Document Type:	Policy	
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Title:	**Managing Expectations (Choice) and Managing Discharge of Patients from Hospital**	
Document Author:	Associate Director Nursing & Professional Practice	
Applicability:	Adult inpatient wards and intermediate care placements	

1 Introduction

This policy supports timely, effective transfer of care of patients ready for discharge from an NHS inpatient setting within Torbay and South Devon NHS Foundation Trust (The Trust), to the most appropriate available setting to meet their needs. It is relevant to all adult inpatients (aged 18+) who require ongoing care and who are required to choose a destination and / or care provider on discharge. The policy and operational guidance for managing expectation on discharge apply equally to all patients, whether or not they need ongoing health or social care and whoever may be funding any such care. This policy also applies to the transfer of patients between wards, for example from Intensive Treatment Unit (ITU) to another ward within the hospital.

Patient participation, engagement and communication are central to the policy and operational guidance for managing expectation on hospital or intermediate care discharge. When verbal or written communication with the patient is stated, it applies equally or alternatively to communicating with the patient's representative, as appropriate and with consent.

2 Purpose

The purpose of this policy is to ensure that patients and families are clear of the process of arranging their discharge, that expectation is managed fairly throughout the discharge planning process, that a clear escalation process is in place for when patients remain in hospital/ intermediate care longer than is clinically required, and that there is a consistent approach.

This policy sets out a framework to ensure that:

- NHS inpatient beds will be used appropriately and efficiently for those who require that service.
- This policy equally applies to all adult inpatient wards including intermediate care.
- Planning for effective transfer of care, in collaboration with the patient, their representatives and all Multi-Disciplinary Team (MDT) members will be commenced on admission.
- The process of offering a discharge destination will be followed in a fair and consistent way and there will be an audit trail of options offered to the patient and / or their representative.
- When patients have completed the required assessment or treatment at their current bedded 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.

3 Definitions

Assessment Fit: The point where a patient can be assessed by external agencies for discharge planning

CHC: NHS Continuing Healthcare

Case Manager: A named staff member from the ward or a member of the hospital case management team. This named person is responsible for coordinating 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.

Discharge to Assess (D2A):

- Discharge to Assess supports the ethos of "Right care, right time", by getting it right for the patient first time.
- Once a patient no longer requires input of an acute nature, and is medically stable for discharge, they are facilitated to receive any additional assessment, care or therapy in an appropriate setting.
- D2A improves patient experience – enables ongoing assessments to be done out of hospital in the right place at the right time – makes these assessments more meaningful for the patient and helps make the right decision about ongoing care.
- D2A prevents unnecessary long stays in inpatient beds, hence ensuring 'patient flow' and allowing unwell patients to easily access care at the 'front door' (emergency zone).
- D2A helps prevent secondary complications of an extended hospital stay ('clinical deconditioning') – loss of muscle mass, mobility, nutrition, sleep, worsening confusion, hospital acquired infection.

DTOC: delayed transfer of care

EDD: Estimated date of discharge. The date the patient is most likely to be ready for safe transfer. The EDD is set within the first 24 hours of admission and may change several times in response to the patient's specific needs.

Hospital Discharge Team (HDT) – A multi organisational team that provide advice, guidance and expertise for the ward team. All partner organisations are represented.

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 may represent patients assessed as lacking capacity under the Mental Capacity Act 2005 when the person does not have any family or friends to consult when important decisions, such as change of accommodation are required. For these patients, there is a statutory duty to consult an IMCA in relation to serious medical treatment or accommodation for longer than eight weeks, where there is no one appropriate to consult other than paid carers.

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 about their care, treatment or, 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.

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.

Representative: A family member, LPA person with Last Power of Attorney for Health and Welfare, friend or other person that the patient has asked to be involved or another advocate. Valid consent, court registered and validated LPA authorisation or a best interests determination will be needed before discussing confidential information with a representative. If there is a Deprivation of Liberty Safeguards (DoLS) authorisation in place, the patient will also have a DoLS Representative. DoLS representatives have a legal right to relevant records relating to the patients accommodation and treatment.

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

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 & they want to set up services themselves, or because they or a representative choose to pay for their care and set it up themselves.

Social care assessment: The Care Act 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 practitioner allocated by adult services.

Step-down care: provides a transition from the current care level to the ultimate place of residence

4 Roles and responsibilities

It is the responsibility of all Trust staff to ensure that this policy is applied in a fair and compassionate nature, that patients and their representatives are as fully engaged as possible in plans for their future care and that inpatient beds and patient flow are managed as effectively as possible to ensure capacity for all patients requiring services.

