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Title:	**Discharge from Hospital**	
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CONTENTS

1. INTRODUCTION

1.1. This policy supports people's timely, effective discharge from an NHS inpatient setting, to the most appropriate available location which meets their needs. It is relevant to all adult inpatients in Torbay and South Devon NHS settings who are required to choose a destination and/or a care provider upon discharge. Both the policy and the process of managing choice on discharge apply equally to all patients, whether or not they need on-going NHS or social care and whoever may be funding any such care.

1.2. This policy is for all patients in both acute and community hospital beds.

1.3. Planning for effective transfer of care should begin on or before admission in partnership with the patient, their representatives and the relevant multi-disciplinary team (MDT) members.

1.4. This policy supports existing guidance on effective discharge, such as the 2015 NICE guidance 'Transition between inpatient hospital settings and community or care home settings for adults with social care needs' , and is based on existing good practice.

1.5. This policy should be read in conjunction with TSDFT Choice, Cost, Risk Policy and the South Devon and Torbay Clinical Commissioning Group Sustainable, Equitable and Affordable Policies.

1.6. The consequences for a patient who is ready for discharge remaining in a hospital bed might include:

- Exposure to an unnecessary risk of hospital acquired infection
- Physical decline and loss of mobility / muscle use
- Frustration and distress to the patient and relatives due to uncertainty during any wait for a preferred choice to become available;
- Increased patient dependence, as the hospital environment is not designed to meet the needs of people who are medically fit for discharge ;
- Severely ill patients being unable to access services due to beds being occupied by patients who are medically fit for discharge.

1.7. Patients, carers and families can find it difficult to make decisions and/or make the practical arrangements for a range of reasons, such as:

- A lack of knowledge about the options and how services and systems work;
- Worry about either the quality or the cost of care uncertainty or conflict about who will cover costs of care.
- Feeling that they have insufficient information and support;
- Concerns about moving into interim accommodation and then moving again at a later stage.
- Reluctance to move to another hospital that is not local to their home because family and/or carers may find it difficult to visit.
- The options available do not meet the patient's preferences
- Concerns that their existing home is unsuitable, cold or needs work done to ensure a safe environment for discharge.
- Worry about expectations of what family and carers can and will do to support them.

1.8. The principles of the 6Cs should be applied to this process – care, compassion, competence, communication, courage and commitment.

2. PURPOSE

2.1. The purpose of this policy is to ensure that choice is managed fairly, sensitively and consistently throughout the discharge planning process, and people are provided with effective information and support.

2.2. This policy sets out a framework to ensure that NHS inpatient beds will be used appropriately and efficiently for those people who require inpatient care, and that a clear escalation process is in place for when patients remain in hospital longer than is clinically required:

- NHS inpatient beds across Torbay and South Devon will be used appropriately and efficiently for those people who require that service.
- When patients have completed required assessments or treatment at their current inpatient setting the individual will not remain in that setting 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 on or before 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 will be consulted on their behalf. This includes Decision Specific capacity assessments.

2.3. When implemented consistently, this policy should reduce the number and length of delayed discharges and result in patients being successfully transferred to services or support arrangements where their needs for health and care support can be met. Ultimately it aims to improve outcomes for patients.

3. PRINCIPLES

MANAGING CHOICE - SUPPORTING PEOPLE TO MAKE DECISIONS

3.1. Patients should not usually be expected to make decisions about their long-term future while in hospital. Consideration should be given to all other options including but not exhaustively; home care, re-enablement or intermediate care and short-term residential placements, where that is appropriate to their needs.

3.2. People should be provided with high quality information, advice and support in a form that is accessible to them, as early as possible before or on admission and throughout their stay, to enable effective participation in the discharge process and in making an informed choice.

3.3. Patients should be involved in all decisions about their care, as per the NHS Constitution, and should be provided with high quality support and information in order to participate, where possible. In the context of a discharge decision, the information relevant to the decision will include an understanding of their care needs on discharge, the process and outcome of the assessment of needs, offers of care and options available.

3.4. Where it is identified that the patient requires a needs assessment under the Care Act 2014, but would have substantial difficulty in engaging in the assessment and care planning process, TSDFT must consider whether there is anyone appropriate who can support the individual to be fully involved. Where an appropriate individual cannot be identified then TSDFT must arrange for an independent advocate.

3.5. Many patients will want to involve others to support them, such as family or friends, carers or others. Where the patient has capacity to make their own decisions about confidentiality and information sharing, confidential information about the patient should only be shared with those others with the patient's consent.

3.6. Where the patient has been assessed as lacking capacity in this respect, information may be shared in his or her best interests in accordance with requirements set out in the Mental Capacity Act 2005 Code of Practice and Appendix 2 of this document.

3.7. Where a patient lacks capacity to make an informed decision with regard to a placement a Best Interest Meeting may be required and should always be considered.

3.8. Where someone is providing unpaid care or considering providing unpaid care post-discharge, they must be informed and invited to be involved in the discharge process and informed about their rights and sources of support. People have a choice about whether or not to provide care for other adults and people must be informed about their choices when establishing whether they are willing and able to provide care. Unpaid and paid carers must be offered the information, training and support they need to provide safe and effective care following discharge, including a carer's assessment.

3.9. The Third Party Delegation Policy should be considered when paid carers such as Domiciliary Agency employees are required to deliver specific or specialised care to an individual.

3.10. Interactions with patients will acknowledge and offer support to address any concerns, whilst reinforcing the message that everyone will work towards the patients discharge from hospital.

3.11. If a patient is not willing to accept any of the available, appropriate alternatives, then it may be that they are discharged, after having had appropriate warning of the risks and consequences of doing so. This option would only be pursued following the offer and rejection of available, appropriate options of care and appropriate safeguards and risk assessments. For patients who may lack capacity to make their own discharge decisions, see Appendix 2.

4. TIMELY DISCHARGE FROM HOSPITAL CARE

4.1. Patients do not have the right to remain in hospital longer than required. Once a patient is clinically ready for discharge they cannot continue to occupy an inpatient bed.

4.2. Planning for effective transfer of care, in collaboration with the patient and/or representatives and all Multi-Disciplinary Team (MDT) members, should be commenced on or before admission. The SAFER patient flow bundle should be applied to support timely discharge.

4.3. 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

4.4. 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.

4.5. The process and timelines within this policy should be clearly communicated to the patient so that by the time a patient is medically fit for discharge they are aware of and understand the discharge process, the decisions and actions that they may need to undertake and the support they will receive.

4.6. If a patient's preferred care placement or package on discharge is not available when they become medically fit for discharge, an available alternative which is appropriate to their health and care needs will be offered on an interim basis, whilst they await availability of their preferred choice.

4.7. If a patient could continue their recovery in a more suitable setting, it is rarely appropriate that they remain in hospital after they are medically stable, ready for transfer and no longer requiring hospital treatment.

4.8. All discussions and decisions made and agreed with the patient and their representatives should be clearly documented in the patient's records.

5. FUNDING ARRANGEMENTS

5.1. This policy applies equally to people regardless of the funding arrangements and the nature of their on-going care.

5.2. Those self-funding care will be offered the same level of advice, guidance and assistance regarding choice as those fully or partly funded by the relevant local authority or NHS Continuing Healthcare (CHC).

5.3. A full assessment for CHC should only be undertaken where the longer-term needs of the individual are clear. In the majority of cases, these assessments should be conducted outside of hospital within a reasonable time frame and should not be a reason for delaying discharge to care outside of hospital. If the individual has a 'rapidly deteriorating condition which may be entering a terminal phase' the NHS CHC Fast Track Pathway should be considered and completed prior to discharge where possible to ensure the appropriate level of care provision is in place where the terminal phase may be days or weeks.

