University Hospital of South Manchester NHS
NHS Foundation Trust

Discharge Destination Policy
Version 1.0

(Previously known as Home of Choice Policy)

Lead executive		Mandy Bailey			
Name / title of author:		Tracey Edwards, Patient Flow Manager Angela Watts, Directorate Manager			
Date reviewed:	August 2014	**Date ratified:**	17/09/2014	**Ratifying Committee:**	Executive Committee
Target audience:	Trust-wide				
Policy Summary:	This policy sets out the procedures in place for the management of all patients that are deemed medically fit for discharge to ensure they leave the acute hospital bed in a safe and timely manner. This will be achieved by placing the patient into a suitable interim setting, should their choice of destination be unavailable.				
Equality Impact Statement:	University Hospital of South Manchester NHS Foundation Trust ('UHSM') strives to ensure equality of opportunity for all service users, local people and the workforce. As an employer and a provider of health care, UHSM aims to ensure that none are placed at a disadvantage as a result of its policies and procedures. This document has therefore had an initial assessment, in accordance with the equality impact proforma incorporated in 'the Checklist for Review and Ratification of UHSM-wide Documents', to ensure fairness and consistency for all those covered by it regardless of their individuality. **This initial impact assessment indicated that the potential discriminatory impact is none.**				
Training impact and plan summary:	Training required will be carried out as part of the dissemination plan via Heads of Nursing, Matrons, Ward Manager and departmental meetings.				
Outline plan for dissemination:		Trust Intranet, Team Brief, Divisional and Directorate Meetings, Matron and Ward Team meetings			
Dissemination lead: name / title / ext n°		Patient Flow Manager - 6475			
This version n°		1.0	**Date published:**	22/09/2014	

Version Control Schedule			
Version number	**Issue Date**	**Revisions from previous issue**	**Date of ratification by Committee**
V1		New document(Previously known as Home of Choice Policy)	17/09/2014

Document Control	
Summary of consultation process	Standard consultation procedure – Trust wide Consultation via Discharge Process Sub Group – Medical Model / Integration Work Discharge Team Trust Solicitors Patient Experience Committee Complex Health and Social Care Directorate
Control arrangements *[Review usually every 3 years, but more frequently if required]*	Compliance monitoring arrangements: Annual audit to be undertaken by the Lead Discharge Nurse. Audit results to form part of annual discharge report to Healthcare Governance Committee Lead Discharge Nurse and Patient Flow Manager are responsible for developing and monitoring improvements required in the form of an action plan to be tabled at the bi monthly Discharge Team meetings and bi annually through Healthcare Governance Committee The Guidance will be reviewed every 2 years by the Lead Discharge Nurse
Associated documents	Mental Capacity Act 2005 UHSM Patient Discharge Policy UHSM Mental Capacity Act Policy UHSM Safeguarding Vulnerable Adults Policy UHSM Complaints and Feedback Policy V3
References	Discharge from Hospital; Pathway, Process and Practice (DoH 2003) NHS constitution 2009 Community Care Delayed Discharges Act 2003 The National Framework for NHS Continuing Healthcare and NHS Funded Capacity 2007

Document Compliance Monitoring Arrangements	
Process for monitoring	Regular audits
Responsible individual / group/ committee	Integrated Health and Social Care Team
Frequency of monitoring	Annual
Role responsible for preparation / approval of report and action plan	Patient Flow Manager
Committee responsible for review of results / approval of action plan	Executive Committee
Individual / group / committee that is responsible for monitoring of action plan	Executive Committee

Contents

1. Introduction and purpose

The NHS is under considerable pressure to only use hospital and community beds for those who need specific hospital treatment for their illness. Beds occupied by people waiting for arrangements outside of the hospital setting (including those waiting for a place in their chosen care home) significantly impact on the daily availability of hospital beds for those patients who need them. Therefore active discharge planning should start on the patient's admission to hospital. This document should be used in conjunction with UHSM's 'Ticket Home', 'Home on Time' and the Patient Discharge Policy.

The decision identifying the on-going needs of a patient should be made, where possible, with the patient and the multidisciplinary team (MDT) normally consisting of a Consultant or Senior Medical Doctor, a Nurse, Allied Health Professional(s), a Social Worker and, if appropriate, a Mental Health Nurse. The relatives / carers should also play an active role in the decision making.

The decision to live in a nursing or residential home is a major one and a number of factors may need to be considered including:

- Proximity of the home to relatives,
- The quality of life the patient will experience,
- Cost of the accommodation.

It is important to recognise that it is not appropriate or in the best interests of the patient to remain in a hospital bed until a place becomes available at the chosen home. This document seeks to deal with these situations and recognise that staying in a hospital setting once medically fit and ready for discharge can be detrimental to the patient's health.

Discharge Planning will commence on admission using the 'Ticket Home' poster and leaflet, and the patient and their family / carer should be fully aware of the process for managing the discharge of a patient once they no longer require acute hospital care. Clear communication from an early stage can avoid the escalation of confusion and subsequent delays in the discharge process. An information leaflet is available outlining the process (Appendix 8).

Where a person's care needs are identified as needing to be met in a residential or nursing home setting, it is acceptable for a patient to move to an interim or transitional placement if their preferred discharge destination is not available once the patient is medically fit for discharge.

The aim of this document is to enable staff to support the patient's transfer from the acute hospital environment to a more appropriate care setting at an optimum time in the patient's care pathway. It applies to patients that require complex discharge arrangements including discharge to residential or nursing home care following their inpatient care episode.

This will ensure that we endeavour to meet the patient's best interest by not remaining in a hospital bed until a place becomes available at the chosen discharge destination as doing so carries the risk of potential harm to the patient. These include:

- Risk of reduced independence
- Increased risk of acquiring an infection
- Increased risk of breakdown in the patient's care network.