This responsibility will be achieved by a clearly communicated agreement between the NHS care setting and the patient. This agreement will make clear that patients will be admitted if appropriate, for a necessary period of treatment and then be transferred home or to an alternative care setting should further care be required. All staff have a responsibility to manage and minimise delayed transfers of care for both the good of the patient and also to promote patient flow and bed availability for new acute admissions across the system.

Accountability for the discharge process will remain with the ward manager. For complex discharge planning, the MDT will work with the Hospital Discharge Team (HDT) and undertake or delegate as appropriate the task of gathering MDT assessments to inform decisions about needs on discharge.

Members of the social care team and CHC assessment team 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.

The MDT led by the ward manager will aim to undertake considerable discussion with the patient and / or representative prior to initiating formal ‘managing expectation’ 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

The ward manager will offer the appropriate level of guidance and support, and will consult their matron / service manager as needed.

Matrons will support ward managers in implementation of the policy. Matrons, Associate Directors of Nursing and Professional Practice and Associate Direcotrs of Operations all have responsibility to play an active and timely role in the escalation process.

5 Key principles

5.1 Why is timely discharge important?

Timely discharge is important for both individual patients benefit and for the health of the local population.

The consequences for an individual patient who is ready for discharge remaining in a hospital or intermediate care bed might include:

- The patient is exposed to an unnecessary risk of hospital-acquired infection.
- The patient is exposed to the risk of hospital-acquired disability (deconditioning whilst in a hospital bed has significant impact on older people's recovery). 30% of people over 70 in hospital beds develop hospital acquired disability. For people aged 80 years and over, 10 days spent in a hospital bed equates to 10 years of muscle wastage
- Uncertainty during any wait for a preferred option of service to become available may cause frustration and distress to the patient and relatives.
- End of Life patients may die in a hospital bed whilst waiting for the most appropriate service to become available.
- Any delay in transfer may increase patient dependence, as the hospital environment is not designed to meet the needs of people who are not unwell.
- Hospital environments can be particularly disabling to people with dementia who manage best in familiar places and may become more confused in hospital.
- Ideally people should make decisions about their long term care outside of hospital, preferably in their own home, or if necessary in an interim bed where assessments can happen in a way that true long term needs are understood.

The consequences for the local population of patients who are ready for discharge remaining in hospital includes:

- The inappropriate use of hospital beds puts additional pressure on the ability of the whole healthcare system to care for patients who do require acute care.
- Lack of flow within the hospital will put other patients at risk.

5.2 The importance of good communication

Patients may find it difficult to choose a discharge destination or care provider for many reasons, such as, but not exclusively:

- Concerns about facing a major life transition of moving from hospital to a care home for the first time.
- Fear about either the quality or the cost of care.
- Reluctance to transfer to another hospital that is not local to their home
- Unwillingness to move into interim accommodation.

Interactions with patients and / or representatives by all members of the multidisciplinary team will acknowledge and offer support with any concerns, whilst reinforcing the message that everyone will work towards the patient's discharge from hospital and it is not appropriate to stay once there is no requirement to remain in that facility.

By the time a patient is clinically ready for transfer of care they and / or their representative should understand that it is not in their best interest to 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 identified available alternative, either as a permanent option or whilst they await availability of their preferred choice.

5.3 Patients self funding their care

Those self-funding care will be offered the same level of advice, guidance and assistance regarding expectation/options as those fully or partly funded by their local authority or Continuing Healthcare (CHC) department. If a patient chooses not to take advice offered or declines guidance and assistance they must make their own arrangements for care on discharge from hospital.

5.4 Mental capacity

Where a patient is assessed as lacking mental capacity in relation to decisions for the discharge arrangements, and no one holds legal decision making power for them, it will be necessary to identify the decision maker under the MCA. This person will be responsible for carrying out a full best interests determination in line with the Mental Capacity Act 2005 (please see appendix 8 for guidelines on identifying the decision maker). The views of family/significant others will be actively sought and taken into account as part of the best interest determination. Any objections or disagreements will be negotiated within this process. In the event of an ongoing dispute about the best interest decision that cannot be resolved further legal advice will need to be sought.

5.5 End of life care

There may be occasions when a patient needs to receive support at the end of their life. Patients who are eligible for NHS Continuing Healthcare Fast Track Funding will be expected to leave hospital when they no longer require hospital based care. Therefore, there will be a requirement that there will be managing expectations discussions initiated with the patient and

their representatives as soon as the individual has been identified as being on a Fast Track pathway. Medical staff will advise on whether patients nearing the end of life are medically stable to transfer.