6. OVERVIEW OF PROCESS

Step 1 - Providing standard information and support	• Start discussion about discharge with patient before or shortly after admission • Determine whether the patient has mental capacity and if not, put in place appropriate measures (see Appendix 2) • Identify discharge coordinator, and other people who have the patient's consent to be involved in discussions and decisions • Provide Information - A TSDFT approved factsheet may be given • Refer to support services and advocacy, as required
Step 2 - Assessing need	• Refer patient and any carers to appropriate team for discharge co-ordination to commence planning and assessment for discharge dependent on complexity of needs • Ensure assessments to clarify care needs and carers' needs are completed [note: NHS CHC assessments should be conducted outside of hospital in the main]
Step 3 - Preparing for discharge	• Discuss available and appropriate options with patient • Refer to support services and/or advocacy, as required • Explain the decision-making process to the patient and advise that the hospital will expect discharge once medically fit • Provide Letter B and tailored information on options which are suitable to meet assessed needs and available funding
Step 4 - Five day window	• Initiates upon provision of Letter B and information on choices to patient, in advance of the estimated discharge date • Allow up to five consecutive days for the patient to consider their available options • Support the patient to make a decision, respond to concerns and offer advice, support and encouragement
Step 5 - Interim placements and packages	• If decision and/or discharge has not been achieved with five consecutive days, MDT to liaise with patient and arrange the offer of an interm placement or package which meets assessed needs • Advise the patient that an interim arrangement for a given length of time is offered with a proposed date for discharge. Details should be provided of how interim funding arrangements relate to funding of subsequent care. • Give appropriate version of Letter C and offer further support
Step 6 - Escalation	• If no agreement has been reached regarding discharge, and/or transfer arrangements are challenged, senior staff to hold formal meeting with patient to understand and resolve issues and reiterate policy • Letter D to be sent following formal meeting or if patient does not engage in formal meeting [note: this applies where reasonable options have been rejected and there are no ground to challenge] • Consult local legal advisors, if neccessary

STEP 1 – PROVIDING STANDARD INFORMATION AND SUPPORT

6.1. The discharge planning process is led by a named health or social care professional (hereafter referred to as the discharge coordinator. This discharge coordinator supports the patient and/or representative in liaison with all those currently involved in the patients care. They also ensure that those who need to be involved after discharge are contacted at the earliest opportunity to discuss the patients' needs and that responsibilities are transferred upon discharge

6.2. If a discharge-planning information leaflet has been agreed locally (i.e. at the hospital), the discharge coordinator 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 required, information must be provided in alternative formats to meet the needs of the patient and/or their representative.

6.3. The discharge coordinator will ensure that the patient is aware of this policy and of the circumstances in which an alternative or interim placement or package might be necessary. All communication will clearly set out the process that the hospital will follow in order to work towards the patient's safe and timely discharge when their need for inpatient treatment ends. It should be made clear that they will receive advice and support in making a decision.

6.4. All patients will be given an Estimated Date of Discharge (EDD) as soon as possible after admission by a consultant or senior clinician. Regular review and discussion about the EDD as part of ward rounds will ensure all parties understand when support will be required to facilitate discharge.

6.5. Patients should be involved in all decisions about their care and supported to do so, where necessary. 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

6.6. At this point, it should be clearly identified who else the patient wishes to be informed and/or involved in the discussions and decisions regarding discharge, and appropriate consent received (if the patient lacks capacity then other legal basis needs to be established – see Appendix 2). This can include, but is not limited to, any formal or informal carers, friends and family members.

6.7. The discharge coordinator will ensure that any carer(s) of the patient are identified and support through the discharge process. This includes providing information on Carer's Assessments and support services and/or referrals to the relevant support services. Ensuring the carer has adequate support in place will reduce the risk of unnecessary readmission of the patient.

STEP 2 – ASSESSING NEED

6.8. The likelihood of the patient and any carers needing health (including mental health) care, social care, housing, or other support after discharge will be considered upon admission or shortly after for referral and assessment by the most appropriate services . This should be from a holistic and patient-centred perspective of a person's needs and the care and support options may include, for example:

- Intermediate care, either bed based or community based
- Social care assessment
- Community nursing services, including community matrons
- Re-enablement
- Short-term placement in a care home
- Care at home support package
- Financial assessment and benefits advice
- Eligibility for NHS Continuing Healthcare or Funded Nursing Care
- Home assessment for aids, adaptations and /or assistive technology
- Other local health, social or voluntary services

6.9. It should be made clear to the patients and/or their carer's, what the assessment in hospital is for, and what further assessments they can expect in the places they are transferred to.

6.10. Any carers of the patient should be advised of their rights to have a carers' assessment, with appropriate information and support, and referral to relevant support services.

6.11. Patients should be actively involved in the assessment process and in the development of care plans to enable full and effective assessments and support planning.

6.12. Patients should be informed of the rights they have to complain about an assessment or decisions about their need for support.

STEP 3 – PREPARING FOR DISCHARGE

6.13. As required, Letter B (version dependent upon destination) will be prepared and given to the patient by the discharge coordinator. Explain the process to the patient and ensure they are aware of all timelines and steps.

6.14. Information should be provided to the patient about the care options available to them, including details of costs. The funding and purpose of intermediate care and re-enablement places should be made clear.

6.15. The Trusts hospital Complex Discharge Team will support complex discharges where there are multiple on-going health and social care needs that require detailed assessment, planning and delivery by a multi-professional team and multiagency working.

6.16. If required, advocacy including Independent Mental Capacity Assessor (IMCA) services should be involved in providing advice and information on behalf of the patient.

6.17. If the patient is assessed to have care needs after discharge, the discharge coordinator will advise the patient at the earliest appropriate opportunity about currently available care providers that can meet their needs and are registered with the Care Quality Commission (CQC). In some cases it is possible that there may be only one appropriate option, and the rationale for this must be explained.

6.18. 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.

6.19. 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.

6.20. 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 at the community hospital closest to their home. The MDT will explain that transfer to an alternative hospital will enable the patient to receive required services in an appropriate setting and maximise their chance of swift recovery.

6.21. 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 a more favoured option.

6.22. 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.

6.23. If it is known that the placement / package is to be funded or provided by the NHS or Adult Social Care, the Trust will advise the patient of their right to look at alternatives that fall within the options available to the Trust, based on their individual needs .

6.24. Consideration may be given to an individual to" top-up" their care provision in some circumstances. Please see the Trust's Choice, Cost, Risk policy for further information.

6.25. Particular consideration should be given to the timings within this policy to prevent breaches of local authority duties relating to discharge.

6.26. If the patient is interested in taking up the offer of a personal budgets (social care), personal health budgets (NHS) or integrated personal budgets, the relevant hospital Complex Discharge Team member will provide information and advise them of the process.

6.27. Those individuals who are funding their own care should be provided with the same level of information, advice and support as people whose care is being funded by the NHS or relevant local authority.

6.28. The ward Multi-Disciplinary Team, including a discharge coordinator, should discuss discharge plans with the patient regularly, in some cases this may be as often as daily conversations. They will endeavour to meet the patient's wishes regarding specific concerns about the appropriateness of a temporary arrangement, if concerns are brought to their attention.

6.29. Patients should be informed of the rights they have to complain and provided with details of how to do so.

6.30. In order to minimise the need for patients to have recourse to formal complaints procedures, statutory agencies should make every effort to ensure that patients are involved in all stages of decisions that affect them, and that their agreement to such decisions is obtained.

STEP 4 – CHOOSING CARE

6.31. Once step 3 is completed by giving appropriate information on packages of care or placements, resolving any disputes and giving Letter B to the patient, the expectation should be that the patient makes a decision about discharge within 5 consecutive days, and either discharge has happened or arrangements are in place to do so.

6.32. If there are particular circumstances, such as an out of area transfer or safeguarding concerns, when it is unreasonable to expect a decision to be made within five days, a longer period may be agreed for an individual.

6.33. Step 3 should be completed well in advance of the EDD, where possible, to prevent avoidable delays to discharge occurring, and in these circumstances more than 5 days can be given as a timescale to people to make arrangements. This is particularly the case with people whose care will be funded by the local authority to prevent breaches of their responsibilities for discharge.

6.34. Patients do not have the right to remain in hospital longer than required. However, they do have the right to respect for private life and not to be treated in an inhuman or degrading way. Therefore it is crucial for the hospital to ensure that the proposed transfer is appropriate and in line with human rights legislation.

6.35. A nominated member of the hospital team will advise the patient that the hospital will expect discharge to be achieved within the agreed timescale.

6.36. The hospital staff will proactively support the patient during this process and will offer advice and support regardless of how the placement is to be funded. Regular communication will be maintained throughout this period by TSDFT staff supporting the discharge and the appropriate community multi-disciplinary team as appropriate.

6.37. Implementation of this policy does not impact on the measurement of delayed transfers of care, which should continue to be reported against the guidance laid out by NHS England.

STEP 5 – INTERIM PACKAGES AND PLACEMENTS

6.38. An interim package of care or placement will be offered to a patient where a decision has not been made within five days of completion of step 3, available options have been declined, or where a decision has been made but the specific package, placement, or adaptation is not yet available. Patients do not have the right to remain in hospital to wait for their preferred option to become available.

