PAN-HERTS VALLEYS POLICY FOR MANAGING CHOICE ON HOSPITAL DISCHARGE

Hertfordshire County Council

West Hertfordshire Hospitals NHS Trust

Herts Valleys Clinical Commissioning Group

Hertfordshire Community NHS Trust

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Staff Audience	**All staff working with inpatients – WHHT, HCC, HCT, HVCCG**
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SUMMARY POINTS

This **policy** defines the **process** by which NHS Trusts and local authority Health and Community Service providers for Herts Valleys CCG must follow to manage choice throughout a person's inpatient stay with regard to discharge planning,particularly at the point they no longer require inpatient care.
The overarching aim is to reduce delayed transfer of care, through early engagement, support and the implementation of a fair and transparent escalation process.

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1 INTRODUCTION

1.1 This policy supports timely and effective discharge from an NHS inpatient setting, to the most appropriate available setting to meet their needs. It is relevant to all adult inpatients in Herts Valleys' NHS provider settings who are required to choose a destination and/or a care provider on discharge. Both the policy and the process of managing choice on discharge applies equally to all patients, whether or not they need ongoing NHS or social care and whoever may be funding any such care.

1.2 Patient engagement and involvement are central to the process for managing choice on hospital discharge. The term patient is used here to describe an individual who has been admitted to NHS inpatient settings. Verbal or written communication with the patient applies equally or alternatively to communicating with the patient's representative, as appropriate and with consent.

2 PURPOSE

2.1 The purpose of this policy is to ensure that choice is managed fairly throughout the discharge planning process, that a clear escalation process is in place for when patients remain in hospital longer than is clinically required, and that there is a consistent approach across Herts Valleys' providers.

2.2 This policy sets out a framework to ensure that:

- NHS inpatient beds across Herts Valleys' providers will be used appropriately and efficiently for those people who require those services.
- When patients have completed required assessment or treatment at their current inpatient setting they will not remain there due to lack of clarity about the need to accept an alternative care provider and/or location if their preferred option is unavailable.
- Planning for effective transfer of care, in collaboration with the patient, their representatives and all MDT members will be commenced before or on admission.
- The process of offering choice of care provider and/or discharge destination will be followed in a fair and consistent way and there will be an audit trail of choices offered to the patient and/or representative.
- Where a patient is unable to express a preference, an advocate e.g. next of kin, will be consulted on their behalf.

3 DOCUMENT DEVELOPMENT

3.1 In December 2013. Herts Valleys' health and social care organisations agreed a joint approach to address the problem caused when patients or their representatives decline available discharge options and remain in hospital inappropriately.

3.2 A decision was taken to develop the policy and process, applicable to all patients, regardless of organisations or individuals funding their care after discharge.

3.3 This policy builds on the previous local policy and process that addressed disputed discharge or patient-choice resulting in delays.

3.4 Other guidance consulted includes:

- Ministry of Justice. Mental Capacity Act 2005
- BGS TOC of frail elderly good practice Jul 10
- Alzheimer's Society Hospital discharge factsheet (FS453LP) Oct 14
- Herts Valleys CCG Continuing Healthcare Standard Operating Procedures Jan 15
- Age UK Hospital discharge arrangements (FS37) May 15
- Age UK Choice of accommodation (FS60) Aug 15
- Various Department of Health policy and guidance documents (see 3.5, below)

3.5 In applying this policy, account will be taken of all related policy and guidance documents issued by the Department of Health, including:

- 1990. National Health Service and Community Care Act Repealed by...
    - 2014. Care Act
- 2002. National Service Framework for older people
- 2003. Community Care (delayed discharges etc.) Act. HSC 2003/009 / LAC (2003)21
- 2003. Community Care (Delayed Discharges etc.) Act Guidance for Implementation
- 2003. Discharge from hospital pathway, process and practice
- 2003. Supplementary checklist on implementing the Direction on Choice of Accommodation: "Discharge from Hospital-A matter of choice" (dh_4073940)
- 2004. Achieving timely simple discharge from hospital: A toolkit for the multi-disciplinary team
- 2004. Choice of Accommodation Guidance Choice of Accommodation Guidance
- 2004. Guidance on National Assistance Act (1948) (Choice of Accommodation) National Assistance (Residential Accommodation) (Additional Payments and Assessment of Resources) (Amendments) (England) Regulations 2001, "Choice Directive" (HSC 2001/015(LAC(2001)18), (LAC(2004)20)
- 2008. NHS Institute for Innovation and Improvement Discharge Planning Toolkit
- 2009. Common assessment framework for adults. A consultation on proposals to improve information sharing around multi-disciplinary assessment and care planning
- 2009 (revised 2013) .The Handbook to the NHS Constitution (dh_113614)
- 2010. Ready to go? Planning the discharge and the transfer of patients from hospital and intermediate care
- 2010. Guidance on Eligibility Criteria for Adult Social Care DH
- 2010 Equality Act
- 2012 The National Framework for NHS Continuing Care and NHS-Funded Nursing Care
- 2013. The NHS Continuing Healthcare (Responsibilities) Directions
- 2016. Care & Support Statutory Guidance (updated 25th April 2016)

4 GLOSSARY

CHC: NHS Continuing Healthcare

Discharge coordinator: A named nurse from the ward, a named social care professional from the local authority or a named CHC health professional. This named person coordinates discharge planning communication.