5.6 People with dementia

People with dementia are unlikely to benefit from repeated moves acoss the healthcare system, but will also not benefit from extended hospital stays. Very early attention should be given to planning their discharge.

5.7 Safeguarding

There may be occasions where a patient cannot move to or return to a care home or domiciliary provider of choice. In these cases the patient should be supported to move to an appropriate provider who is able to meet their assessed needs on an interim basis. They will then be supported to return to their provider of choice by the relevant Clinical Commissioning Group/ Local Authority once the safeguarding issue is resolved.

6.0 Operational Guidance For Managing Expectation

6.1 Overview

The Managing Expectation Process comprises three phases of good practice that apply to all patients and three formal stages that are utilised when delays occur.

The initial phases of good practice that apply to EVERY patient in order to provide support and prevent the need for further escalation are:

- Provision of information
- Assess likely ongoing care needs
- Prepare for discharge

If delays occur after the initial phases, stages 1 to 3 represent the formal escalation process:

- Stage 1 – Formal meeting 1 to agree discharge plan (patient and/or representative, ward manager, IC lead, or HDT representative)
- Stage 2 – Formal meeting 2 if plan not achieved (patient and/or representative, ward manager or IC lead + matron senior +HDT Lead)
- Stage 3 – Legal Process following discussion with Trust Leads (patient and/or representative, Associate Director Nursing and Professional Practice + Ward Manager or IC lead and Senior HDT Lead)

6.2 Give standard information on admission

6.2.1 The discharge planning process will be led by the MDT, including relevant external agencies. This team will support the patient and / or representative through the process, starting with information giving at the point of admission and will ensure that those who need to be involved after discharge are contacted at the earliest opportunity to discuss the patient's needs and the transfer of responsibilities on discharge. This must be recorded in the notes.

6.2.2 A member of the MDT will ensure the Patient Information on Admission information leaflet (appendix 1) is given to all adult patients or their representatives on admission, will discuss the leaflet content with them, and will record this in the patient record. For elective admissions the leaflet may be given prior to admission.

6.2.3 All communications will reinforce the expectation that patients leave the hospital as soon as their need for inpatient treatment ends (they are medically stable). At this point they may not be back to pre-admission level as recovery may continue after leaving hospital.Therefore discharge will take place when their needs reach the level that can be managed by alternative services (e.g. supported at home, in a care home or in a community hospital if a clear need for hospital care is identified).

6.2.4 Patients receiving care in higher dependency settings eg ITU (and their representatives) will also be made aware that when their need for treatment in this area is complete they will move to an area able to meet their needs.

6.3 Assess for ongoing needs

6.3.1 Whilst the patient is still undergoing hospital treatment, the discharge plan will include establishing care needs after discharge, and accurately recording the ongoing needs of the individual on the patient records.

6.3.2 The MDT will work with the patient to understand their wishes for the future. The team will adopt a strengths based approach to acknowledge peoples own skills, attributes and own support mechanisms. The first intention should be to discharge the patient to their own home (Home First) with appropriate support. This may be through family or friend support, an existing care package, rehabilitation or reablement support through a Discharge to Assess (D2A) pathway model or with no support if not required. If concerned about risk, the MDT can use the Choice and control: Risk enablement policy.

6.3.3 If the patient has or is likely to have ongoing health or social needs after discharge the MDT, supported by advice from HDT team, will ensure accurate completion of a referral clearly describing the ongoing needs to be met to ensure effective discharge planning.

6.4 Prepare for discharge

6.4.1 The MDT will advise the patient and / or representative of their estimated discharge date (EDD) as soon as able (taking into account the expectation of being medically stable). The MDT will support the patient to make plans to be ready for transfer on this date.

6.4.2 The HDT will advise the patient and / or representative and the MDT about eligibility for, and availability of suitable care provider(s) at the earliest appropriate stage. 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, a community rehabilitation bed, intermediate care or 'step down' care. Patients do not have the right to remain in hospital once they are safe to transfer because they or their representative has refused or not reviewed the available option(s).

6.4.3 If more than one appropriate option which meets the patient's needs is available, when the patient is ready for transfer or discharge from hospital, the MDT led by the ward manager or a senior therapist will offer to support the patient and / or representative to decide **within two calendar days**.

6.4.4 If the patient has been referred for community hospital input they and / or their representative will already be aware that a bed might not be available at the community location closest to their home. The ward team will explain that transfer to a reasonable alternative hospital will enable the patient to receive required services in an appropriate setting and maximise their chance of swift recovery and that the patient will not be able to remain in an acute bed.

6.4.5 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.