6.39. The interim package or placement is distinct from intermediate care or re-enablement.

6.40. Where decision and/or discharge is not achieved within five consecutive days of completion of step 3, members of the MDT will liaise within two working days. The MDT will discuss and seek to agree the recommended interim package or placement with the patient. Consideration of interim arrangements must be accompanied by a risk assessment, including impact on any carers.

6.41. The MDT may then advise the patient that an interim package or placement, which meets their assessed needs, is being offered, the reasons why the offer is appropriate, and a proposed date for transfer.

6.42. The interim package or placement will be confirmed with letter C (version dependent upon funding arrangements). Letter C will be prepared and given to the patient by a hospital representative. It is important that the letter is addressed to the patient, is personalised to reflect their circumstances and that the process is also discussed with the patient.

6.43. Funding arrangements for an interim placement will be discussed with the patient and their representative on an individual basis.

6.44. The interim package / placement will allow further time for the choice of package / placement to be resolved outside of hospital. This interim option would normally be in one of the initial packages / placements offered, if still available.

6.45. Discussions regarding permanent options will continue throughout the interim placement with a designated person from the relevant organisation.

STEP 6 – ESCALATION PROCESS

6.46. If no agreement has been reached regarding discharge arrangements after steps 1-5, and transfer arrangements are challenged by the patient, the TSDFT senior manager / clinician in the hospital will support the discharge coordinator to continue plans for transfer to an interim placement or package of care.

6.47. The patient will be provided with details of complaints and appeals procedures throughout the process.

6.48. The most appropriate TSDFT senior manager / clinician will arrange a formal meeting with the patient. The formal meeting enables all parties to discuss concerns and seek to agree transfer to the most appropriate care provider, at least as an interim option.

6.49. TSDFT will send letter D following the formal meeting, summarising the discussion, including discussions around risks, and next steps.

6.50. Letter D should also be sent if the patient does not engage in the formal meeting, including details of the reasons why the patient did not engage.

6.51. TSDFT will continue to work with the patient throughout this process to try and understand and address barriers to a decision being made.

6.52. If the patient declines NHS treatment and a care or support package, they may be discharged from hospital. In those circumstances they will be advised in advance of any discharge on the further NHS or social care support they may be able to access in the community and warned of the risks if they refuse such support.

6.53. Care should be taken to ensure that TSDFT meets its duty to serve an assessment notice and a discharge notice as appropriate on the local authority where it appears that the patient's discharge may be unsafe without the provision of appropriate care, and some cases may justify an adult safeguarding referral, including for cases which may amount to self-neglect.

6.54. The local director or senior manager in the hospital will consult local legal advisors and escalate as required to ensure discharge from hospital, in order to safeguard the health and wellbeing of the patient and other patients.

7. MENTAL CAPACITY

7.1. All patients should be assumed to have mental capacity to make a decision about their on-going care, including as regards discharge. A capacity assessment should be undertaken at any point during the process if their capacity, in relation to the discussions and decisions on discharge, is in doubt.

7.2. Appendix 2 sets out in detail how the application of this policy should be adapted for cases where the patient may lack capacity to make the relevant decisions at the appropriate time.

8. CONSULTATION AND APPROVAL PROCESS

8.1. This policy was developed nationally by a collaboration of partners with input from people working across the system, both locally and national and has been adapted for use in Torbay and South Devon.

9. REVIEW, REVISION

9.1. This policy will be reviewed at least every 3 years by the TSDFT Care and Clinical Policies Group and Health Records Committee.

EXCEPTIONAL ARRANGEMENTS IN CRITICAL PERIODS OF DEMANDS FOR SERVICES.

There may be extraordinary circumstances both locally and or nationally which may need to be considered alongside this policy. This may include major incident or critical escalation as outlined in NHS England Operational Pressures Escalation Levels Framework guidance.

10. MONITORING COMPLIANCE AND EFFECTIVENESS

10.1 Monitoring will take place by the Trusts Performance Team.

10.2 Monitoring in each hospital will be undertaken on a biannual basis, facilitated by the relevant manager and/or lead for Operational discharge services.

10.3 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;
- Review of when choice information is provided;
- Patient and/or representative feedback and complaints;
- Number of Delayed Transfers of Care (DToC);
- Length of Delayed Transfers of Care (DToC);
- Details of complaints/ concerns
- Equality monitoring

11. EQUALITY AND DIVERSITY

The Trust is committed to preventing discrimination valuing diversity and achieving equality of opportunity. No person (staff, patient or public) will receive less favourable treatment on the grounds of the nine protected characteristics (as governed by the Equality Act 2010): sexual orientation; gender; age; gender re-assignment; pregnancy and maternity; disability; religion or belief; race; marriage and civil partnership. In addition to these nine, the Trusts will not discriminate on the grounds of domestic circumstances, social-economic status, political affiliation or trade union membership.

The Trust is committed to ensuring all services, policies, projects and strategies undergo equality analysis. For more information about equality analysis and Equality Impact Assessments please refer to the Equality and Diversity Policy.

Appendix 1

GLOSSARY

Advocacy: a service to help people be involved in decisions, explore choices and options, defend their rights & responsibilities, and speak out about issues that matter to them.

CHC: NHS Continuing Healthcare is defined as a package of on-going care for an individual aged 18 or over which is arranged and funded solely by the NHS where the individual has been found to have a 'primary health need'.

Deprivation of liberty: when an individual without mental capacity to consent is under continuous supervision and control and is not free to leave.

Discharge coordinator: the named individual responsible for coordinating a patient's discharge. This could be a named nurse from the ward, a named social care professional from the local authority, an appropriate person from a voluntary sector organisation contracted to co-ordinate statutory services and act as patient advocate, or a named CHC health professional.

EDD: Estimated or expected date of discharge. This means when the patient is clinically assessed as ready for discharge or 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.

Independent Mental Capacity Advocate (IMCA): 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.

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

Intermediate care: Short-term care provided free of charge by the NHS for people who no longer need to be in hospital but may need extra support to help them recover. It lasts for a maximum of six weeks and can be in the patient's home or in a residential setting.

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

Medically fit for discharge: Further inpatient medical care or treatment is no longer necessary, appropriate or offered. Any further care needs can more appropriately be met in other settings, without the need for an acute inpatient hospital bed.

Mental capacity: Being able to make a specific decision at a specific time (see Appendix 2).

Patient: The individual receiving treatment in hospital.

Re-enablement: Re-enablement services are meant to help people adapt to a recent illness or disability by learning or relearning the skills necessary for independent daily living at home. Re-enablement should be provided free of charge by the Trust for up to six weeks. It can be extended at the Trust's discretion.

Self-funder: A person who financially meets the full cost of their social care needs (apart from re-enablement care and the 12 week property disregard), because their financial capital exceeds the

threshold for adult services funding, their level of need is not deemed to be high enough for local authority funding, or because they or a representative choose to pay for their care.

Appendix 2

HOSPITAL DISCHARGE AND MENTAL CAPACITY ISSUES

All staff must follow the five guiding principles of the Mental Capacity Act 2005 ("MCA"). This means:

- Presume that adults from 16 are mentally capable of making their own decisions;
- Do not determine the person lacks capacity until all practicable steps to support them have been taken without success;
- Do not consider someone to lack capacity because they make a decision we consider to be unwise;
- When the patient is assessed to lack capacity we must act in their best interests;
- Before taking any action or decision on their behalf we must consider if it can be achieved in a less restrictive way.

Capacity is specific to the decision that must be made, at the relevant time, and so it is possible that a patient who has been assessed as having capacity to consent to or refuse the treatment they have had as an inpatient may lack capacity to make decisions around discharge and care planning (and vice versa). Where there is a reason to doubt capacity for a particular decision, it must be specifically assessed, in accordance with the MCA, the MCA Code of Practice and relevant case law and documented appropriately.

All practicable steps must be taken to support the patient to make the decision before concluding that they are unable to make it themselves. This might involve taking a number of steps such as a providing information in a different format or breaking information down into smaller chunks.

If a person is assessed to lack capacity this means that staff have tested whether they can:

- Understand the information relevant to the decision,
- Retain the information long enough to make a decision,
- Use and weigh the information as part of the decision making process and
- Communicate the decision they want to make.

In the context of a discharge decision, the information relevant to the decision will include an understanding of their care needs on discharge, the process and outcome of the assessment of needs, offers of care and options available, with the person being given concrete information to consider, not starting with a blank sheet approach.