Discharge process: Transition planning for the patient's move from a hospital, whether to primary care, an acute hospital or to a specialist tertiary care setting.

EDD: Estimated or expected date of discharge. When the patient is most likely to be ready for safe transfer. The EDD is initially based on average length-of-stay data and may change several times in response to the patient's specific needs.

Hospital: Place of treatment, either acute or community

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

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

IMHA: Independent mental health advocate, who will support patients who have been detained under the Mental Health Act 1983 to be involved in important decisions, such as change of accommodation.

Locally: At the hospital or inpatient unit the patient has been admitted to.

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

Medically Stable: No longer requiring inpatient care or treatment at that hospital, so ready for discharge or transfer to another setting.

Nurse in Charge: This is likely to be a ward sister, charge nurse or ward manager.

Patient: An individual who has been admitted for NHS inpatient services. References to interactions with a patient should be taken to include the person in hospital and/or their representative as appropriate.

Ready-date: Date at which the patient is clinically ready to leave hospital.

Representative: A family member, person granted power of attorney, friend that the patient has asked to be involved or another advocate. Appropriate consent will be needed before discussing confidential information with a representative.

Self-funder: A person who financially meets the full cost of their social care needs, whether because their financial capital exceeds the threshold for adult services funding or because they or a representative choose to pay for their care.

Social care assessment: The assessment of a person's social care needs that all adult patients are entitled to, regardless of financial status. A social care professional will help identify suitable care and assist with discharge from hospital if asked.

Social care professional: Social worker or care manager allocated by adult services.

5 MANAGING CHOICE

5.1 Engagement, involvement and communication are central to the process of managing choice on hospital discharge. Verbal or written communication with the patient applies equally or alternatively to communicating with the patient's representative, as appropriate and with consent.

5.2 Potential consequences of a patient ready for discharge and remaining in hospital may include:

- exposure to unnecessary risk of hospital-acquired infection
- frustration and distress whilst waiting for a preferred choice to become available
- patient decompensation and increasing dependence as the hospital environment is not designed to meet the needs of people who are deemed medically stable for discharge
- additional pressure on the ability of the whole healthcare system to meet the needs of emergency and elective patients

5.3 Patients may find it difficult to choose a discharge destination or care provider for many reasons including:

- anxiety at facing a major life transition of moving to a care home or other community setting
- fears relating to the quality and/or cost of care
- reluctance to transfer to another hospital because relatives and friends may find it difficult to visit due to location and transportation
- unwillingness to move into interim accommodation and then move again later

5.4 Interactions with patients or representatives will acknowledge and offer support with any concerns, whilst reinforcing the message that everyone will work towards the patient's discharge from hospital.

5.5 By the time a patient is clinically ready for transfer of care they and/or their representative should understand that they cannot continue to occupy the inpatient bed. If their preferred location or care provider is not available they will be aware that they must accept an available alternative, either as a permanent option or whilst they await availability of their preferred choice.

5.6 The MDT will work jointly to offer open and consistent management of choice, to minimise stress to the patient and/or representative, and to involve them as appropriate with the discharge process. The MDT will maintain communication with patients and representatives and manage expectation.

5.7 Patients self-funding care will be offered the same level of advice, guidance and assistance regarding choice as those patients fully or partly funded by their local authority or NHS Continuing Healthcare (CHC). If a patient chooses not to take the advice offered or declines guidance and assistance they must make their own arrangements for care upon discharge from hospital. A decision made on the patient's behalf by the MDT or a legal representative must be made in the patient's best interest, in line with the Mental Capacity Act 2005. A representative's decision to decline support or guidance would need to be carefully considered.

5.8 If a patient could continue their recovery in a more suitable setting, it is never appropriate that they remain in hospital after they are medically stable, ready for transfer and no longer requiring hospital treatment.

6 CHOICE OF AVAILABLE OPTIONS AND INTERIM CARE

6.1 A discharge plan should include patient choice where possible and recognise the patient's autonomy to choose from available options. If more than one appropriate option is available when the patient is ready for transfer or discharge from hospital, the MDT will offer to support the patient and/or representative to choose.

6.2 If only one identified home or hospital can currently meet the patient's care needs, transfer to this single currently available option should not be rejected by the family and/or representative.

6.3 There may be occasions when a patient needs to transfer to another hospital but the preferred hospital has no vacancies. Patients and/or representatives do not have the right to remain in the current hospital longer than required because they do not wish to accept treatment at an available, more suitable alternative. If they choose to decline the offered transfer, discussions should start regarding discharge from NHS care.