2. Policy Statement

This document is provided to support the management of patient care, along with the patient's family / carers / advocate, during the decision making process. It aims to ensure that;

- All patients are treated fairly and without discrimination;

- Patients, relatives and carers should be fully involved from the beginning in the discharge planning process which should be initiated when the patient is admitted to hospital and a proactive approach taken to ensure the discharge is appropriate, safe and timely;

- The patient, where practicable, should agree with the discharge destination;

- The MDT will always seek the permission of the patient to allow full involvement of relatives / carers in the discharge planning process. Where patients are unable to present their own views or wishes, relative / carer / advocate views will be obtained ensuring where possible that their interests or wishes do not conflict with those of the patient;

- Processes outlined in the Continuing Health Care (CHC) guidance should always be followed;

- Formal discussions with the patients and records of all decisions will be recorded in the patient's health records and discharge planning documentation. All entries must be signed and dated;

- At all times, Health and Adult Social Care staff will act in the best interest of the patient;

- Where the patient is discharged to an interim placement outside the Trust, an allocated Social Worker / Care Manager will maintain contact with the patient and will ensure that when a place becomes available in the patients home of choice, and where funding arrangements permit, that arrangements will be made to transfer the patient to that home if that is still their wish. CHC processes in local authorities may differ and agreements are dependent on local CHC guidance.

3. Scope and Exclusions

This policy applies to all UHSM employees including the Integrated Health and Social Care Team.

4. Processes

4.1 Application of this Policy

This document applies to patients in the following situation:

- Patients for whom an agreed multidisciplinary assessment has identified that discharge from hospital or community health facility is appropriate but who require care home (residential or nursing) placement. This placement will be funded by Social Services, the NHS or the patient, dependant on the outcome of financial and health assessments;

- Patients who have identified a care home of choice but accommodation is not immediately available, or are having difficulty identifying a home of choice;

- Patients who are awaiting packages of care to be arranged, and / or completion of aids / adaptations to their home or housing issues such as decorating, cleaning;

- Patients who have stated that they are unwilling for transfer of care to take place until a bed is available in a care home of their choice;

- Patients for whom an interim placement has been identified which meets their assessed physical or mental needs.

This process will be fully supported by members of the Integrated Health and Social Care Team.

If at any point during the application of this policy, challenges are made towards members of staff (for example, the threat of legal action) this must be escalated to the Chief Operating Officer with immediate effect.

4.2 Patients who Lack Capacity

The patient (where able) has the right to decide and be involved in the choice of their transfer or discharge destination.

Where there are concerns that a patient lacks the capacity to decide where to be discharged to an assessment of capacity should be undertaken. If the assessment identifies that the patient does currently lack the capacity to make that decision, a Best Interest Meeting will be organised prior to the decision regarding the choice of accommodation is made. ***The process outlined below for handling the discharge will apply but letters replaced with those in Appendix 7 (for stage 1 of the process) and Appendix 8 (for stage 2 of the process).***

The principles of the Mental Capacity Act (2005) should be adhered to at all times. For further information and guidance see the Trust's Mental Capacity Act Policy (1) and Safeguarding Vulnerable Adult Policy (2)

(1) http://uhsm-intranet/policies/Trustwide%20policies%20operational%20policies%20and%20guidel/Mental%20Capacity%20Act%20Policy%20V2.00.pdf
(2) http://uhsm-intranet/policies/Trustwide%20policies%20operational%20policies%20and%20guidel/Safeguarding%20Vulnerable%20Adults%20Policy%20V3.00.pdf

4.3 Process for Patients Waiting in a Hospital Bed for Care Home Placement

This guidance should be followed where the MDT assessment of the patient indicates that the patient is close to being fit for discharge and therefore not requiring any further inpatient care. The full MDT should be satisfied that the patient's condition cannot be further improved by inpatient rehabilitation or intermediate care and that placement in a residential or nursing home is the most appropriate option to meet the patient's needs. The key component of the assessment process will be the involvement of the patient at all stages (Appendix 2).

Some local authorities use an interim care setting to have the patient's needs further assessed and / or receive further treatment from the MDT. It is acceptable for a patient to move from an acute setting to an interim placement until a permanent / alternative choice becomes available.

The Integrate Hospital and Social Care Team (IHSCT) for the patients' ward will be responsible for ensuring that appropriate discussions take place with the patient at all stages of the assessment and planning process. All such discussions will be recorded in the patient's health records and on the discharge planning documentation.

Patients, families and carers should be directed to the Department of Health's Discharge Guidance if they have any queries or concerns with the proposed management of the discharge.

All internal process and assessments must be completed before the following process is implemented:

4.3.1 Stage 1: Day 1 – Day 7

Once all assessments and meetings are complete the patient and/or family / carers will receive written confirmation of discharge plans (Stage 1 letter, Appendix 3), the date and to whom this was given / sent will be documented in the patients records by the issuer. Where possible, this will be given directly to the patient and / or relative by the Ward Manager or Discharge Nurse.

The patient, family / carers will engage with the IHSCT within 7 days to facilitate discharge to the discharge destination. A copy of this policy should be given to the patient, family / carer.

In the case of a patient requiring a nursing / residential home placement, a shortlist of appropriate establishments with vacancies will be provided along with the preferred provider lists for the relevant local authority. Patients, families / carers will be made aware that the list provided is non exhaustive and a full list can be found at www.cqc.org.uk.

All further information and support required is to be provided by the IHSCT to facilitate a safe and efficient discharge to the appropriate destination.

If the family cannot be contacted following receipt of the initial confirmation, the patients discharge / transfer plans will still continue to ensure that their best interests of the patient are being addressed by hospital staff.

For patients who are self funding, escalation to the Divisional Director of Operations and Chief Nurse will be required due to the potential need to commence legal proceedings or the family being billed for the on-going care in hospital.

4.3.2 Stage 2: Day 8 – Day 10

In the event of;

- A discharge is delayed beyond the timeframe outlined in the Stage 1 letter, a member of IHSCT will ensure that all the necessary information and support has been given to the patient, families / carers.

- If the patient remains medically fit for discharge and the MDT assessments identify no changes.

- If the patient, families / carers have not engaged with IHSCT to facilitate discharge or the delay is due to the points set out in section 3.3 of this guidance.