Options which are not available (e.g. placements which are not available, care which is not considered clinically appropriate, or care which will not be funded) should not be considered in either capacity assessments or in best interest decision-making. A patient with capacity cannot insist on staying in hospital after they are medically fit for discharge and so neither is it an option for a patient who lacks capacity for the discharge decision.

Where a patient, despite all reasonable efforts to support them, lacks capacity for discharge decisions, the decision must be made in their best interests (see MCA s4).

It is important to identify who the decision maker is as it could be a number of different people. The decision maker may be an attorney (if a health and welfare Lasting Power of Attorney has been granted, and is valid, applicable and registered) or a Deputy (if a health and welfare Deputy has been appointed by the Court). If neither of these are appointed then it will be the health or care professional who needs to make the decision in question. The wishes and feelings of the patient are paramount, but this does not mean they will always get what they want, any more than a patient with capacity would.

"Best interests" is interpreted widely, and goes beyond medical risk and benefit to include social, psychological and emotional factors. Before making a best interests decision, it should be tested by

asking whether the patient's best interests can be achieved in a way which is less restrictive of their rights and freedoms.

A patient is entitled to an Independent Mental Capacity Advocate (IMCA) where it is proposed that an NHS body or a local authority provides accommodation in a care home for 8 weeks or longer unless there is someone to consult about their best interests other than a paid professional (MCA s38-39).

If the proposed placement or care package on discharge puts a patient without capacity to consent to it at risk of being deprived of liberty (Article 5, European Convention of Human Rights), currently as interpreted by the Supreme Court in Cheshire West [2014] UKSC 19 to mean "under continuous supervision and control and not free to leave" then additional safeguards are required to ensure that the deprivation is lawful.

Where the proposed deprivation of liberty is in a hospital or a registered care home, a referral must be made for a standard authorisation under the Deprivation of Liberty Safeguards (DoLS). However, DoLS do not extend to other placements, such as supported living or domiciliary care and so any proposed deprivation of liberty there can only be authorised by the Court of Protection. [In either case, case law has found that it is preferable for any proposed deprivation of liberty to be authorised in advance by a prior referral to DoLS or Court application – see for example Re AJ (DoLS) [2015] EWCOP 5, or Re AG [2015] EWCOP 78]

[It may be appropriate to seek legal advice on cases where deprivation of liberty after discharge appears to be an issue.]

Appendix 3

SUMMARY OF LEGAL RESPONSIBILITIES AND RIGHTS

This appendix includes a brief summary of selected key legal responsibilities held by participating organisations and the rights that patients have in relation to the specific topic of this policy, with references to specific legislation and case law.

This list does not cover all of the legal complexities in relation to this issue – it is only provided as a guide to the people reading this policy and should not be used in place of legal advice.

	Responsibility or right in relation to choice at discharge	**Relevant legislation / case law**
Hospital (NHS Trust)	No clinician or Trust is obliged to offer anything which is not clinically indicated. This includes provision of an acute inpatient bed.	R (Burke) v GMC [2005] EWCA Civ 1003; Aintree University Hospitals NHS FT v James [2013] UKSC 67
	A Trust is obliged to carry out its functions "effectively, efficiently and economically", which is not consistent with prolonged occupation of inpatient beds by patients who are medically fit for discharge	NHS Act 2006 (as amended) s26, 63
	In some cases, where the patient's refusal to leave hospital when medically fit for discharge constitutes a nuisance or disturbance, an offence may be committed and there is a power to remove the patient	Criminal Justice and Immigration Act 2008, ss119-121 [and see NHS Protect guidance]
	Alternatively, other remedies may be available to Trusts under property law	Barnet PCT v X [2006] EWHC 787
	Where appropriate, where the Trust considers it will not be safe to discharge a patient unless arrangements for care and support are in place it must give notice to local authority, including provision in some circumstances for a financial remedy against the local authority where discharge is delayed as a result of failure to meet needs	Care Act 2014, Schedule 3, Care and Support (Discharge of Hospital Patients) Regulations 2012, and Delayed Discharge (Continuing Healthcare) Directions 2013
	Responsibility to seek authorisation for any deprivation of liberty occurring in the hospital	MCA Schedule A1, paras 1-3 , 24 and 76
Local Authority	Responsibility to assess a patient's needs for care and support where it appears to the local authority that the patient may have such needs	Care Act 2014 s9
	Responsibility to assess a carer's needs for support and choice about caring	Care Act 2014 s10
	Responsibility to provide patient's choice of accommodation in care home / shared lives / supported living, where this is to be arranged by the local authority, in some circumstances	Care Act 2014 s30, Care and Support and After-care (Choice of Accommodation) Regulations 2014

	Responsibility to provide information and support on choices	Care Act 2014 s4
	Responsibility to offer choices / involve the patient in preparation of a care and support plan	Care Act 2014 s25
	Responsibility to provide a Care Act advocate if a patient would experience substantial difficulty in participating in the assessment of need or care planning process unless there is another (unpaid) appropriate person to fill this role	Care Act 2014, s67
	Responsibility to authorise deprivation of liberty in care homes and hospitals	MCA Schedule A1 paras 21, 50
Clinical Commissioning Group [and NHS England]	Responsibility to ensure an assessment for eligibility for NHS funded Continuing Healthcare where it appears that there may be a need for such care. [This is the responsibility for NHS England for military personnel and prisoners]	NHS Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) Regulations 2012, reg 21
Patient	Right to assessment for care and support by local authority and for NHS Continuing Healthcare as appropriate	Care Act 2014, s9 and NHS Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) Regulations 2012, reg 21
	No right to insist on particular treatment which is not clinically indicated, including provision of an acute inpatient bed when medically fit for discharge	Barnet PCT v X [2006] EWHC 787; R (Burke) v GMC [2005] EWCA Civ 1003
	Right to be involved in decision making about care	NHS Constitution
	Right to choice of accommodation in care home / shared lives / supported living, where this is to be arranged by the local authority, in some circumstances (but no right to remain in hospital when medically fit for discharge while preferred choice is awaited)	Care Act 2014 s30, Care and Support and After-care (Choice of Accommodation) Regulations 2014
	Right to respect for family life and to not be treated in an 'inhuman or degrading' way	Human Rights Act 1998 s6 in relation to Articles 3 and 8 of the European Convention of Human Rights
Carer	Right to carer's assessment / support and choice about caring i.e. willingness to provide care	Care Act 2014 s10

Appendix 4

LETTERS

CHOICE LETTER B1

Date: ……

Dear *<Name>*

You now need to choose a care package at home

In order for you to receive the right on-going care we request that you take the following actions:

1. Consider the care at home options currently available to you;
2. Choose one of these care at home options;
   OR
   Advise us of an alternative option that you have arranged.

We request that you make your decision within 5 days of receiving this letter {or insert a longer timeframe if letter is sent more than 3 days before the EDD}. We will arrange for a temporary package of care or accommodation to be made available to you if you need longer than 5 days to make your decision, or need to wait for your preferred care provider.

Additional information to help you with your decision
The recent assessment looked at your care needs and wellbeing and showed that you will need a care package at home following discharge on {*insert estimated discharge date*}.

We want to help you leave this hospital as soon as possible because home is the best place for you to recuperate, and will give you more independence than being on a hospital ward.

To support you at this time we will ensure that:

- You now have all of the information about the choices currently available to you, including details of any costs, and you have spoken about this with a member of the team;
- You have access to further high quality information, advice and support to make your decisions [*include details of where this can be accessed*];
- This includes [*include details of support service*] and the option to involve your family, friends and carers to support you, as you wish.
- You can make a complaint or appeal at any stage of the discharge process by contacting [*insert details of local complaints and appeals procedures*].

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

Yours sincerely,
[*Letter to be signed by senior clinician*]

CHOICE LETTER B2

Date: ……

Dear <Name>

You now need to choose a care home.

In order for you to receive the right on-going care we request that you take the following actions:

1. Consider the care home options currently available to you, including visiting any care homes;
2. Choose one of these care homes;
   OR
   Advise us of an alternative option that you have arranged.

We request that you make this decision within 5 days of receiving this letter {or insert a longer timeframe if letter is sent more than 3 days before the EDD}. We will arrange for temporary accommodation to be made available to you if you need longer than 5 days to make your decision, or need to wait for your preferred choice if it has no current vacancies.