6.4 There may be occasions when a patient needs care at home or to move to a care home, and the preferred care provider or location is not available. This might be for many reasons, including that the patient's own home might not be ready to support the discharge or there are no vacancies at the preferred care provider. Patients do not have the right to remain in hospital longer than required because they or their representative has refused or not reviewed available options.

6.5 If appropriate and possible, the patient will be helped to return to their previous home, perhaps with care and support or following an interim period of rehabilitation.

6.6 The patient and/or representative will be given information about what would be involved if the patient requires a domiciliary care package, care home placement, intermediate care or 'step down' care. Refusal to make a choice about available options or refusal to accept a single available temporary option must not lead to the patient remaining in the hospital.

6.7 If available options are, or a single available option is rejected as a permanent move, it may be necessary for the hospital, in consultation with the local authority or CHC department to implement discharge to an alternative or interim location. If the patient is awaiting a care home, the local authority or CHC department will offer to keep the patient's name on a waiting list for their preferred choice, subject to required quality and commissioning strategy. Unless circumstances determine otherwise, the local authority or CHC department will ensure that patients making an interim move should make only one such move before entering the care home of their choice.

6.8 If a patient and/or representative indicate that they would prefer to stay in the interim care home permanently, either when offered a place in one of their original choices or during the waiting process, the local authority or CHC department will endeavour to negotiate this. Any waiting list the patient is on will be amended accordingly if the patient is accepted on a permanent basis. If the patient is not accepted on a permanent basis, they will remain on the waiting list as before.

6.9 If a hospital is considering implementing discharge in line with this policy, Trust legal advisers will be consulted.

7 DISCHARGE PLANNING

7.1 The MDT will plan Discharge in line with the quality discharge standards.

7.2 The MDT will follow this policy and process and take a proactive approach to managing choice of discharge location and care provider. See Appendix 2 for a flow chart regarding the managing choice process.

7.3 The MDT will apply the key principles of the Mental Capacity Act 2005 when planning discharge with patients and/or representatives. See Appendix 3 for a flow chart regarding managing choice for patients who lack capacity to choose themselves, including liaising with a representative or advocate.

7.4 The MDT will identify when the patient no longer requires inpatient care at the current hospital and is medically stable, at which point the patient will be discharged to an appropriate location, with appropriate care if required.

7.5 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.

7.6 With elective admissions, discharge planning will start prior to admission but with unplanned admissions a well-developed discharge plan will start upon admission. Discharge plans will be recorded on a locally agreed discharge planning tool or documentation in the patient's records.

7.7 No discharge will be delayed if there is an available, appropriate interim option.

8 ESCALATION PROCESS

8.1 Responsibility for the discharge process will remain with the ward manager 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 any additional resource allocated by the patient's local authority and/or CHC department.

8.2 The Nurse-in-Charge will offer the appropriate level of guidance and support and will consult their matron / service manager as needed. All staff will proactively chase progress with the discharge.

8.3 If the patient's local authority and/or CHC department have agreed a process to fund care without prejudice whilst a patient awaits assessment or completion of a Decision Support Tool (DST), a social care or CHC professional will be allocated to coordinate the discharge. They will carry out or request assessments and inform the patient, representative and MDT of the outcome without delay. They will apply for appropriate funding in a timely manner and support the patient and/or representative to choose from available options that meet required quality and cost criteria.

8.4 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.

8.5 The Choice Process comprises six stages.

Stages 1 to 3 apply to EVERY patient in order to provide support and prevent the need for further escalation:

Stage 1 – Information provided
Stage 2 – Referred for service to support discharge
Stage 3 – Available care offered

Stages 4 to 6 represent the formal escalation process:

Stage 4 – Available options declined
Stage 5 – Formal meeting held to agree interim plan
Stage 6 – Legal process followed

9 CONSULTATION AND APPROVAL PROCESS

9.1 This policy was developed in 2015 with multidisciplinary professionals from across Herts Valleys' providers through the System Resilience Group (SRG).

9.2 This policy has been adapted from the Pan-Dorset Policy for Managing Choice to incorporate the requirements of the existing local policy and the needs of the Herts Valleys' providers.

9.3 Herts Valleys CCG patient representatives were involved in the review of this policy.

9.4 Once approved, this policy will replace the all existing choice policies in operation at al local level.

10 REVIEW, REVISION

10.1 This policy will be reviewed at least every 3 years.

11 MONITORING COMPLIANCE AND EFFECTIVENESS

11.1 Monitoring will take place by hospital matrons / service managers with their teams and through other senior executive groups such as the System Resilience Group (SRG).

11.2 Monitoring in each hospital will be undertaken on a biannual basis, facilitated by the local manager or lead nurse for discharge services.

11.3 Local monitoring will include an audit of:

- Staff training to check that training courses are relevant to the policy and ensure training is undertaken.
- Policy effectiveness.
- Patient and/or representative feedback and complaints.