6.4.6 When discussing the need for care, all MDT members will take account of problems resulting from lack of availability. If options are severely restricted (for instance where the patient has complex needs) or if the patient is on a waiting list for a popular home, the patient may have to transfer to somewhere that is not in their preferred location on a short-term basis. Equally if a person needs a package of care to support them at home but this is not available they may need to consider moving to a care home until this care is ready.

6.4.7 If there is currently only one available option the patient and / or representative should be encouraged to accept this either on a permanent or temporary basis. Patients should be reminded that ***'You do not have to move anywhere permanently that you do not wish, but, you are unable to wait here while waiting for your service of choice'.*** When a patient transfers temporarily to a home that is not their preferred choice, services will continue to discuss permanent options with the patient and / or representative.

6.4.8 The patient and / or representative will be helped to make informed decisions regarding discharge within 2 calendar days from when an offer of care is made, or from when the MDT and patient have agreed future needs (if private arrangements are being made by the patient).

6.4.9 If a patient and / or representative is not happy with proposed arrangements to facilitate discharge, the relevant professional will discuss the situation with the patient or their representative to ensure that their concerns are fully explored and the MDT remain confident that the option which has been offered will meet the assessed needs of the patient. It is expected that this will encourage resolution of any potential barrier to discharge and seek support from MDT members involved to ensure the patient's needs on discharge have been appropriately identified and the options provided are suitable and appropriate taking into account the patient's assessed needs.

6.4.10 The patient and / or representative will be directed to the patient advice and liaison service (PALS) for advice and information regarding advocacy if required.

6.4.11 The local process to escalate and manage delayed transfers of care (DTOC) will be followed throughout the Managing Expectation operational guidance.

6.4.12 If transfer or discharge arrangements are not agreed the relevant lead (ward or HDT) will escalate to the ward manager. The ward manager or deputy will start the formal managing expectation process. Relevant staff will continue to encourage patients to make their own decisions throughout this process.

6.5 STAGE 1 – Formal Meeting 1 and Formal Letter 1

6.5.1 The formal managing expectation process cannot be implemented until at least one option has been offered which meet's the patients identified care needs.If there are concerns that timely discharge plans have not been identified or if there has been a decline of a suitable service that will meet the individuals need, the ward manager, deputy or senior therapist will consult any specialist staff involved and escalate to the matron / service manager for support.

6.5.2 The ward manager, deputy or senior therapist will immediately invite the patient and / or representative to **formal meeting 1**, to explore any concerns and discuss plans for discharge.

6.5.3 The ward manager or nominated representative will give or send **formal letter 1** to the patient and / or representative at or soon after the meeting, even if the patient and / or representative did not attend. An example letter is provided at appendix 2 but the letter should be drafted as required for each patient and circumstance. Further examples are in appendices 5 and 6.

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

6.5.5 If an available discharge destination or permanent care provider has still not been agreed after formal meeting 1, the matron / service manager/HDT will support the ward lead and social care or CHC professional with discharge planning. All parties will aim to agree **transfer to an appropriate available care provider** at least as an interim option. The matron / service manager will consult any specialist staff involved for guidance and, if it appears that there will be further delay escalate as required.

6.6 STAGE 2 – Formal Meeting 2 and Formal Letter 2

6.6.1 The Matron will arrange **formal meeting 2** if discharge plans have still not been agreed within 2 calendar days of formal meeting 1. This 2nd formal meeting is to discuss plans for transfer to an alternative available option or interim care whilst a permanent option is sought. Where there is a dispute regarding proposed discharge to alternative accommodation, MDT members will try to reach a consensus view with the patient and / or representative.

6.6.2 The Matron /HDT Lead/ Associate Director of Nursing and Professional Practice/ Associate Director of Operations will give or send **formal letter 2** to the patient and / or representative at, or soon after the meeting, even if the patient and / or representative did not attend (see appendix 3).

6.6.3 The MDT will work with the patient and / or representative to arrange an appropriate means of meeting the patient's care needs at the point of discharge. As long as the patient is medically stable and mentally / clinically ready for discharge, the MDT will agree a **discharge date as soon as appropriate following formal meeting 2**. The allocated social care or CHC professional will lead the process of making arrangements for a patient to transfer to the identified care provider or location on the agreed date.

6.7 STAGE 3 – Legal Process and Formal Letter 3

6.7.1 If no agreement has been reached regarding discharge arrangements after stages 1–2 and transfer arrangements are challenged by the patient and / or representative, the Associate Director of Nursing and Professional Practice/ Associate Director of Operations will support the matron / service manager to **continue plans for transfer to an interim location or alternative care provider**.