The following actions will be taken:

The IHSCT will arrange a review meeting with the patient, family / carers within 3 working days. This meeting is to be chaired by a Trust Matron or Manager from the relevant Directorate (or the IHSCT manager if no local representative is available) and attended by at least one health professional and one social care worker from IHSCT. This meeting is to be documented in the patient's health records and an invitational letter (Appendix 4) will be issued to the patient family / carer.

The person chairing the meeting will:

- Confirm with IHSCT that an appropriate interim placement is available;
- Ensure that all information and support required to facilitate discharge has been given;
- Reiterate the patient no longer requires an acute hospital bed and remaining in hospital is not an appropriate course of action as it is detrimental to the patients health and wellbeing;

- Explain the next part of the process is that a further timeframe (maximum of 7 days) is to be given from the date of this meeting and the patient, family / carer will be asked to agree to a local vacancy for interim placement;
- A formal letter will be issued outlining the plan (including timeframe) from the meeting and the interim options available to the patient, family / carer;

The relevant Head of Nursing and Divisional Director of Operations will be informed of the meeting and the outcome.

4.3.3 Stage 3: Day 17 – Day 24 (following time given to the family as described in Stage 2)

If there is no interim placement identified and agreed by the date specified in the letter and there is no indication of availability at the discharge destination of choice, a member of the IHSCT should inform the patient's consultant. Divisional Director of Operations should then convene a final review meeting inviting the patient, family / carer to finalise discharge arrangements. This will be confirmed in writing (Stage 3 letter, Appendix 5).

The Chief Nurse and Director of Operations should be informed that such a meeting is being convened as it may result in the patient being transferred and/or that legal proceedings may be considered.

This planning meeting where practicable will be convened within 3 working days of the agreed timeframe to ensure all risk issues have been considered. The meeting will include where practicable:

- The Divisional Director of Operations
- Adult Social Care Manager
- IHSCT Nurse
- Consultant
- Trust Executive or Representative
- Trust Legal Team Member
- GP

Once the meeting has been arranged with the relevant Trust staff a final meeting letter should be issued (Appendix 6) to the patient, family / carers.

The outcome of the meeting will be documented in the patient's health records and written confirmation of the outcome will be sent to all present at the meeting. The patients discharge will then follow the agreed plan.

4.4 Governance

Any complaints regarding the discharge process will be investigated by the relevant Head of Nursing or Directorate Manager as per UHSM's Complaints and Feedback Policy.

4.5 Performance Monitoring

An annual audit of the use and outcome of this policy will be undertaken by the IHSC Team Manager and the Senior Specialist Discharge Nurse. Outcomes will be reported through the Clinical Standards Sub Committee.

5. Duties related to the implementation of this policy

Employees

All employees have a duty to read and be aware of this policy and to ensure it is adhered to and used appropriately for the safe and timely discharge of UHSM patients.

Managers
All Managers have the responsibility to ensure this policy is communicated effectively with their department's employees, any training requirements are fulfilled and the policy is used appropriately by all members of their team.

Appendix 1

University Hospital of South Manchester NHS
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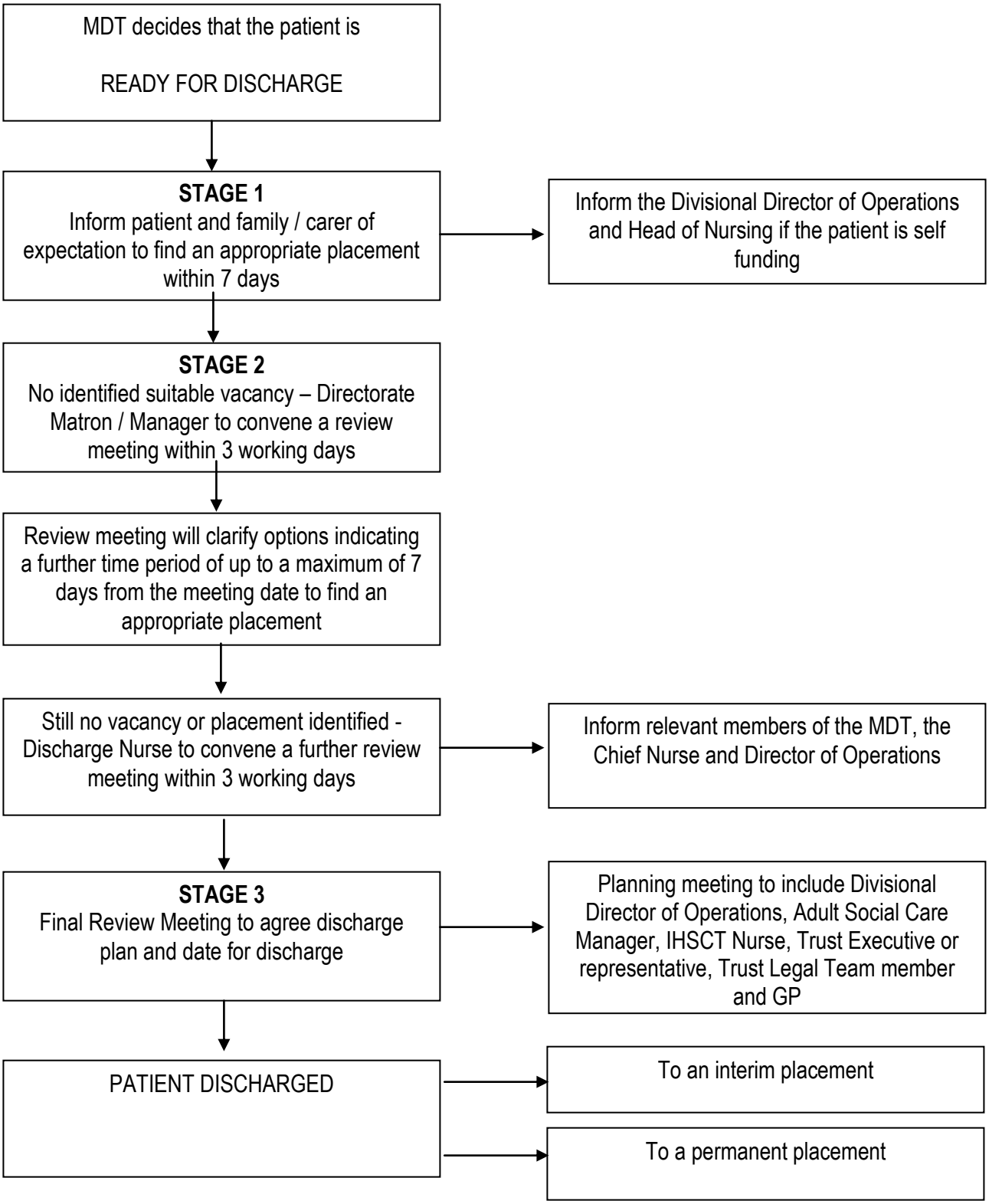
EQUALITY IMPACT ASSESSMENT of Discharge Destination Policy