12 PROCESS FOR MANAGING CHOICE ON HOSPITAL DISCHARGE

1 STAGE 1 – GIVE STANDARD INFORMATION

1.1 The discharge planning process is led by the Ward Manager. The ward team will support the patient and/or representative with all currently involved in the patient's care and discharge planning.They also ensure that those who need to be involved after discharge are contacted at the earliest opportunity to discuss the patient's needs and that responsibilities of care are transferred on discharge.

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

1.3 If a discharge-planning information leaflet has been agreed locally (i.e. at the hospital), the admitting nurse or another member of the multidisciplinary team (MDT) will give this to all adult patients or their representatives on admission, and discusses the leaflet content with them. For elective admissions the leaflet may be given prior to admission. If appropriate, the leaflet may be given to the patient's representative and an Easy Read leaflet may be given to the patient.

1.4 The Ward Manager or Nurse-in-Charge must ensure that the patient and/or representative are aware of the pan-Herts Valleys policy and process for managing choice on hospital discharge, and of the circumstances in which a move to alternative or interim accommodation or care might be necessary. All communications reinforce the expectation that patients will leave the hospital as soon as their need for inpatient treatment ends.

2 STAGE 2 – REFER FOR SERVICES TO SUPPORT DISCHARGE

2.1 If the patient is likely to have ongoing health or social needs after discharge the MDT will ensure timely referral to other services and that the managing choice pathway is followed and recorded. (**see appendices**).

2.2 The referrer must explain expectations to the patient and/or representative and provide factsheet 1 if appropriate to provide confirmation of the process. (**see appendices)**.

2.3 If the patient is found eligible for care funded by CHC or their local authority, a representative from the relevant organisation will identify and arrange appropriate, available services. 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. The organisation arranging care ensures the patient and/or their representative and Ward Manger and/or Nurse-in-charge are informed of all currently available options.

2.4 In certain circumstances, a third party may choose to "top-up" social services funding to pay for a more expensive care option. This can be discussed with the social services representative.

2.5 A patient or representative cannot "top-up" CHC payments to fund a more expensive care option and if a person is eligible for CHC, the local authority is prevented in law from funding care. However, the patient's CCG will offer the option of a personal health budget, which can give more flexibility and choice of care.

2.6 A patient can refuse NHS-funded care offered by their CHC department but they would not then be eligible for local authority funding and would need to self-fund their preferred option.

2.7 In line with the Mental Capacity Act 2005, a person with power of attorney or who is a court appointed guardian can choose to self-fund their preferred option on behalf of the patient but this decision would need to be in the patient's best interest. Support is offered to the appointee making decisions of this nature, which may be life-changing for the patient.

3 STAGE 3 – OFFER OPTIONS AND PREPARE FOR DISCHARGE

3.1 The social care or CHC professional or a member of the ward team will advise the patient and/or their representative about currently available care providers that can meet their needs (which might be only one option at that time) and any potential cost or contribution at the earliest appropriate stage.

3.2 If social services identify that the patient will 'self-fund' their care, the social care professional will inform the individual responsible for discharge planning whether or not the patient has care arranged. If not, they will offer to help the patient and/or representative find available option/s.

3.3 If there is currently at least one available option, the patient cannot remain in hospital to wait for further choices and must accept one that is available, at least on a temporary basis. The person offering care will endeavour to meet the patient's and/or representative's wishes regarding specific concerns about the appropriateness of a temporary arrangement if concerns are brought to their attention.

3.4 If the patient has been referred for inpatient rehabilitation they and/or their representative will be made aware that a bed might not be available in the community setting closest to their home. The MDT will explain that transfer to an alternative setting will enable the patient to receive required services in an appropriate environment and optimise their recovery.

3.5 The MDT must explain expectations to the patient and/or representative and provide factsheet 2 if appropriate to provide confirmation of the process. (**see appendices)**.

3.6 When a patient is assessed as needing to transfer to a care home, they or their representative will be encouraged by the MDT to consider all available options simultaneously and to choose one without delay. The person offering care will also offer advice on the practical and financial implications of each option.

3.7 If post hospital options are severely restricted or the patient is on a waiting list for a specific location, the patient and/or representative must accept transfer to somewhere that is not their first preference on a short-term basis. They will not have the option of remaining in hospital to wait for their preferred option to be available. The patient and/or representative will be advised of available care homes that can temporarily meet their care needs while they wait for their preferred option.

3.8 If an identified home can meet the patient's care needs and is the only currently available, appropriate option, transfer to that home should not be rejected by the patient and/or representative. When a patient transfers temporarily to a home that is not their preferred choice, a representative from the relevant organisation will continue to discuss permanent options with the patient and/or representative (**see 6.7 on p9**).

3.9 When a patient is assessed as needing to transfer to another hospital, the MDT will explain the benefits of transferring to a different hospital if their preferred choice is full. If an identified community hospital can meet the patient's care needs and is the only currently available appropriate option, transfer to that hospital should not be rejected by the family and/or representative.