6.7.2 The HDT Lead/ Associate Director of Nursing and Professional Practice/ Associate Director of Operations supported by the matron will consult local Trust advisors regarding legal proceedings and escalate as required to ensure discharge from hospital, in order to safeguard the health and wellbeing of this and other patients.

6.7.3 The Associate Director of Nursing and Professional Practice/ Associate Director of Operations or appropriate representative will send **formal letter 3** to notify the patient and / or representative that legal advice will be sought to facilitate discharge (see appendix 4).

7 Overall Responsibility for the Document

The Ward Flows working group will remain responsible for the development, implementation and review of this policy.

8 Consultation and Ratification

The review period for this document is set as default of three years from the date it was last ratified, or earlier if developments within or external to the Trust indicate the need for a significant revision to the procedures described.

Non-significant amendments to this document may be made, under delegated authority from the Director, by the nominated owner. These must be ratified by the Director.

Significant reviews and revisions to this document will include a consultation with named groups, or grades across the Trust. For non-significant amendments, informal consultation will be restricted to named groups, or grades who are directly affected by the proposed changes.

9 Dissemination and Implementation

Following approval and ratification, this policy will be published in the Trust's formal documents library and all staff will be notified through the Trust's normal notification process.

Document control arrangements will be in accordance with The Development and Management of Formal Documents.

The document owner will be responsible for agreeing the training requirements associated with the newly ratified document with the named Director and for working with the Trust's training function, if required, to arrange for the required training to be delivered.

10 Monitoring Compliance and Effectiveness

MONITORING COMPLIANCE AND EFFECTIVENESS

9.1 Monitoring will take place by hospital matrons / service managers with their teams and through other senior executive groups.

9.2 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.
- Red to green data

- The effectiveness of this policy will be reflected in reducing delayed transfers of care figures, in particular with a reduction in patient/family action delays and disputes attributed at reluctant discharge.

- DToC figures are routinely monitored by the ADO of Moor to Sea.

11 References and Associated Documentation

- Community Care (Delayed Discharges etc) Act 2003 (http://www.legislation.gov.uk/ukpga/2003/5/contents)
- Care Act 2014 (http://www.legislation.gov.uk/ukpga/2014/23/contents/enacted)
- Last 1000 days http://www.last1000days.com/
- Why not Home, Why Not today? www.local.gov.uk/sites/default/files/documents/NEW0164_DTOC_Brochure_Online_Spreads_1.0.pdf
- Mental Capacity Act 2005 (https://www.legislation.gov.uk/ukpga/2005/9/contents)
- Delayed transfers of care: a quick guide – The King's Fund (https://www.kingsfund.org.uk/publications/delayed-transfers-care-quick-guide)
- The NHS Choice Framework (https://www.gov.uk/government/publications/the-nhs-choice-framework/the-nhs-choice-framework-what-choices-are-available-to-me-in-the-nhs)

- Deprivation of Liberty Safeguards: resources (https://www.gov.uk/government/publications/deprivation-of-liberty-safeguards-forms-and-guidance)

Appendix 1	Linked to Patient Information Leaflet 25610 Patient Transfer and Discharge

Appendix 2	Managing Expectations Process- Example of Formal Letter 1

ALL LETTER/TEMPLATES TO BE USED/ APPLIED AS APPROPRIATE.

Date:……

When a patient has been assessed under the Mental Capacity Act 2005 as not having capacity to make decisions about their discharge, this letter can be given to an appropriate representative, once the necessary information sharing principles have been followed, but it is written as if to the patient.

Dear ……

REDUCING DELAYED DISCHARGE – AVAILABLE OPTIONS

We are pleased that you are now medically stable and ready to leave this hospital. The formal meeting you were invited to was arranged to discuss how to help you move on from this hospital now that you no longer need treatment here. All assessments or treatments have been completed and it has been agreed that you are now ready for discharge.

Tailor this letter to the person's specific needs, e.g.:

- You need to transfer to another hospital but your preferred hospital is full. You will be told which hospital can offer you the treatment you need. We will arrange for you to transfer to that hospital.

- You need care at home but a care agency has not yet been found that can offer this care. You will be told which care homes can accommodate you while you are awaiting this care. We will arrange for you to transfer temporarily to a care home until your care at home is ready.

- You need to transfer to a care home but would prefer not to move to those offered by your local authority/NHS continuing healthcare team. You must choose an available home to move to temporarily whilst you continue to wait or search for your preferred home. A named health or social care professional will continue to help you find and transfer to your preferred long-term choice when it becomes available.