Additional information to help you with your decision
The recent assessment looked at your needs and wellbeing and showed that you will need to be discharged to a care home {insert for how long if a temporary placement} on {insert estimated discharge date}.

We want to help you leave this hospital as soon as possible because a care home is the best place for you to recuperate, and will give you more independence than being on a hospital ward.

To support you at this time we will ensure that:

- You now have all of the information about the choices currently available to you including details of any costs, and you have spoken about this with a member of the team;
- You have access to further high quality information, advice and support to make your decisions [include details of where this can be accessed];
- This includes [include details of support service] and the option to involve your family, friends and carers to support you, as you wish.
- You are able to make a complaint or appeal at any stage of the discharge process by contacting [insert details of local complaints and appeals procedures].

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

Yours sincerely,
[Letter to be signed by senior clinician]

CHOICE LETTER B3

Date: ……

Dear <Name>

You now need to choose an available housing option.

In order for you to receive the right on-going care we request that you take the following actions:

1. Consider housing support options currently available to you, including undertaking any visits;
2. Choose or agree to one of these housing support options;
   OR
   Advise us of an alternative option that you have arranged.

We request that you make this decision within 5 days of receiving this letter {or insert a longer timeframe if letter is sent more than 3 days before the EDD}. We will arrange for temporary accommodation to be made available to you if you need longer than 5 days to make your decision, or need to wait for your preferred choice if it has no current vacancies.

Additional information to help you with your decision
Your recent assessment looked at your care needs and wellbeing. It showed that you will need support from housing support services before being discharged on {insert estimated discharge date}.

We want to help you leave this hospital as soon as possible because supported housing is the best place for you to recuperate, and will give you more independence than being on a hospital ward.

To support you at this time we will ensure that:

- You now have all of the information about the choices currently available to you, including details of any costs, and you have spoken about this with a member of the team;
- You have access to further high quality information, advice and support to make your decisions [include details of where this can be accessed];
- This includes [include details of support service] and the option to involve your family, friends and carers to support you, as you wish.
- You are able to make a complaint or appeal at any stage of the discharge process by contacting [insert details of local complaints and appeals procedures].

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

Yours sincerely,
[Letter to be signed by senior clinician]

CHOICE LETTER C1

Date: ……

Dear <Name>

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

We understand that you are well enough to leave hospital and move to a care home, but <you have not yet found one that you like> OR <the one you prefer is not able to offer you a room at this time>.

We do not wish to cause you or your family anxiety, but unfortunately you will not be able to stay at this hospital whilst you continue to <search> OR <wait> for a care home.

- Staying in a care home will allow you to recuperate and give you more independence than being on a hospital ward;
- A care home is the best place for you to continue your recovery once your acute illness is over;
- Severely ill patients may be unable to access services, if beds in this hospital are occupied with patients who are medically fit for discharge.

As it has taken longer than 5 days to organise your discharge, we are now offering to transfer you to temporary accommodation in the following location, which has been assessed as suitable to meet your short-term needs because <insert reason for decision>. We will discuss the funding of this placement with you based on your individual needs.

Discharge destination:	<Name of location>
Address:	<Address of location>
Tel number:	<Phone number of location>
Proposed date of transfer/discharge:	<Discharge date>

You will be offered further support there with any decisions you need to make and you can wait there until transfer to a preferred home can be arranged.

Please discuss discharge plans with <insert name and contact details>. You will need to either transfer to the temporary accommodation outlined above or inform us of an alternative arrangement to leave the hospital without further delay.

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.

If you would like to make a complaint or appeal against this decision then please [insert details of local complaints and appeals procedures].

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

Yours sincerely, [letter to be signed by senior clinician]

CHOICE LETTER C2

Date: ……

Dear <Name>

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

We understand that you are well enough to leave hospital with care at home but <you have not yet found a care service that you like> OR <the care service you prefer is not able to accommodate you at this time>.

We do not wish to cause you or your family anxiety but unfortunately you will not be able to stay at this hospital whilst you continue to <search> OR <wait> for a care at home package.

- Leaving hospital will allow you to recuperate and give you more independence than being on a ward;
- Severely ill patients may be unable to access services, if beds in this hospital are occupied with patients who are medically fit for discharge.

As it has taken longer than 5 days to organise your discharge, we are now offering to transfer you to temporary accommodation in the following location, which has been assessed as suitable to meet your short-term needs because <insert reason for decision>. We will discuss the funding of this placement with you based on your individual needs.

Discharge destination:	<Name of location>
Address:	<Address of location>
Tel number:	<Phone number of location>
Proposed date of transfer/discharge:	<Discharge date>

You will be offered further support there with any decisions you need to make and you can wait there until your preferred care at home package can begin.

Please discuss discharge plans with <insert name and contact details>. You will need to either transfer to the temporary accommodation outlined above or inform us of an alternative arrangement to leave the hospital without further delay.

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.

If you would like to make a complaint or appeal against this decision then please [insert details of local complaints and appeals procedures].

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

Yours sincerely,
[Letter to be signed by senior clinician]

CHOICE LETTER C3

Date: ……

Dear <*Name*>

Notification of plan to transfer to interim care whilst waiting for housing support services

We understand that you are now well enough to leave hospital but require housing support services <*that are not yet completed*> *OR* <*that you have not yet decided upon*>*.*

- We do not wish to cause you or your family anxiety but unfortunately you will not be able to stay at this hospital whilst you continue to <*wait*> *OR* <*decide*> upon housing support services.
- Leaving hospital will allow you to recuperate and give you more independence than being on a ward;
- Severely ill patients may be unable to access services, if beds in this hospital are occupied with patients who are medically fit for discharge.

As it has taken longer than 5 days to organise your discharge, we are now offering to transfer you to temporary accommodation in the following location, which has been assessed as suitable to meet your short-term needs because <*insert reason for decision*>. We will discuss the funding of this placement with you based on your individual needs.

Discharge destination:	*<Name of location>*
Address:	*<Address of location>*
Tel number:	*<Phone number of location>*
Proposed date of transfer/discharge:	*<Discharge date>*

You will be offered further support there with any decisions you need to make and you can wait there until the housing support services <*are completed*> *OR* <*are available*>*.*

Please discuss discharge plans with <*insert name and contact details*>*.* You will need to either transfer to the temporary accommodation outlined above or inform us of an alternative arrangement to leave the hospital without further delay.

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.

If you would like to make a complaint or appeal then please [*insert details of local complaints and appeals procedures*].

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

Yours sincerely, [*letter to be signed by senior clinician*]

CHOICE LETTER D

Date: ……

Dear <Name>

Confirmation of discharge plans following formal meeting

Thank you for meeting with us on <insert date> to discuss your discharge arrangements from this hospital and on-going care requirements.
OR
{Dr ??} and the discharge team met in your absence on <insert date> to discuss your discharge arrangements from this hospital and on-going care requirements.

Discharge options discussion
We want to help you leave this hospital as soon as possible now you no longer need hospital care. A hospital ward is not the best place for you to continue your recovery and other types of services are now better equipped to support your needs. In addition we have a responsibility to make sure that beds on our wards are available for people who need treatment that can only be provided in a hospital.

At the meeting we discussed the following points:
<insert summary discussion here>.
We discussed the following options to enable the discharge process to proceed:
<insert options provided here>.

Discharge plan discussion
The following discharge plan was agreed:
<insert agreed next steps here>.
OR
We noted the reasons why you are unwilling to engage with this process:
<insert reasons here>.

The risks of you refusing the care options provided after being discharged from NHS hospital care were also discussed and identified:
<insert risks identified here>.

We will continue to work with you to try to come to a mutually agreeable solution. However, in the meantime the hospital will now need to consult our legal advisers about your situation and how we can arrange for you to be safely discharged from this hospital as soon as possible. We have a responsibility to consider and to ensure your health and wellbeing throughout this process. You also have the right to consult with your own legal advisers.

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.

If you would like to make a complaint or appeal against any part of the discharge process then please [insert details of local complaints and appeals procedures].

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

Yours sincerely, [letter to be signed by senior clinician]

Appendix 5

Standard Operating Procedure

Title: Completion of Discharge Summary for Patients in Torbay and South Devon NHS Foundation Trust Community Hospitals	
Prepared by: Matron, Brixham Hospital	
Presented to: Deputy Director of Nursing TSDFT	**Date: 23 March 2017**
Ratified by: Deputy Director of Nursing TSDFT	**Date: 29 March 2017**
	Review date: 31 March 2019

1. Purpose of this SOP

To ensure standardised completion and communication of discharge summaries for all patients discharged from Torbay and South Devon NHS Foundation Trust (TSDFT) Community hospitals. The discharge summary is complimentary to, but in no way replaces other forms of multidisciplinary documentation.