		Yes/No	Comments
1.	**Does the guidance affect one group less or more favourably than another on the basis of:**		
	• Race	No	
	• Ethnic origins (including gypsies and travellers)	No	
	• Nationality	No	
	• Gender	No	
	• Culture	No	
	• Religion or belief	No	
	• Sexual orientation including lesbian, gay, bisexual and transgender people	No	
	• Age	No	
	• Disability	No	
2.	**Is there any evidence that some groups are affected differently?**	No	
3.	**If you have identified potential discrimination, are any exceptions valid, legal and/or justifiable?**	No	
4.	**Is the impact of the guidance likely to be negative?**	Yes	Patients may be moved against their will or to a home not of their choice. Risk of negative feedback regarding the Trust from patients, relatives/carers.
5.	**If so can the impact be avoided?**	Yes	Patients can remain in an acute bed unnecessarily at the risk to their own health and this will deny other patients hospital admission and the treatment they require. Involving the patient, relative/carers in discharge planning from admission ensuring clear communication at each step.
6.	**What alternatives are there to achieving the guidance without the impact?**	Nil	Nil alternatives
7.	**Can we reduce the impact by taking different action?**	No	

Appendix 2

Process Flow Chart for Patients Waiting for Care Home Placement



Appendix 3

Stage 1 letter

Dear

Your consultant [INSERT NAME] informed you that you were medically safe for transfer / discharge on the [INSERT DATE]. This was further discussed with you on [INSERT DATE] by [INSERT NAMED NURSE AND MEMBER OF INTEGRATED HEALTH & SOCIAL CARE TEAM] who explained that following assessment, we would like you to identify a care home for [INSERT PATIENT'S NAME] on-going care needs.

We do not wish to cause you any additional anxiety or distress, but you will be aware that there are many people requiring hospital care and we need to be able to offer treatment to all patients at the earliest opportunity. We are asking you to let us know of your preferred care home within 7 days of the date on this letter.

A member of the Integrated Health and Social Care Team will be available to support you during the next 7 days and will provide you with information relating to local care homes and current vacancies. In the event of no decision being made in this timescale hospital staff will begin the process of finding an interim solution. We may also have to do this if the care home of your choice does not have a vacancy.

If you are unhappy with the service you have received it is important for you to tell us. You can raise your concerns with the Clinical Director, Head of Nursing or Divisional Director of Operations or the Patient Experience Team who will investigate in accordance with the NHS Complaints Procedure. You can receive feedback verbally or in writing, dependent upon your wishes. However, it is the aim of the Trust to ensure that you lave hospital with support and understand the reasons for the decisions which will always be made in the patients best interests.

If you have any further questions please do not hesitate to contact a member of the Integrated Health and Social Care Team.

Yours sincerely

Chief Executive

Appendix 4

Stage 2 letter

Dear

Your consultant [INSERT NAME] has let us know that you were medically ready for discharge on the [INSERT DATE]. This was further discussed with you on [INSERT DATE] by [INSERT NAMED NURSE AND MEMBER OF INTEGRATED HEALTH & SOCIAL CARE TEAM] who explained how your continued care would need to be met therefore I sent you a letter on [INSERT DATE]. We asked you to identify a care home to us within 7 days of the date on the letter.

The Multidisciplinary Team responsible for your care have been over your records and identified that there is no change in the decision that you no longer in need of active acute hospital care.

Within the next 3 days you will need to meet with a management team member to review the position so far and to discuss interim arrangements pending your decision and / or a vacancy being available at your preferred care home.

The aim of the meeting will be to explore the options available to you with you and your family / carer and members of the multidisciplinary team. You will then be given a further 7 days to identify a placement with our support.

We do not wish to cause you any undue anxiety or distress, but you will be aware that there are many people requiring hospital care and we need to be able to offer treatment to all patients at the earliest opportunity. As mentioned in the first letter, as a result of no care home being identified we are now in a position to identify an interim solution. This will be discussed with you at a meeting scheduled for [INSERT MEETING DETAILS].

If you are unhappy with the service you have received it is important for you to tell us. You can raise your concerns with the Clinical Director, Head of Nursing or Divisional Director of Operations or the Patient Experience Team who will investigate the issues in accordance with the NHS Complaints Procedure. You can receive feedback verbally or in writing, dependent upon your wishes. However, it is the aim of the Trust to ensure that you are discharged with support and fully aware of the reasons for the decisions which will be made in the patients best interests.

If you have any further questions please do not hesitate to contact the Nurse in Charge or a senior member of staff.

Yours sincerely

Chief Executive

Appendix 5

Stage 3 letter

Dear

Your consultant [INSERT NAME] has informed you that you were medically stable and fit for transfer/discharge on the [INSERT DATE]. I understand that your preferred place of residence following discharge is [INSERT NAME OF CHOSEN ESTABLISHMENT] but that they are not able to accommodate you at the present time.

A meeting will now be convened with a member of the Executive Team and the Trust Legal Team to agree that we have been compliant with Trust Discharge Destination Policy, a copy of which was made available to you at the start of this process.