- Care has not yet been identified that can meet your needs but the team caring for you will continue to work with you to try and identify a suitable option. As soon as you are offered at least one appropriate option you will need to agree transfer without delay.

Some services after discharge are funded by the health service and some services may incur a charge. You will be provided with further information as necessary.
If you would like a copy of this letter to be given to someone else please speak to one of the nurses on your ward. Please do not hesitate to ask if you have any questions.

Yours sincerely

Ward Lead

Appendix 3	Managing Expectations Process- Example of Formal Letter 2

Date: ……

When a patient has been assessed under the Mental Capacity Act 2005 as not having capacity to make decisions about their discharge, this letter can be given to an appropriate representative, once the necessary information sharing principles have been followed, but it is written as if to the patient.

Dear ……

NOTIFICATION OF INTERIM CARE – ARRANGEMENTS FOR DISCHARGE

I understand that you are now medically stable and are ready to leave this hospital but you have not yet agreed a discharge destination. You have been invited to meetings to discuss discharge. You may be trying to wait for your preferred option but discharge from this hospital is now a matter of urgency. We do not wish to cause you or your family anxiety but your continued stay in this hospital is not in your best interest.

Tailor this letter to the person's specific needs, e.g.:

- We know that you would prefer to move to a hospital that is currently full but you cannot remain here to wait for that hospital. You will need to accept a transfer to another hospital. A hospital that can offer you a bed is detailed below.
- We know that you would prefer to go straight home but a care agency has not yet been found that can provide the support you need and you cannot remain in this hospital while the search continues. You will need to move to a care home until it is safe for you to return home.
- You or your legal representative may be responsible for paying care fees unless you are eligible for local authority or NHS continuing healthcare funding. However, if you are appealing a local authority or NHS decision regarding funding, fees you have paid may be reimbursed if your appeal is upheld.

We know that arranging longer term care can be difficult but you cannot remain in this hospital while waiting for your preferred choice. You will need to accept a temporary option whilst you look for alternatives. A suitable care home is detailed below. When you have your review there shortly after transfer your care manager will help you decide whether you wish to continue looking for long-term alternatives or to stay there.

Please contact the ward lead to discuss discharge plans to the location below or to inform us of alternative arrangements to leave the hospital in the next few days. If we do not hear from you, the hospital will make arrangements for safe transfer to the location below as soon as possible.
If you would like further information or support, or you wish to discuss the content of this letter in more detail, please do not hesitate to contact me.

Discharge location: ……
Address: ……
Tel number: ……
Yours sincerely

Matron / Service Manager

Appendix 4	Managing Expectations Process- Example of Formal Letter 3

Date: ……

When a patient has been assessed under the Mental Capacity Act 2005 as not having capacity to make decisions about their discharge, this letter can be given to an appropriate representative, once the necessary information sharing principles have been followed, but it is written as if to the patient.

Dear ……

FINAL NOTIFICATION – DATE OF TRANSFER TO ALTERNATIVE CARE

I am writing further to the notification letter you were recently sent [DATE], informing you of the 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 arrangements for discharge.
As outlined in the notification letter, we will now instigate 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.

Tailor this letter to the person's specific needs, e.g.:

- You or your legal representative may be responsible for paying care fees unless you are eligible for local authority or NHS continuing healthcare funding. However, if you are appealing a local authority or NHS decision regarding funding, fees you have paid 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 of care without your involvement.
Discharge destination: ……
Address: ……..
Tel number: …… Date of transfer/discharge: ……
Care coordinator name & contact number: ……

Yours sincerely

Associate Director of Nursing and Professional Practice/ Associate Director of Operations

Appendix 5 Illustrative Letter Re: Wait for Package of Care

Ward staff:

Please stick patient label here

Date: ……..

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, such as their next of kin.

Dear Sir or Madam

Notification of interim care whilst waiting for a care package at home

The team caring for you at Torbay and South Devon NHS Trust have assessed that you are medically stable to leave hospital with support from a care agency at home. Unfortunately, no care agency has been found that can start the care visits you need and you agreed that you would not be safe at home without care.

We do not wish to cause you or your family anxiety however Torbay and South Devon NHS Foundation Trust is unable to accommodate you whilst you wait for a start date from a care agency. Therefore the local authority, in partnership with the Trust, has agreed to find a temporary care home room for a short stay. This is until your return home with care can be arranged.

Please discuss discharge plans with the nurse or staff member in charge of your care. You will need to transfer temporarily to the care home found for you or to inform us of an alternative arrangement to leave the hospital within the next two days.