4 STAGE 4 – AVAILABLE CARE DECLINED

4.1 If a patient and/or representative is dissatisfied with proposed arrangements to facilitate discharge, MDT members will explain clearly that refusal to choose an available care provider or location will not prevent the discharge process proceeding.

4.2 At this stage, the Ward Manager encourages resolution of any potential barrier to discharge and seek support from MDT members involved. The patient and/or representative is provided details by the ward or directed to the patient advice and liaison service (PALS) for advice and information regarding advocacy if required.

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

4.4 If discharge arrangements are not agreed, the Ward Manager escalates to the Matron for support. The local process to escalate delayed transfers of care (DTOC) is followed throughout the Managing Choice process. The Matron starts the formal process. All parties continue to encourage patients to make their own choices throughout this process.

4.5 If discharge plans are not agreed after a suitable option has been offered the Matron consults any specialist staff involved and escalates to the Lead for Discharge Planning for support. The Lead for Discharge Planning or deputy invites the patient and/or representative to a formal meeting, to discuss plans for discharge within 48 hours.

5 STAGE 5 – FORMAL MEETING AND FORMAL LETTER 1

5.1 If the patient's representative/s do not engage with discharge planning or are unable to attend a formal meeting this should go ahead without them and a follow-up letter should be sent afterwards summarising discussion and plans.

5.2 The formal meeting enables all parties to discuss and agree transfer to the most appropriate available care provider at least as an interim option. The Lead for Discharge Planning will consult the Matron and specialist staff involved for guidance and, if it appears that there will be further delay escalate as required.

5.3 If the patient has declined transfer to a reasonable alternative hospital, they 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.

5.4 The Lead for Discharge Planning or Nominated Deputy gives or sends formal letter 1 to the patient and/or representative at or soon after the formal meeting, even if the patient and/or representative did not attend. An example letter is provided in the appendices but the letter can be amended as required dependent on circumstance (**see appendices**).

5.5 Social services, CHC and ward staff continue to support the patient and/or representative where possible to finalise plans for discharge. If required, the social care or CHC professional continues to search for available care options.

5.6 The MDT 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. The allocated social care or CHC professional leads the process of making arrangements for a patient to transfer to an identified care provider or location on the agreed date.

6 STAGE 6 – LEGAL PROCESS AND FORMAL LETTER 2

6.1 If no agreement has been reached regarding discharge arrangements 48hrs after stage 5, and transfer arrangements are challenged by the patient and/or representative, the Director of Operations or Nominated Deputy supports the Lead for Discharge Planning to continue plans for transfer to an interim location or alternative care provider.

6.2 The Lead for Discharge Planning or Nominated Deputy supported by the Director of Operations or Nominated Deputy consults the local Trust advisors regarding legal proceedings and escalates as required to ensure discharge from hospital, in order to safeguard the health and wellbeing of the patient.

6.3 In the event that there are irreconcilable differences as to what is in the best interests of an incapacitated patient the Director of Operations or Nominated Deputy consults the local Trust advisors regarding legal proceedings.

6.4 The social care or CHC team involved provides details of a suitable interim option.

6.5 The Director of Operations or Nominated Deputy sends formal letter 2 to notify the patient and/or representative that legal advice will be sought and discharge instigated to the named interim option (**see appendix 6)** .

CHOICE PATHWAY FORM

Affix patient label Patient name Address Date of birth Hospital no/NNN	Hospital Ward Ward Manager Discharge Planning Lead Matron

STAGE & ACTION	**Date**	**Initial/sign**
1 – START DISCHARGE PLANNING ON ADMISSION (every patient) **Discharge planning leaflet** discussed with patient/representative Patient informed of EDD and that they will be told when it is revised Locally agreed discharge planning tool or paperwork started		
2 – REFER FOR SERVICE Patient referred to community services if appropriate **Factsheet 1** given to patient/representative Expectation managed regarding availability of preferred option		
3 – OFFER SERVICE OR CARE (options offered): **Factsheet 2** given to patient/representative		
4 – AVAILABLE OPTIONS DECLINED by (name and relationship): Reason given for decline:		
5 – Formal meeting held to discuss interim transfer (invited/attendees): **Choice Letter 1** given to patient/representative from the Lead for Discharge Planning or Nominated Deputy		
5 – INSTIGATE DISCHARGE TO INTERIM OPTION Alternative or interim discharge location sourced: **Choice Letter 2** given to patient/representative from Director of Operations or Nominated Deputy		
END: Reason process terminated (start new form if process re-started):		

File in patient's notes and copy to appropriate CHC or social services team if requested

SUMMARY OF THE 6-STAGE MANAGING CHOICE PROCESS

Stage 1: Start discharge-planning discussions and give information leaflet

Start to discuss discharge planning with patient and/or representative before or shortly after admission. Explain process for reviewing estimated date of discharge (EDD).

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Stage 2: Refer to service/s required to support discharge (factsheet 1 must be given)

Refer to required services, e.g. another hospital, social services, community mental health team (CMHT) or NHS Continuing Healthcare (CHC) when patient is ready to have needs assessed for discharge. All parties follow **Managing Choice Process** for all discharges.

