assessment of the patient's capacity to participate in an informed way in these discussions and, where they do not believe that the capacity exists, they should move forward by taking account of other existing regulation and guidance such as for example the Mental Capacity Act.

Other relevant considerations

55.Other provisions and requirements under the Care Act may also be relevant to considerations arising to the discharge of hospital patients with care and support needs. Reference should be made to these, most notably those relating to:

• Wellbeing
• Prevention
• Assessment and care planning
• Carers
• Duty to co-operate

- Integration
- Safeguarding
- Ordinary residence
- Continuity of care