If you would like further information or support, or you wish to discuss the content of this letter in more detail, please do not hesitate to contact the gate on the numbers below.

Hospital discharge team contact name and phone number: ……

Discharge Co-ordinator contact number: ……
Yours sincerely

Name of person sending

Ward staff:

Appendix 6 Illustrative Letter Re: Wait for Housing

Please stick patient label here

Date: ……..

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, such as their next of kin.

Dear Sir or Madam,

Notification of temporary housing or care home stay until able to go home

The team caring for you at Torbay and South Devon NHS Foundation Trust have assessed that you are medically stable to leave hospital. Unfortunately, this is not possible at present as your home needs preparing for your return, or it may be that a new home needs to be found.

We do not wish to cause you or your family anxiety but Torbay and South Devon NHS Foundation Trust is unable to accommodate you whilst you wait for your home to be made ready or alternative accommodation sought. Therefore, the local authority, in partnership with the hospital, has agreed to find a temporary place for you to stay.

The Hospital Discharge Team can make arrangements for your move to the temporary place. When your home has been made ready, they will also help with making arrangements for your transfer home.

Please discuss discharge plans with the nurse in charge of your care. If you do not wish to transfer to the temporary location found by the hospital team you will need to inform us of an alternative location, so that you can leave Torbay and South Devon NHS Foundation Trust within the next two days. Otherwise, we will make arrangements for the transfer to the temporary location as soon as possible.

If you would like further information or support, or you wish to discuss the content of this letter in more detail, please do not hesitate to contact one of the people below.

Contact name: ……..……..

Hospital Discharge Coordination Team: ……

Yours sincerely

Name of person

Appendix 7 Power of Attorney

A Power of Attorney authorises someone else to make decisions on behalf of an individual. There are three types of Power of Attorney that may affect a decision around hospital discharge: a health & welfare lasting power of attorney, a property & financial affairs lasting power of attorney and an enduring power of attorney

Lasting Power of Attorney

Lasting Power of Attorney [LPA] has been available from October 2007, which is when the Mental Capacity Act 2005 came into effect. There are two types of LPA: health & welfare and property & financial affairs.

Key Points about LPAs:

Someone who holds a health & welfare LPA has no right to make decisions about property & financial affairs, unless they also hold a property & financial affairs LPA. If someone holds only a health & welfare LPA, he cannot make a decision to spend a patient's money. Equally, someone who only holds a property & financial affairs LPA has no right to make decisions about health and welfare.

Health and Welfare and property and financial affairs LPAs can only make decisions on behalf of the patient in the best interest when they lack capacity to do so themselves. Both types of LPA must be registered with the Office of the Public Guardian. If a patient has the capacity to make a decision about hospital discharge, anyone who may hold an LPA for that patient can support the patient with that decision but is not able to override a the patient's decision if the patient is assessed as having capacity to make that decision.

Enduring Power of Attorney

Prior to October 2007, enduring power of attorney [EPA] was used by people who wanted to appoint someone else to make financial decisions on their behalf. After October 2007, EPA was replaced by Lasting Power of Attorney, but EPA authorisations drawn up before October are still valid once they have been registered with the Office of the Public Guardian.

EPA only applies to financial decisions. They do not give the person holding an EPA any right to make a decision about health or welfare.

Like the Property and Financial Affairs LPA, an EPA can be put into force while the donor still has mental capacity.

Appendix 8 Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DOLS) Considerations for Hospital Discharge Process

This is a quick guide to delivering an MCA compliant hospital discharge process for people who lack mental capacity to decide upon their accommodation for the purposes of care or treatment.

Identifying the Decision Maker

At the outset, it is important to identify the person responsible for assessing capacity and making a best interests decision (the decision maker) on behalf of the person lacking mental capacity at each stage of the discharge process.

The MCA Code of Practice at 4.38 says:

'The person who assesses an individual's capacity to make a decision will usually be the person who is directly concerned with the individual at the time the decision needs to be made. This means that different people will be involved in assessing someone's capacity to make different decisions at different times.'

In order to help identify the most appropriate decision maker, it may be helpful to separate out the decisions that need to be made in relation to hospital discharge into two basic stages:

a) When is the person medically and physically ready for discharge?

b) Where they should go on discharge to have their needs met on an interim or permanent basis.

In relation to (a) above, medical readiness will usually be decided upon by the consultant/doctor responsible for the person's medical treatment in hospital, although they may delegate this as appropriate (See 5.8 of the MCA Code of Practice). Regarding physical readiness, this may be a joint decision, but one person will implement the decision. See MCA Code of Practice at 5.11 below.