I am sure you will understand that acute hospital beds are in great demand and that we need to ensure that they are available for patients who need them for urgent specialist medical and nursing treatment and care. It is therefore important that those patients who have been assessed as medically fit for discharge move to a more suitable placement promptly. It is also rarely in a patient's best interests to remain in hospital once they are fit for discharge. We therefore request that you accept the interim arrangements offered and accept that your transfer out of the hospital will occur by [INSERT DATE].

If you are dissatisfied with the service you have received it is important for you to tell us. You can raise your concerns with the Clinical Director, Head of Nursing or Divisional Director of Operations or the Patient Experience Team who will investigate the issues in accordance with the NHS Complaints Procedure. You can receive feedback verbally or in writing, dependent upon your wishes. However, it is the aim of the Trust to ensure that you are discharged with support and fully aware of the reasons for the decisions which will be made in the patients best interests.

If you have any further questions please do not hesitate to contact any member of the staff.

Yours sincerely,

Chief Executive

Appendix 6

Final meeting letter arrangements

Dear

Your consultant [INSERT NAME] informed you that you were medically stable and fit for discharge/transfer on the [INSERT DATE]. This was further discussed with you on [INSERT DATE] by [INSERT NAME] who explained how your continued care would be met and how any interim care arrangements would work. We again met with you on [INSERT DATE] to discuss arrangements should the situation remain unchanged 7 days from the meeting date. Despite recent communications you have still not made arrangements to allow us to transfer your care to a place of your choice.

A meeting will now be convened with a member of the Executive Team and the Trust Legal Team to agree that we have been compliant with Trust Discharge Destination Policy, a copy of which was made available to you at the start of this process.

Whilst we do not wish to cause you any undue anxiety or distress, you will be aware that there are other people requiring acute hospital care and we need to be able to offer treatment to these patients at the earliest opportunity. Unless you make arrangements to leave the hospital the Trust will have no choice but to take steps to ensure the safe discharge / transfer of [INSERT PATIENT'S NAME] to a setting able to provide the appropriate support, which may include legal action for which you could be required to pay our legal costs. I hope such steps will not be necessary.

If you are dissatisfied with the service you have received it is important for you to tell us. You can raise your concerns with the Clinical Director, Head of Nursing or Divisional Director of Operations or the Patient Experience Team who will investigate the issues in accordance with the NHS Complaints Procedure. You can receive feedback verbally or in writing, dependent upon your wishes. However, it is the aim of the Trust to ensure that you are discharged with support and fully aware of the reasons for the decisions which will be made in the patients best interests.

If you have any further questions please do not hesitate to contact any member of the staff.

Yours sincerely

Chief Executive

Appendix 7

STAGE 1 LETTER – (Carer/Relative Letter)
PATIENT WHO LACKS CAPACITY

Dear

We are pleased to hear that the Consultant responsible for [INSERT PATIENT'S NAME] treatment in hospital has confirmed that [INSERT PATIENT'S NAME] is now medically fit to be discharged from hospital.

A Health and Social Services Assessment has been completed and [INSERT PATIENT'S NAME] care needs have been fully discussed with you and with [INSERT PATIENT'S NAME], as far as appropriate.

As you may be aware, [INSERT PATIENT'S NAME] has been assessed as lacking the mental capacity to make a valid decision concerning their living arrangements following discharge. Therefore, hospital staff are obliged to work with other professionals and with the family and friends of [INSERT PATIENT'S NAME] to identify an appropriate placement for [INSERT PATIENT'S NAME] in line with his / her "best interests".

[INSERT NAMES] of the Integrated Health & Social Care Team have discussed this with you and we would be grateful if you could now inform us of your views regarding appropriate accommodation for [INSERT PATIENT'S NAME] so that your preferences can be taken into account in reaching a decision, and to ensure that [INSERT PATIENT'S NAME] can be discharged safely and promptly. It is hoped that professionals and family and friends will be agreed on their preference for an appropriate placement. We are asking you to inform of us your preferred care home within 7 days of the date on this letter.

If you have any queries or wish to discuss this further, please contact a member of the Integrated Health & Social Care Team on [INSERT CONTACT NUMBER].

If you are dissatisfied with the service you have received it is important for you to tell us. You can raise your concerns with the Clinical Director, Head of Nursing or Divisional Director of Operations or the Patient Experience Team who will investigate the issues in accordance with the NHS Complaints Procedure. You can receive feedback verbally or in writing, dependent upon your wishes. However, it is the aim of the Trust to ensure that you are discharged with support and fully aware of the reasons for the decisions which will be made in the patients best interests.

If you have any further questions please do not hesitate to contact any member of the staff.

Thank you for your co-operation.

Yours sincerely,

Chief Executive

Appendix 8

STAGE 2 LETTER – (Carer/Relative Letter)
PATIENT WHO LACKS CAPACITY

Dear

We are pleased to hear that the Consultant responsible for [INSERT PATIENT'S NAME]'s treatment in hospital has confirmed that [INSERT PATIENT'S NAME] is now medically fit to be discharged from hospital. A Health and Social Services Assessment has been completed and [INSERT PATIENT'S NAME]'s care needs have been fully discussed with you, and with [INSERT PATIENT'S NAME], as far as appropriate.

I am sure you will understand that acute hospital beds are in great demand and that we need to ensure that they are available for patients who need them for urgent specialist medical and nursing treatment and care. It is therefore important that those who have been assessed as medically fit for discharge move to a more suitable placement promptly. It is also rarely in a patient's best interests to remain in hospital once they are fit for discharge.

As you may be aware, [INSERT PATIENT'S NAME] has been assessed as lacking the mental capacity to make a valid decision concerning their living arrangements following discharge. Therefore, hospital staff are obliged to work with other professionals and with family and friends of [INSERT PATIENT'S NAME] to identify an appropriate placement for [INSERT PATIENT'S NAME] in line with his / her "best interests". We have discussed [INSERT PATIENT'S NAME] with you and have taken into account your views about where he / she should now live.