2. Scope of this SOP

This SOP covers all community hospitals within TSDFT, with the following exceptions:

2.1. Paignton Hospital will continue to use Infoflex.

2.2. Teign Ward on Newton Abbott hospital will add Stroke communication to an independent document t to be given to the patient and GP as appropriate. This information does not need to be sent to Torbay Hospital Pharmacy.

3. Competencies Required

3.1 The document will be completed and signed by the GP responsible for the patient's discharge, who must be registered with the General Medical Council in the UK and employed in the capacity of providing medical services to our hospitals by TSDFT.

4. Patients Covered

4.1 Any patient who is being discharged from a ward in a TSDFT hospital.

5. Location of Proforma

5.1. This document needs to be computer generated to reduce error and replaces any pre-existing handwritten To Take Away TTA ordering duplicate book of forms.

5.2 An original template of the proforma document is available on iCare, under Community hospitals; Forms; Community Hospital Discharge Summary.

6. Procedure

6.1 The relevant information should be completed electronically 48 hours prior to the planned discharge by the Prescriber responsible for discharging the patient, except for prescriptions for controlled drugs.

The copy to be sent to Torbay Hospital via email from the Prescribers email account for dispensing must have the controlled drug prescription entered with quantities and dosage in

words and figures (this can be computer generated), but it must be hand signed by the prescriber.

6. Once the required information has been entered electronically and emailed to Pharmacy a copy MUST be printed and signed.

6.2.1 The original signed sheet should be sent to Pharmacy within 72 hours of request. One copy should be emailed to the patient's registered GP before the patient leaves the ward,.

6.2.2 An email copy, where possible, should be sent to the patients GP surgery. Where this is not possible a signed copy of the document should be sent/posted.

6.2.3 One copy should be given to the patient, with instructions to share this copy with any care home, nursing or residential home where they may reside.

6.2.4 One copy should be stored in the patient's hospital notes.

6.3 If the Take Home medications include a prescription for a Controlled Drug, the original must be sent to Torbay Hospital pharmacy in a sealed pharmacy bag with the next available courier. This must be received by Torbay Hospital before they are able to release the drugs. This is a legal obligation, and Torbay hospital cannot breach this law.

Monitoring Tool

Standards:

Item	%	Exceptions
All forms to be completed adequately and completely and submitted in appropriate time to Torbay Hospital pharmacy for dispensing	100	Nil
How will monitoring be carried out?	Audit/Incidents	
When will monitoring be carried out?	At least annually	
Who will monitor compliance with the guideline?	Provider Medicines Management Team	

Appendix 1 – Community Hospital Discharge Summary

Appendix 1

COMMUNITY HOSPITAL DISCHARGE SUMMARY

PLEASE USE BLOCK CAPITALS

Patient's Name:		**D.o.B**	
NHS No:		**Hospital No:**	

GP: ……. **Box No:…….**

Surgery:……..

Admitted from:			**Discharged to:**		
Admitted date:			**Discharge date:**		
Hospital:		**Tel:**		**Discharging Dr**:	
Main Diagnosis:					
Key Details from admission:					
Changes to medication:					
Changes to GP Care Plan:					
Package of Care on discharge:					
De-Escalation Planning discussed: **(tick)**		**Patient Discharged with TEP (tick)**			
Follow Up Appointments:					
GP Actions:					

DRUG & FORM OF PREPARATION	DOSE	FREQUENCY	DURATION	ROUTE OF ADMIN	QUANTITY SUPPLIED

DRUG ALLERGIES & SENSITIVITIES:				**DATE DISPENSED:**	
CLINICAL CHECK:		**DISPENSED BY:**		**FINAL CHECK:**	
CONTROLLED DRUGS MUST BE ORDERED ON A DEDICATED CONTROLLED DRUGS PRESCRIPTION IN ADDITION TO BE RECORDED ABOVE					
PRESCRIBER'S NAME IN CAPITALS & SIGNATURE:					

Appendix 6

DISCHARGE FROM HOSPITAL TO RESIDENTIAL OR NURSING CARE HOME USING THE TRUSTED ASSESSMENT SCHEME

INTRODUCTION

This appendix identifies specific considerations when using the Trusted Assessment (TA) scheme to support patient's timely, effective discharge from an NHS inpatient setting, to the most appropriate available nursing or residential care home able to meet their needs. The TA can only be used with care homes who have signed the Trusted Assessor Memorandum of Understanding, co-signed by Torbay and South Devon NHS Foundation Trust and South Devon and Torbay Clinical Commissioning Group. The TA pathway is then potentially relevant to all elderly inpatients in Torbay and South Devon NHS settings who require discharge to a care home, whether one they were resident in prior to discharge, or when unable to be discharged home following hospital treatment. Both the policy and the process of managing choice on discharge apply equally to all patients, whether or not they need ongoing NHS or social care and whoever may be funding any such care.

PURPOSE

The purpose of the TA policy is to prevent any unnecessary delayed transfers of care to care homes. Homes who have signed the Memorandum of Understanding can accept, via secure email, the Trusted Assessment carried out by a member of the Complex Hospital Discharge Team. The Trusted Assessment informs the potential provider of the patient's physical, social and emotional needs. The provider is then able to confirm if they are suitably equipped and have current capacity to meet the patient's known and anticipated health and social needs, without requiring members of their staff to visit the hospital to make these assessments themselves.

PRINCIPLES

When a patient is ready for discharge from hospital but requires discharge to a care home, consideration should be given to all their physical, social and emotional needs and the environment in which these can best be met.

Trusted Assessor discharge care plans must allow the accepting care provider to meet the requirements of Regulations 9,10,11 and 12 of the Health and Social Care Act 2008 (Regulated Activities) 2010 link (accessed 19/11/18). Also, Introducing Fundamental Standards Consultation on proposals to change CQC registration regulations 2010, link (accessed 19/11/18) and all other relevant legal requirements. They must therefore include the following specific requirements:

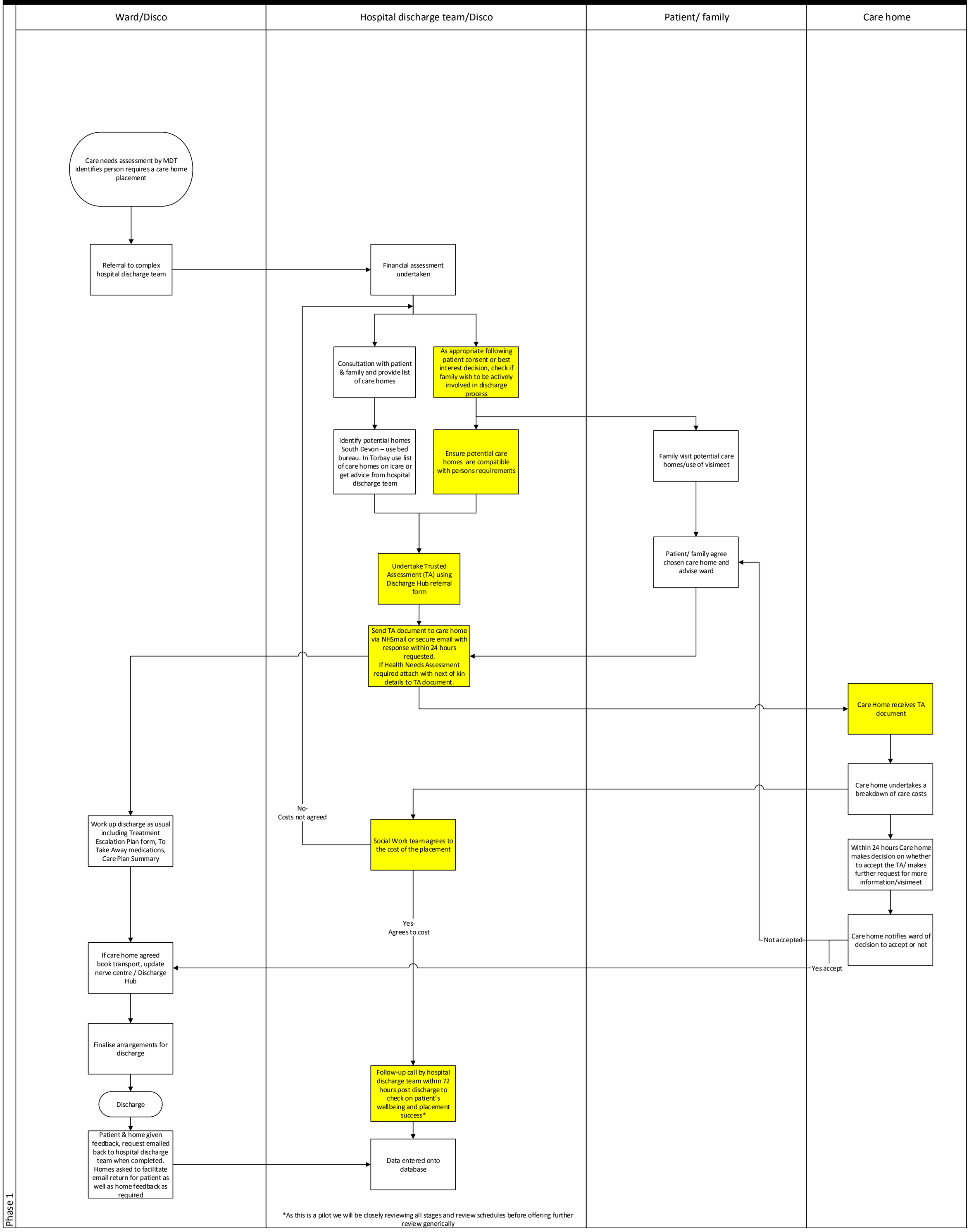
- The discharge care plan must include an assessment of the person's health and social care needs
- Risks associated with the person's care needs assessed, steps on how to manage and mitigate those risks in the delivery of the regulated activity for which the accepting provider is registered are clearly set out
- Risks associated with the transition from the more intensive care of a hospital to that of the chosen care home must be considered and addressed