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Stage 3: Offer available discharge service/s (factsheet 2 must be given)

Discuss discharge plans with patient and/or representative regularly. Ensure assessments to clarify care needs are complete. Explain to patient and/or representative that they must accept an available discharge option, either as an interim or permanent plan. Ward representative or CHC or social care professional offer patient and/or representative at least one option.

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Stage 4: Start formal process if available service declined and arrange formal meeting

If patient and/or representative are reluctant to accept option/s offered, ward representative or CHC or social care professional discuss concerns and encourage them to reconsider. Clarify rationale for transfer to alternative or interim option if their preferred option is not available. Agree urgent date within 48 hrs for formal meeting if discharge plan still not agreed or concerns remain.

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Stage 5: Hold formal meeting to minimise delay and send formal letter 1

Patient and/or representative invited to formal meeting, which is held even if patient and/or representative do not attend. Give information and encouragement to access support. Clarify process. Give/send a letter clarifying what was discussed, what follow-up arrangements have been made, any agreements and the rationale for transfer to alternative or interim care. Ward notify social care/CHC professional of expected ready-date and request an interim option.

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Stage 6: Establish best option and send formal letter 2 before instigating discharge

If no agreement has been reached around discharge, consult Trust legal advisors before letter is sent to patient or representative. Send letter to explain that discharge to the identified temporary alternative or interim option will go ahead in line with the Managing Choice Policy.

ADDITIONAL INFO FOR PATIENTS WHO LACK MENTAL CAPACITY

Stage 1: Discharge-planning information leaflet given to patient's representative

Support the patient to express their views if possible and offer an **Easy Read** discharge planning leaflet to the patient if appropriate. If a **Mental Capacity Assessment** confirms the patient lacks capacity to make decisions regarding discharge plans a **Best Interest Decision** is made. A representative with registered power of attorney for health and welfare or a court appointed guardian can choose care as long as this is in the person's best interest. Alternatively, the NHS or local authority decision maker should consult with the patient, their representatives and the MDT before making a best interest decision. If the patient has no representative, an independent mental capacity advocate should be consulted before a discharge decision is made.

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Stage 2: Factsheet 1 may be given to the representative

The **Managing Choice Process** is the same for all patients regardless of capacity.

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Stage 3: Factsheet 2 may be given to the representative

Regularly discuss discharge plans with the patient if appropriate and with the representative or IMCA.

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Stage 4: Invite representative and/or IMCA to formal meeting

If a representative with power of attorney for health and welfare or a court appointed guardian is reluctant to accept options offered, the ward representative or CHC or social care professional discuss concerns. Clarify rationale for transfer to an alternative or interim option if the preferred option is not available, and explain that this must be accepted if it is in the patient's best interest. Agree urgent date for formal meeting within 48hrs if discharge plan still not agreed or concerns remain.

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Stage 5: Send formal letter 1 to the representative

Patient and representative or IMCA invited to formal meeting. If representative does not engage with discharge plans they are not acting in the patient's best interest and an urgent referral should be made to IMCA explaining this. Give information and encouragement to access support. Clarify process. Give/send a letter to the representative clarifying what was discussed, what follow-up arrangements have been made, any agreements, the rationale for transfer to alternative or interim care and why this is in the patient's best interest. Ward notify social care/CHC professional of expected ready-date and request an interim option.

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Stage 6: Send formal letter 2 to the representative before instigating discharge

If transfer arrangements are still disputed by a representative, consult IMCA and Trust legal advisors before sending a letter to the representative to explain that discharge to the identified temporary alternative or interim option will go ahead in line with the Managing Choice Policy.

FACTSHEET 1

DISCHARGE PLANNING FACTSHEET 1

REFERRAL AND ASSESSMENT

Dear Sir or Madam

This factsheet is to explain the assessment and discharge process. With your permission, we will request an assessment to find out what services you might need to be safely discharged from hospital. A health or social care professional will discuss your needs with you, with your family or with any others you would like involved. We want to find out whether, with the right help and support you can return home from this hospital or whether care elsewhere might be needed.

If you need care at home, if you need to stay in a care home or if you need to transfer to another hospital, the team looking after you at this hospital can help arrange this. We will do all that we can to help you and to give you the information you need to make a decision.

If you require support upon discharge but your preferred choice is not available when you reach this time, it will not be possible for you to stay in this hospital waiting. You would need to accept an alternative option temporarily. Discharge from hospital is not a good time to consider long-term care but we know that it can take time to make even temporary arrangements. We will do our best to help you make arrangements as quickly as possible.

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

With best wishes for a speedy recovery.

The team caring for you at this hospital

On behalf of NHS healthcare and local authority services in Hertfordshire.

When a patient has been assessed under the Mental Capacity Act 2005 as not having capacity to make decisions about their discharge, this factsheet can be given to a representative.