[I understand that your preferred place of residence for [INSERT PATIENT'S NAME] following discharge is [INSERT NAME OF CHOSEN ESTABLISHMENT] but that they are not able to offer accommodation at the present time it has been decided that they are not the most appropriate placement to meet [INSERT PATIENT'S NAME] needs.

We have considered what placements are available that can meet [INSERT PATIENT'S NAME]'s care needs, and have decided that [INSERT PATIENT'S NAME] should move to [INSERT NAME OF ESTABLISHMENT]. [*This is a temporary placement, until the chosen placement becomes available* – DELETE WHERE APPLICABLE].

[NAME OF PLACEMENT] has confirmed that a bed will be available for [INSERT PATIENT'S NAME] on [INSERT DATE]. We therefore intend to discharge [INSERT PATIENT'S NAME] from the hospital on that day. We would welcome your assistance with the move process, if possible. If you have any queries, or if you wish to discuss this further then please contact a member of the Team on [INSERT CONTACT NUMBER].

Unless arrangements are made for [INSERT PATIENT'S NAME] to leave the hospital it may be necessary for the Trust to take steps to compel them to leave, including possible legal action. I hope such steps will not be necessary.

If you are dissatisfied with the service you have received it is important for you to tell us. You can raise your concerns with the Clinical Director, Head of Nursing or Divisional Director of Operations or the Patient Experience Team who will investigate the issues in accordance with the NHS Complaints Procedure. You can receive feedback verbally or in writing, dependent upon your wishes. However, it is the aim of the Trust to ensure that you are discharged with support and fully aware of the reasons for the decisions which will be made in the patients best interests.

If you have any further questions please do not hesitate to contact any member of the staff.
Yours sincerely

Chief Executive

Appendix 9

"YOUR MOVE"

Information to help you when discussing your move from hospital or a Residential or Nursing Home

Moving on from Hospital

Since you were admitted to hospital the Doctors, Nurses, Therapists and Social Workers who have been involved in your care have been working together with you to assess your needs for health and social care support when you leave hospital.

It is now agreed by you and/or your family / carer and the hospital team that your needs will be best met in a Residential or Nursing Care Home. We are seeking to safely make this move so that someone else who is waiting for treatment can come into the hospital.

We understand that the decision to live in a Residential or Nursing Home is a major one and one that involves important and significant changes for you and your family / carers.

This leaflet provides you, your family / carers with information you will need to make your decisions once you no longer need hospital treatment or are ready to be discharged to a Residential or Nursing Home.

Advice and guidance on choosing a home

Our integrated team of Discharge Nurses and Social Workers will offer you advice and guidance about planning your discharge from hospital. This will involve discussing your care needs with you and your family / carers giving you written information about the homes that can meet your needs.

Social Workers will offer advice and assistance with any funding that you may be entitled to and can provide you with information on the Residential and Nursing Homes. Independent advice can also be sought from other agencies such as Age Concern.

Timescale of Events

It is important that you continue to receive care and support in the most appropriate environment. To help us to do this, we need your cooperation and support to find a Residential or Nursing Home.

We will therefore ask you, your family / carers to make a choice of accommodation that is suitable without undue delay.

Once you and your family / cares have chosen a home you may have to wait until a place at that home becomes available. If the wait is likely to be more than 7 days we will work with you to find an acceptable alternative until the vacancy becomes available at your home of choice.

If you do not identify a choice of accommodation, or refuse the alternative temporary accommodation offered within a further 7 day period, the Trust will be required to take the necessary steps to discharge you to an alternative place of care.

Appendix 10

Underlying Principles

Discharge from Hospital Pathway Process and Practice, Department of Health 2003
Key Points:

- Unnecessary admissions are avoided and effective discharge is facilitated by a "whole system approach" to assessment processes and the commissioning and delivery of services.
- The engagement and active participation of people who use the services and their carer(s) as equal partners is central to the delivery of care and in the planning of a successful discharge.
- Discharge is a process and not an isolated event. It has to be planned at the earliest opportunity across the primary, hospital and social care services, ensuring that patient and their carer(s) understand and are able to contribute to the care planning decisions as appropriate.
- The process of discharge planning should be co-ordinated by an acting named person who has responsibility for co-ordinating all stages of the patient journey. This involves liaison with the pre-admission case co-ordinator / care manager / community matron, district nurse or social worker in the community at the earliest opportunity and the transfer of those responsibilities on discharge.
- Staff should work within a framework of integrated multidisciplinary and multi-agency team working to manage all aspects of the discharge process.
- Effective use is made of transitional and intermediate care services so that existing acute hospital capacity is used appropriately and patients achieve their optimal outcome.
- The assessment for and delivery of health and social care needs is organised so that individuals understand the continuum of health and social care services, their rights and receive advice and information to enable them to make informed decision about their future care.

National Framework for NHS Continuing Healthcare and NHS Funded Care 2007
Overview:

The Department of Health describes continuing care as the provision of care over an extended period of time as the result of disability, accident or illness to meet both physical and mental health needs. It can be provided in a range of settings from an NHS Hospital, Care Home or Hospice to a person's own home.

Continuing Care can include both health and social care funding. This may vary between local authorities. Every patient over age 18, who may have continuing care needs must be considered for eligibility for NHS Continuing Healthcare before any long term plans are put in place.

If individuals, following a multi-disciplinary assessment are identified as possibly meeting the criteria and a referral made to a team of funded NHS care assessors team. They will carry out their assessment and apply the criteria to determine eligibility. The above applies regardless of whether the individual is in a hospital, care home or their own home. The NHS is responsible for arranging as well as funding continuing care services.

Mental Capacity Act 2005
Overview:

The Mental Capacity Act (MCA) applies in England and Wales to everyone who works within the Health and Social Care. The MCA is based on best practice and creates a single coherent framework for managing mental capacity issues. It puts the individual at the heart of decision making and places a strong emphasis on supporting and enabling the individual to make their own decisions.

There must always be a presumption that a person has capacity to make decisions. Do not assume that people with cognitive/mental health issues lacks capacity on all decisions.

The assessment of capacity must be a particular decision at a particular time and not a range of decisions.