- The Trusted Assessor must discuss the discharge care plan with the patient and valid agreement to the care plan must be given and recorded
- Where the patient lacks capacity to make decisions about their care, the Trusted Assessor, hospital managers and other relevant persons and organisations must follow the requirements of the Mental Capacity Act 2005 when making best interest decisions about the proposed discharge. This includes when they think it is in the person's best interest to be deprived of their liberty so that they can get the care and treatment they need
- The patient must be medically ready for discharge before any needs assessment can be adopted by an adult social care provider

Ref 20170109 900805 v1.0 Trusted assessors- guidance for CQC staff link

After the care home has agreed to meet the patient's needs and accept them on discharge from hospital, whilst the patient remains in hospital, if any additional care needs develop, the hospital has the responsibility of agreeing in writing with the care home that the care home can meet these additional needs or support the patient in receiving care for these needs from alternative sources.

Trusted Assessor new process for October 2018



Appendix 8

Trusted Assessor Memorandum of Understanding

The Trusted Assessor (TA) is an initiative proposed by NHS England and supported by the LGA and Care Provider Alliance which aims to reduce delayed transfers of care from hospital to residential or nursing homes. The purpose is to aid safe and timely discharges from hospital seven days a week, allowing care home providers to accept and trust a patient assessment from the hospital, rather than attending the hospital to undertake their own assessments.

The Trusted Assessment is agreed in partnership between the registered parties involved and does not remove or replace any parties statutory responsibilities All parties must therefore be confident that the provider has sufficient information to determine that they can confidently meet a person's care needs based on the 'trusted assessor's' discharge care plan and assessment.

Appendix 9

Trusted Assessor

Memorandum Of Understanding (MoU)

Agreement Between:

(A) Torbay and South Devon NHS Foundation Trust (TSDFT)

And

(B) Name Care Home(s)

(C) South Devon & Torbay Clinical Commissioning Group

Document Reference Information

Version	3
Status	Ratified
Clinical Lead	Sarah Bradley
Ratified By and Date	Signatories to the MOU - 20 November 2018
Date Effective	23 November 2018
Date of Next Formal Review	23 May 2019
Target Audience	TSDFT, SD&T CCG and local Residential and Nursing homes

The Parties to this Memorandum of Understanding, collectively known as Providers, are:

A. Torbay and South Devon NHS Foundation Trust (TSDFT), Torbay Hospital, Lowes Bridge, Torquay TQ2 7AA

B. Add care home name

C. South Devon & Torbay Clinical Commissioning Group, Pomona House, Torquay TQ2 7FF

PURPOSE

The above Parties are collaborating to provide a Trusted Assessor service (the Service) to provide a timely, enhanced discharge from hospital to care homes, ensuring appropriate healthcare service to patients who have on-going care needs within a care home setting.

This Memorandum of Understanding is intended to enable the delivery of the objectives of a Trusted Assessor model, making best use of existing services and resources for all Parties and ensuring appropriate ongoing and timely care for all patients. It defines the circumstances and approach under which the Parties will work together to prepare to deliver the Service, and also describes how the relationship between the Parties will be managed and governed.

Nothing in this Memorandum of Understanding impacts on the statutory duties and responsibilities of the Parties, or to their reporting responsibilities and their separate accountabilities. This Memorandum of Understanding does not place additional legal responsibilities on any Party, nor does it imply any transfer of responsibility between the Parties

The Parties warrant that they have the power to enter into this Memorandum of Understanding through it being formally signed by:

- For Torbay and South Devon NHS Foundation Trust - Chief Operating Officer
- List care homes - name and role title (Manager)
- For South Devon & Torbay Clinical Commissioning Group – Chief Operating Officer

The Parties to this Memorandum of Understanding enter into it intending to honour all of their obligations and to work collaboratively to resolve issues as they arise.

The Trusted Assessor Service assesses patients who are medically optimised for discharge from hospital into a residential or nursing care home.

Changes in CQC guidance means that care homes must now confirm that they are happy to use the Trusted Assessment.

We are therefore asking the Care Home to sign up to confirm that, whenever appropriate, the Care Home can utilise the Trusted Assessor through signing this document, it does not mean the parties are under any obligation to use the service, but have the option available to do so.

The Trusted Assessor service includes:

- Complete assessments of patients who have been declared medically optimised for discharge and are waiting to be discharged into a care home. The assessments will meet the requirements of regulations 9, 10, 11 and 12 of the Health and Social Care Act 2008 (Regulated Activities) 2010, link (accessed 19/11/18). Also, Introducing Fundamental Standards Consultation on proposals to change CQC registration regulations 2010, link (accessed 19/11/18)

- The Assessments developed from appropriate multi-disciplinary teams, collated by a Trusted Assessor, a member of the Complex Hospital Discharge Team who, as such, undertakes mandatory ongoing social work training.

- The aim is to run 7 days a week, Discharges can occur outside of normal 'office' hours if agreed and the care home have capacity and deemed to be in the patient's best interest.

- Electronic sharing of Trusted Assessments from the hospital to the home ideally through secure NHS mail, or an alternative secure mechanism which is GDPR compliant.

- A follow up call from a Trusted Assessor, within 72 hours after each admission to the home, to gather feedback or any learning on the discharge. All feedback will then be addressed within 72 working hours, except in unforeseen or unavoidable circumstances. If a care home is unable to meet a person's requirements after a discharge, the Trusted Assessor will discuss the issue with the home to understand the difficulties and will try to identify steps that could be taken to support the resident staying in the home or moving on. If the Trust and the home conclude that it is not in the best interest of the patient to remain in that placement, or wish to give any feedback, please refer this to the hospital discharge team tsdft.hadt@nhs.net / 01803 654740. If a patient is considered to be unsafe and at risk, the hospital discharge team would consider the most appropriate course of action for the patient in line with the Health and Social Care Act 2008

Terms and conditions

- Care Home managers will be signing this on behalf of the care home, agreeing to use the service.

- If the care home wishes to remove their consent, they must formally write to tsdft.feedback@nhs.net informing them of their decision. The home would then no longer be a Trusted Assessor Home and would complete their own assessments of the patients at point of notification.

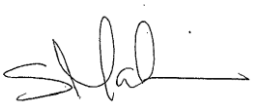
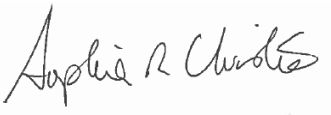
- The assessment received from the Trusted Assessor must be adopted and recorded in the individual care plan.