FACTSHEET 2

DISCHARGE PLANNING FACTSHEET 2
ACCEPTING AN AVAILABLE OPTION

Dear Sir or Madam

Following your admission to this hospital we would like to support you with arrangements for safe discharge with the right level of care.

Your recent assessment shows that you will need support or treatment elsewhere. A member of the team caring for you will advise you of currently available options and you will need to choose one of these or to arrange an alternative option that is available at this time. If you have not had this information yet, please let us know.

If your first choice has no current availability, you will be asked to move to a temporary option that is available whilst you wait for your preferred choice to be ready. If you need treatment at another hospital but your preferred hospital is full, you will have to transfer to an available hospital. You may remain on the waiting list for your preferred hospital.

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. The team caring for you at this hospital will help make arrangements for your discharge as soon as a suitable option is available.

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

With best wishes

The team caring for you at this hospital

On behalf of NHS healthcare and local authority services in Hertfordshire.

When a patient has been assessed under the Mental Capacity Act 2005 as not having capacity to make decisions about their discharge, this factsheet can be given to a representative.

Please stick patient address label here

Date: ……..

Dear……..

CHOICE LETTER 1A

Notification of plan to transfer to another hospital

The team caring for you at this hospital have assessed that you need to transfer to another hospital for further treatment or rehabilitation. We understand that you may prefer not to move to a different hospital but you cannot remain here and you are not yet able to return safely home.

We do not wish to cause you or your family anxiety but you will not be able to stay at this hospital until you are ready to return home. We will have to transfer you to a suitable hospital that can offer the treatment you need without delay.

If you would like, we can ask that your name remains on the waiting list for a different hospital, which may be able to offer you a bed after a few days. However, please be aware that your preferred hospital may remain full and you may become well enough to return home from the alternative hospital very quickly.

Please discuss transfer plans with the nurse in charge of your ward or the person below. We will make arrangements for transfer to the most appropriate hospital that is able to offer you a bed.

If you would like a copy of this letter to be given to someone else or you have any questions please speak to the person below or any member of the team caring for you. Please do not hesitate to ask if you have any questions.

Ward contact name and phone number: ……

Yours sincerely

Lead for Discharge Planning
On behalf of NHS and local authority services in Hertfordshire

When a patient has been assessed under the Mental Capacity Act 2005 as not having capacity to make decisions about their discharge, letters may be given in their best interest to their representative.

Please stick patient address label here

Date: ……..

Dear……..

CHOICE LETTER 1B

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

We understand that you are ready to leave hospital and move to a care home but you have not yet found one that you like or the one you have found is not able to offer you a room at this time.

We do not wish to cause you or your family anxiety but you will not be able to stay at this hospital whilst you continue to search or wait for a care home. We will ask the health or social care team to find a care home that can offer a temporary room. You will need to stay there until transfer to your preferred home can be arranged.

If you have not yet found a long-term care home you like, the health or social care team can help you. They will offer to help make arrangements for your move to the temporary care home. When a date has been agreed for you to transfer to your preferred care home, they can help make arrangements for that move too.

Please discuss discharge plans with the nurse in charge of your ward. You will have to either transfer to the temporary care home offered or to inform us of an alternative arrangement to leave the hospital within 48 hours of receiving this letter. If we do not hear from you we will make arrangements for transfer to the temporary care home as soon as possible.

If you would like a copy of this letter to be given to someone else or you have any questions please speak to one of the people below or any member of the team caring for you. Please do not hesitate to ask if you have any questions.

Ward contact name and phone number: ……

Health or Social Care name and phone number..…….....

Yours sincerely

Lead for Discharge Planning
On behalf of NHS and local authority services in Hertfordshire

When a patient has been assessed under the Mental Capacity Act 2005 as not having capacity to make decisions about their discharge, letters may be given in their best interest to their representative.

Please stick patient address label here

Date: ……..

Dear……..

CHOICE LETTER 1C

Notification of plan to transfer to interim care whilst waiting for a care package

We understand that you are ready to leave hospital with care at home but a care package has not yet been found and you would not be safe at home without care.

We do not wish to cause you or your family anxiety but you will not be able to stay at this hospital whilst you wait for a start date from a care agency. We will ask the health or social care team to find a care home that can offer a temporary room. You will only need to stay there until your return home with care can be arranged.

The health or social care team can make arrangements for your move to the temporary care home and continue to help you arrange care at home. When the care at home is ready to start, the care home can also help make arrangements for your return home.

Please discuss discharge plans with the nurse in charge of your ward. You will have to either transfer to the temporary care home found by the health or social care team or to inform us of an alternative arrangement to leave the hospital within 48 hours of receiving this letter. If we do not hear from you we will make arrangements for transfer to a temporary care home as soon as possible.

If you would like a copy of this letter to be given to someone else or you have any questions please speak to one of the people below or any member of the team caring for you. Please do not hesitate to ask if you have any questions.

Ward contact name and phone number: ……

Health or Social Care name and phone number..…….....