The MCA set out 5 key principals which underpin the legal requirements. These are;

1. A person must be assumed to have capacity unless it is established that they lack capacity;

2. A person is not to be treated as unable to make a decision unless all practicable help to enable him / her do so has been taken without success;

3. A person is not to be treated as unable to make a decision merely because he makes an unwise decision;

4. An act done or decision made on or on behalf of a person who lacks capacity must be done, or made, in his / her best interest;

5. Before the act is done, or decision is made, it must be considered whether the purpose for which it is needed can be effectively achieved in a way that is less restrictive to the person's rights and freedom of action.

No one can assume that a person lacks capacity because of old age, how they look or how they behave. No one can assume a person cannot make a decision because of their inability to make complicated decisions or because they have not been able to make a decision like that in the past.

Where a person has to make a decision on behalf of a person who lacks capacity, they must decide what is in the person's best interest.

This can only be done properly by listening to what the person wants, consulting people who know them, and making sure they are involved at every step of the process.

Assessing Capacity

The person who assesses an individual's capacity to make a decision will usually be the person who is directly involved with the individual at the time the decision needs to be made. The decision to be made will determine who completes the capacity assessment. The establishment of capacity to consent is the responsibility of the person proposing the medical treatment or social care.

The Functional Test of Capacity

In order to decide whether an individual has the mental capacity to make a particular decision, you must decide whether there is an impairment of, or disturbance in the functioning of the person's mind or brain (permanent or temporary).

If impairment is established, the second question you must answer is, does the impairment or disturbance make the person unable to make the particular decision?

The person will be unable to make the particular decision if after all appropriate help and support to make a decision has been given to them they cannot do the following things:

1. Understand the information relevant to that decision, including understanding the likely consequences or making or not making the decision;

2. Retain the information;

3. Use or weigh up that information as part of the process of making the decision;

4. Communicate their decision whether by talking, using sign language interpreter, or other means.

Every effort should be made to find ways of communicating with someone before deciding that they lack capacity to make a decision based solely on their inability to communicate.

An assessment must be made on the balance of probabilities i.e. is it more likely than not that the person lacks capacity? You should show in your records why you have come to the conclusion that the person lacks capacity to make a particular decision.

Independent Mental Capacity Advocate (IMCA)

If a person lacks capacity and medical treatment and / or a move is being proposed and there is nobody other than paid staff to consult with on behalf of the person who lacks capacity to consent then the relevant NHS body or local authority must instruct an IMCA. Staff will need to await the IMCA's "report" before they can proceed to a best interest decision, unless it is urgent or an emergency.

Any act done or decision made on behalf of a person who lacks capacity must comply with the five principals set out in section 1 of the Act.

Advanced Decisions

The Act also introduces the legal framework for advanced decisions. An advance decision enables someone aged 18 and over, while still capable, to refuse specified medical treatment for a time in the future when they may lack the capacity to consent to or refuse that treatment. It has the same effect as a decision that is made by a person with capacity: healthcare professionals must follow the decision. If the advance decision refuses life-sustaining treatment, it must:

- Be in writing (it can be written by a someone else or recorded in healthcare notes);
- Be signed and witnessed, and
- State clearly that the decision applies even if life is at risk.

To establish whether an advance decision is valid and applicable, healthcare professionals must try to find out if the person:

- Has done anything that clearly goes against their advance decision;
- Has withdrawn their decision;
- Has subsequently conferred the power to make that decision on an attorney, or
- Would have changed their decision if they had known more about the current circumstances.

Advance decisions to refuse treatment for mental disorder may not apply if the person who made the advance decision is or is liable to be detained under the Mental Health Act 1983.

NHS Constitution 2009
Key points:

The Constitution establishes the principles and values of the NHS in England. It sets out the rights to which patients, public and staff are entitled, and pledges which the NHS is committed to achieve, together with responsibilities which the public, patients and staff owe one another to ensure the NHS operates fairly and effectively.

In respect of discharge, the patient has the right to:
Respect, consent and confidentiality

- Each person will be treated with respect and courtesy
- Personal information will be kept confidential, patient records will be kept safe and secure
- Patient's can have access to their own health records, including any letters sent between clinicians about their care.

Informed Choice

- Patients have a right to make choices about their NHS care and to information to support these choices.

Involvement in Healthcare

- Patients have a right to be involved in discussions and decisions about their healthcare, and to be given information to enable them to do this.

The NHS commits to:

- Make the transition between services / discharge as smooth as possible
- Ensure decisions are made in a clear and transparent manner.

Patient's and Carer's Discharge Standards

Patients being discharged from hospital have the right:

- To full information on their diagnosis and the assessment of their health and social needs in preparation for discharge
- To be fully involved in planning their own discharge, together with a relative, carer or friend as appropriate
- For the discharge plan to start on or before admission where possible
- To full information on the services available in the community relevant to their care
- To full information on short or long term nursing or residential care; including financial implications
- To be given an appropriate contact number where they can get help or advice on discharge
- To be given a clear, legible discharge letter detailing the support services provided for them, where appropriate
- To full information on health authority eligibility criteria for continuing care
- The discharge planning team to be available as a point of contact to offer support and advice to patients, carers, statutory and voluntary agencies
- Information on advocacy support
- To have access to the Trust complaints procedure and any complaint regarding their discharge arrangements investigated and a full explanation given
- If still not satisfied, then to be given access to the Health Service Commissioner.

Source: *Discharge from hospital: pathway, process and practice, Appendix 4.3 Department of Health 2003 [Page 45].*

Appendix 11

Intermediate Care Service / Discharge Destination Policy 2014

There are 39 Intermediate Care beds in South Manchester as part of UHSM community services. Patients are admitted to these beds following a period in hospital or directly from home to prevent an unnecessary hospital admission. The average length of stay is approximately 27 days. The vast majority of patients (86%) return to their own homes following a period of rehabilitation on the unit. Some patients (12%) are unable to return safely to their own homes and are assessed as needing to transfer from Intermediate Care to either a Residential or Nursing Home.