  If you have any questions, please contact the Hospital Discharge Team tsdft.hadt@nhs.net / 01803 654740 / Torbay Hospital switchboard 01803 614567

Signed:

This form, when signed by TSDFT, CCG and the Provider, will record the agreement of the parties to utilise Trusted Assessments on a matter relating to the above Agreement on an ongoing basis, as set out in this document.

This agreement is from the day of signing until _____

Shelley Machin For and on behalf of **Torbay and South Devon NHS Foundation Trust**	 _____ System Director for Torbay _____ Date: 2/11/18
Sophia Christie For and on behalf of **Torbay and South Devon Clinical Commissioning Groups**	 _____ Chief Executive _____ Date: 05/10/2018
XXXXXXXX For and on behalf of **Care Home**	_____ Title _____ Date:

Document Control Information

This is a controlled document and should not be altered in any way without the express permission of the author or their representative.

Please note this document is only valid from the date approved below, and checks should be made that it is the most up to date version available.

If printed, this document is only valid for the day of printing.

This guidance has been registered with the Trust. The interpretation and application of guidance will remain the responsibility of the individual clinician. If in doubt contact a senior colleague or expert. Caution is advised when using clinical guidance after the review date, or outside of the Trust.

Ref No:	2113		
Document title:	Discharge from Hospital		
Purpose of document:			
Date of issue:	23 November 2018	**Next review date:**	23 November 2021
Version:	3	**Last review date:**	31 March 2017
Author:	Head of Complex Care and Operational Support		
Directorate:	Organisation-Wide		
Equality Impact:	The guidance contained in this document is intended to be inclusive for all patients within the clinical group specified, regardless of age, disability, gender, gender identity, sexual orientation, race and ethnicity & religion or belief		
Committee(s) approving the document:	Care and Clinical Policies Group		
Date approved:	20 November 2018		
Links or overlaps with other policies:			

Have you identified any issues on the Rapid (E)quality Impact Assessment. If so please detail on Rapid (E)QIA form.	Yes ☐	
	Please select *Yes*	*No*
Does this document have implications regarding the Care Act? *If yes please state:*	☐	☐
Does this document have training implications? *If yes please state:*	☐	☐
Does this document have financial implications? *If yes please state:*	☐	☐
Is this document a direct replacement for another? *If yes please state which documents are being replaced:*	☐	☐

Document Amendment History

Date	Version no.	Amendment summary	Ratified by:
26 January 2017	1	New	Care and Clinical Policies Group Chief Nurse Medical Director
31 March 2017	2	Appendix 5 added	Deputy Director of Nursing TSDFT
19 February 2018	2	Review date extended from 2 years to 3 years	
23 November 2018	3	Revised	Care and Clinical Policies Group

The Mental Capacity Act 2005

The Mental Capacity Act provides a statutory framework for people who lack capacity to make decisions for themselves, or who have capacity and want to make preparations for a time when they lack capacity in the future. It sets out who can take decisions, in which situations, and how they should go about this. It covers a wide range of decision making from health and welfare decisions to finance and property decisions

Enshrined in the Mental Capacity Act is the principle that people must be assumed to have capacity unless it is established that they do not. This is an important aspect of law that all health and social care practitioners must implement when proposing to undertake any act in connection with care and treatment that requires consent. In circumstances where there is an element of doubt about a person's ability to make a decision due to 'an impairment of or disturbance in the functioning of the mind or brain' the practitioner must implement the Mental Capacity Act.

The legal framework provided by the Mental Capacity Act 2005 is supported by a Code of Practice, which provides guidance and information about how the Act works in practice. The Code of Practice has statutory force which means that health and social care practitioners have a legal duty to have regard to it when working with or caring for adults who may lack capacity to make decisions for themselves.

"The Act is intended to assist and support people who may lack capacity and to discourage anyone who is involved in caring for someone who lacks capacity from being overly restrictive or controlling. It aims to balance an individual's right to make decisions for themselves with their right to be protected from harm if they lack the capacity to make decisions to protect themselves". (3)

All Trust workers can access the Code of Practice, Mental Capacity Act 2005 Policy, Mental Capacity Act 2005 Practice Guidance, information booklets and all assessment, checklists and Independent Mental Capacity Advocate referral forms on iCare

http://icare/Operations/mental_capacity_act/Pages/default.aspx

Infection Control

All staff will have access to Infection Control Policies and comply with the standards within them in the work place. All staff will attend Infection Control Training annually as part of their mandatory training programme.

Rapid (E)quality Impact Assessment (EqIA) *(for use when writing policies)*

Policy Title (and number)		**Version and Date**	
Policy Author			

An (e)quality impact assessment is a process designed to ensure that policies do not discriminate or disadvantage people whilst advancing equality. Consider the nature and extent of the impact, not the number of people affected.

Who may be affected by this document?

Patients/ Service Users ☐	Staff ☐	Other, please state… ☐

Could the policy treat people from protected groups less favourably than the general population?
PLEASE NOTE: Any 'Yes' answers may trigger a full EIA and must be referred to the equality leads below

Age	Yes ☐ No☐	Gender Reassignment	Yes ☐ No☐	Sexual Orientation	Yes ☐ No☐
Race	Yes ☐ No☐	Disability	Yes ☐ No☐	Religion/Belief (non)	Yes ☐ No☐
Gender	Yes ☐ No☐	Pregnancy/Maternity	Yes ☐ No☐	Marriage/ Civil Partnership	Yes ☐ No☐

Is it likely that the policy could affect particular 'Inclusion Health' groups less favourably than the general population? (substance misuse; teenage mums; carers[1]; travellers[2]; homeless[3]; convictions; social isolation[4]; refugees)	Yes ☐ No☐

Please provide details for each protected group where you have indicated 'Yes'.

VISION AND VALUES: Policies must aim to remove unintentional barriers and promote inclusion

Is inclusive language[5] used throughout?	Yes ☐ No☐ NA ☐
Are the services outlined in the policy fully accessible[6]?	Yes ☐ No☐ NA ☐
Does the policy encourage individualised and person-centred care?	Yes ☐ No☐ NA ☐
Could there be an adverse impact on an individual's independence or autonomy[7]?	Yes ☐ No☐ NA ☐

EXTERNAL FACTORS

Is the policy a result of national legislation which cannot be modified in any way?	Yes ☐ No☐

What is the reason for writing this policy? (Is it a result in a change of legislation/ national research?)

Who was consulted when drafting this policy?

Patients/ Service Users ☐	Trade Unions ☐	Protected Groups (including Trust Equality Groups) ☐
Staff ☐	General Public ☐	Other, please state… ☐

What were the recommendations/suggestions?

Does this document require a service redesign or substantial amendments to an existing process? ***PLEASE NOTE: 'Yes' may trigger a full EIA, please refer to the equality leads below***	Yes ☐ No☐

ACTION PLAN: Please list all actions identified to address any impacts

Action	Person responsible	Completion date

AUTHORISATION:
By signing below, I confirm that the named person responsible above is aware of the actions assigned to them

Name of person completing the form		**Signature**	
Validated by (line manager)		**Signature**	

Please contact the Equalities team for guidance:
For South Devon & Torbay CCG, please call 01803 652476 or email marisa.cockfield@nhs.net
For Torbay and South Devon NHS Trusts, please call 01803 656676 or email pfd.sdhct@nhs.net
This form should be published with the policy and a signed copy sent to your relevant organisation.

Clinical and Non-Clinical Policies – Data Protection

Torbay and South Devon NHS Foundation Trust (TSDFT) has a commitment to ensure that all policies and procedures developed act in accordance with all relevant data protection regulations and guidance. This policy has been designed with the EU General Data Protection Regulation (GDPR) and Data Protection Act 2018 (DPA 18) in mind, and therefore provides the reader with assurance of effective information governance practice.

The UK data protection regime intends to strengthen and unify data protection for all persons; consequently, the rights of individuals have changed. It is assured that these rights have been considered throughout the development of this policy. Furthermore, data protection legislation requires that the Trust is open and transparent with its personal identifiable processing activities and this has a considerable effect on the way TSDFT holds, uses, and shares personal identifiable data.

Does this policy impact on how personal data is used, stored, shared or processed in your department? Yes ☐ No ☐

If yes has been ticked above it is assured that you must complete a data mapping exercise and possibly a Data Protection Impact Assessment (DPIA). You can find more information on our GDPR page on ICON (intranet)

For more information:

- Contact the Data Access and Disclosure Office on dataprotection.tsdft@nhs.net,
- See TSDFT's Data Protection & Access Policy,
- Visit our Data Protection site on the public internet.