Yours sincerely

Lead for Discharge Planning
On behalf of NHS and local authority services in Hertfordshire

When a patient has been assessed under the Mental Capacity Act 2005 as not having capacity to make decisions about their discharge, letters may be given in their best interest to their representative.

Please stick patient address label here

Date: ……..

Dear……..

CHOICE LETTER 1D

Notification of plan to transfer to a temporary location until housing ready

We understand that you are ready to leave hospital but that your home will need cleaning or adaptation before you return or you will need a new home to be found.

We do not wish to cause you or your family anxiety but you will not be able to stay at this hospital whilst you wait for your home to be made ready. We will ask your Social Worker to find a temporary place for you to stay until your return home can be arranged. Your Social Worker can make arrangements for your move to the temporary place and when your home is ready, they can also help with making arrangements for your transfer home.

Please discuss discharge plans with the nurse in charge of your ward. If you do not wish to transfer to the temporary location found by your Social Worker you will have to inform us of an alternative location, so that you can leave the hospital within 48 hours of receiving this letter. Otherwise, we will make arrangements for transfer to the temporary location as soon as possible.

If you would like a copy of this letter to be given to someone else or you have any questions please speak to one of the people below or any member of the team caring for you. Please do not hesitate to ask if you have any questions.

Ward contact name: ……

Ward contact phone number: ……

Social Worker name: ……

Social Worker phone number: …….....

Yours sincerely

Lead for Discharge Planning
On behalf of NHS and local authority services in Hertfordshire

When a patient has been assessed under the Mental Capacity Act 2005 as not having capacity to make decisions about their discharge, letters may be given in their best interest to their representative.

Our reference:
To:

Date:

Dear……..

CHOICE LETTER 2

FINAL NOTIFICATION – DATE OF TRANSFER TO ALTERNATIVE CARE

I am writing further to the letter you were recently sent, informing you of proposed arrangements for your discharge. This hospital has offered you all 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.

As outlined in the notification letter, we will now instigate safe transfer to the location below, which has been assessed as suitable to meet your needs. Should this transfer be refused, the Trust will be required to take legal advice to facilitate discharge.

You will be told you if you are responsible for paying care fees. If you are appealing a local authority or NHS decision regarding funding, the fees you pay may be reimbursed if your appeal is upheld.

If you would like further information or support regarding discharge arrangements please speak to the ward lead. If we do not hear from you, we will assume that you are happy with the content of this letter and that we continue to arrange transfer without your involvement. Please do not hesitate to ask if you have any questions.

Discharge destination:

Address:

Tel number: Date of transfer/discharge:

Health and Social Care name & contact number:

Yours sincerely

Director of Operations
On behalf of NHS and local authority services in Hertfordshire

When a patient has been assessed under the Mental Capacity Act 2005 as not having capacity to make decisions about their discharge, letters may be given in their best interest to their representative.

EQUALITY IMPACT ASSESSMENT	
Date of assessment	October 2015
Author	Jane Waite, Head of IDT, WHHT James Mason, System Resilience Project Manager, HVCCG
Assessment area	Herts Valleys CCG's Provider's inpatient facilities
Purpose	To set out the standard process for: • Actively involving patients/representatives in discharge planning. • Informing and supporting patients/representatives to choose an available discharge location or care provider on discharge from hospital. • Resolving delayed transfer of care.
Objectives	That once a patient has completed their inpatient treatment and is deemed clinically stable for transfer of care they will be transferred to an appropriate setting or care provider without delay.
Intended outcomes	Discharge and transfer of care from hospital will be timely, effective, consistent and dependent on the clinical needs of patients rather than availability of their preferred location or care provider

What is the overall impact on those affected?

Ethnic Groups	Gender groups	Religious Groups	Disabled Persons	Other
Positive	Positive	Positive	Positive	Positive

Available information

This policy has been written in accordance with government guidelines, with consideration of feedback from user groups.

Assessment of overall impact

Issues relating to both the Equality Act and the CCG's duty in relation to inequality (in section 14T of the NHS Act 2006, as amended) were considered during the policy discussion and development stage and that they will be further considered as part of the further consultation and monitoring of the policy.

Language: This policy applies equally to all patients in all hospitals. Translation services are available if needed.

Age: This policy applies equally to all patients in all hospitals. Although most patients who need care on discharge are older people, this policy is likely to promote equality amongst this group.

Physical or mental disability: This policy applies equally to all patients in all hospitals. 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).

Socio-economic: (*this was considered in the context of the CCG's section 14T duties).*

This policy applies to all patients in all hospitals. Eligibility for funding and supply of equipment is part of the assessment and discharge process.

There is no further evidence found of a differential impact on patients. No impact was found on staff either. Staff are able to access training as required on equality and diversity, adult protection, conflict resolution, information governance, mental capacity and risk management. Staff are informed of local arrangements for interpreting services.

Consultation

This policy was developed in consultation with health and social care professionals across Herts Valleys CCG.

Actions
Future consultation should include seeking further feedback from patient representatives as part of the monitoring plan.