This document applies to patients in the following situation:

- A patient for whom an agreed multidisciplinary assessment has identified that discharge from an Intermediate Care bed is appropriate but who now require a care home (residential or nursing) placement;

  This placement will be funded by Social Services, the NHS or the patient, dependant of the outcome of financial and health assessments;

- Patients who have identified a care home of choice but accommodation is not immediately available, or are having difficulty identifying a home of choice;

- Patients who have stated that they are unwilling for transfer of care to take place until a bed is available in a care home of their choice;

- Patients for whom an interim placement has been identified which meets their assessed physical or mental needs;

- Patients who are being treated by UHSM but whose home address lies outside of the Manchester area.

This process will be fully supported by the Intermediate Care Service and the wider organisation.

Patients who Lack Capacity

The patient (where able) has the right to decide and be involved in the choice of their transfer or discharge destination.

Where there are concerns that the patient lacks the capacity to decide where to be discharged to, an assessment of capacity should be undertaken. If this assessment finds that the patient lacks the capacity to make that decision, a Best Interest Meeting will be organised prior to the decisions being made regarding the choice of accommodation type.

The process outlined below for handling the discharge should apply but letters replaced with those in Appendices 7 (for Stage 1) and 8 (for Stage 2).

The principles of the Mental Capacity Act (2005) should be adhered to at all times. For further information and guidance see the Trust's Mental Capacity Act Policy and Safeguarding Vulnerable Adult Policy.

Process for patients waiting in an Intermediate Care bed for nursing or residential placement:

This guidance should be followed where the MDT assessment of the patient indicates that the patient is close to being fit for discharge and therefore not requiring any further inpatient care. The full MDT should be satisfied that the patient's condition cannot be further improved by Intermediate Care and that placement in a residential or nursing home is the most appropriate option to meet the patient's needs. The key component of the assessment process will be the involvement of the patient at all stages.

Some local authorities use an interim care setting to have patients / client's needs further assessed and / or receive further treatment from the MDT. It is acceptable for a patient to move from an Intermediate Care setting to an interim placement until a permanent / alternative choice becomes available.

The MDT will be responsible for ensuring that appropriate discussions take place with the patient at all stages of the assessment and planning process. All such discussions will be recorded in the patient's health records and on the discharge planning documentation. Any care plan will clearly state who the key Discharge Nurse and Social Worker are for the patient.

Patients, families and carers should be directed to the Department of Health's Discharge Guidance if they have any queries or concerns with the proposed management of the discharge.

Stage 1: 1-14 DAYS for ICT

The process of planning discharge will adhere to the current Trust Patient Discharge Policy and the appropriate local authority discharge guidance.

All patients, families / carers identified as requiring discharge support will be issued the Intermediate Care leaflet. The date and to whom the leaflet was given will be documented in the patient's records by the issuer.

Once all assessments and meetings are complete the patients', family / carers will receive written confirmation of discharge plans (Stage 1 letter, Appendix 2), the date and to whom this was given / sent will be documented in the patients records by the issuer. Where possible, this will be given directly to the patient and / or relative.

In the case of a patient requiring a nursing / residential home placement a shortlist of appropriate establishments with vacancies will be provided along with the preferred provider lists for the relevant local authority. Patients, families / carers will be made aware that the list provided is non exhaustive and a full list can be found at www.cqc.org.uk.

All further information and support required is to be provided by the unit MDT to facilitate a safe and efficient discharge.

If the family cannot be contacted following receipt of the initial confirmation the patients discharge / transfer plans will still continue to ensure that the best interests of the patient are being addressed by Trust staff.

Stage 2: Day 14-16 for ICT

In the event of:

- A discharge is delayed beyond the timeframe outlined in the Stage 1 letter, a member of the MDT will ensure that all the necessary information and support has been given to the patient, families / carers;

- If the patient remains medically fit for discharge and the MDT assessments identify no changes;
- If the patient, families / carers have not engaged with the service to facilitate discharge or the delay is due to the points set out in section 3.3 of this guidance in the main section of this policy.

The following actions will be taken:

The MDT will arrange a review meeting with the patient, family / carer within 5 working days. This meeting is to be chaired by a Senior Nurse or Manager from the unit and attended by at least one other health professional and the social care worker for the patient. This is to be documented in the patient's health records and an (invitational letter) will be issued to the patient, family /carer.

The person chairing the meeting will:

- Confirm with the Social Worker that an appropriate interim placement is available;
- Ensure that all information and support required to facilitate discharge has been given;
- Reiterate the patient no longer requires an Intermediate Care bed and that remaining in such a bed is not an appropriate course of action and could be detrimental to the patients health and wellbeing;
- Explain the next part of the process is that a further (maximum of 7 days) is to be given from the date of this meeting. The patient, family / carer will be asked to agree to a local vacancy for interim placement;
- A Stage 2 letter (Appendix 3) will be issued outlining the plan (including timeframe) from the meeting and the interim options available to the patient family/carer;

Stage 3: Day 17 – Day 24 (following time given to the family as described in stage 2)

If there is no interim placement identified / agreed by the date specified in the letter and there is no indication of availability at the discharge destination of choice, a member of the MDT should inform the patient's consultant. A Senior Manager should then convene a final review meeting inviting the patient family/carer/ advocate to finalise discharge arrangements. This will be confirmed in writing (Stage 3 letter, Appendix 4).

The Chief Nurse / Director of Operations should be informed that such a meeting is being convened as it may result in the patient being transferred and/or that legal proceedings may be considered.

This planning meeting where practicable will be convened within 2 working days to ensure all risk issues have been considered. The meeting will include where practicable:

- The Divisional Director of Operations
- Adult Social Care Manager
- IHSCT Nurse
- Hospital Executive or Representative
- Hospital Legal Team Member
- GP

The outcome of the meeting will be documented in the patient's health records and written confirmation of the outcome will be sent to all present at the meeting. The agreed patients discharge will then follow the agreed plan.

Governance

Any complaints received will be investigated by the Senior Nurse / Clinical Lead along with other members of the MDT as appropriate as per the Trust's Complaints and Feedback Policy.