'5.11 There are also times when a joint decision might be made by a number of people. For example, when a care plan for a person who lacks capacity to make relevant decisions is being put together, different healthcare or social care staff might be involved in making decisions or recommendations about the person's care package. Sometimes these decisions will be made by a team of healthcare or social care staff as a whole. At other times, the decision will be made by a specific individual within the team. A different member of the team may then implement that decision, based on what the team has worked out to be the person's best interests.'

In relation to (b) above, this would normally be the relevant care manager, from either the Local Authority or Clinical Commissioning Group according to the particular funding arrangements, after discussion with other professionals as necessary.

Mental Capacity Assessment

Where a person has been assessed as lacking mental capacity in relation to the decision relevant to their hospital discharge, the principles and processes specified in the MCA and the MCA Code of Practice must be followed.

Carers (whether family carers or other carers) and care workers do not have to be experts in assessing capacity, but to have protection from liability when providing care or treatment, they must have a 'reasonable belief' that the person they care for lacks capacity to make relevant decisions about their care or treatment. To have this reasonable belief, they must have taken 'reasonable' steps to establish that that the person lacks capacity to make a decision or consent to an act at the time the decision or consent is needed. They must also establish that the act or decision is in the person's best interests

Health or care professionals, who are qualified in their particular field, are expected to carry out a more detailed and thorough MCA assessment and record them, reflecting their higher degree of knowledge and experience. Although the Act itself does not say professionals need to record capacity assessment, there is strong evidence from case law that it should be recorded formally. An assessment of a person's capacity to give valid consent to the provision of services will be part of the discharge/care planning processes for health and social care needs, and should be recorded in the relevant documentation. For significant matters relating to accommodation or care and treatment, a clear record of assessment of capacity as per the process prescribed in the MCA 2005 and the outcome should be kept, providing evidence of the process and reasoning behind the outcome.

Best Interests Determination

Before carrying out best interest determination, the decision maker should check to see if there is another person with decision making power (e.g. a Lasting Power of Attorney for 'personal welfare' or Deputy appointed by the Court of Protection). If there is an LPA or deputy with relevant decision making power that person can make the decision. However, para 5.2 of the MCA Code of Practice states the 'best interests principle' covers all aspects of financial, personal welfare and healthcare decision-making and actions. It applies to anyone making decisions or acting under the provisions of the Act, including:

• family carers, other carers and care workers

• healthcare and social care staff

• attorneys appointed under a Lasting Power of Attorney or registered

Enduring Power of Attorney

• deputies appointed by the court to make decisions on behalf of

someone who lacks capacity, and

• the Court of Protection.

There is a statutory checklist which must be followed when making best interests decisions. The decision maker must involve a person lacking mental capacity, so far as is reasonable and practicable, in any decisions affecting their welfare. If it is practical and appropriate to do so, they must also consult other people for their views about the person's best interests and to see if they have any information about the person's wishes and feelings, beliefs and values. When consulting, it is important to remember that the

person who lacks the capacity to make the decision or act for themselves still has a right to keep their affairs private – so it would not be right to share every piece of information with everyone. The best interest checklist also requires that the decision maker to explore whether there is a less restrictive way to deliver the care or treatment required.

Sometimes it will be helpful to have a best interests meeting to help gain the views of all interested parties, particularly where there is contention over what is in the relevant person's best interests. If there are disputes or disagreements over the best interests decision-making, efforts should be made to resolve issues through dialogue or mediation and if there are irreconcilable differences then legal advice must be sought.

Independent Mental Capacity Advocacy (IMCA)

An IMCA must be instructed, and then consulted, for people lacking capacity who have no-one else to support them ('unbefriended' people) other than paid staff, whenever:

- an NHS body is proposing to provide serious medical treatment (''Serious medical treatment" means treatment which involves providing, withholding or withdrawing treatment of a kind prescribed by regulations made by the appropriate authority), or
- an NHS body or local authority is proposing to arrange accommodation(or a change of accommodation) in hospital or a care home, and
    - the person will stay in hospital longer than 28 days, or
    - they will stay in the care home for more than eight weeks

Deprivation of Liberty Safeguards (DoLS) Considerations when discharging people to residential care settings

For people assessed as lacking capacity to make a decision about the accommodation they will require to receive care and treatment on discharge from hospital, it will be necessary to consider the Deprivation of Liberty Safeguards (DoLS) and the implications for practice.

If on discharge, the person will be under continuous supervision and control and not free to leave, they meet the "acid test" for a Deprivation of Liberty (DoL) and legal authorisation for the DoL will be necessary.

If the discharge will be into a registered care setting (i.e. a care home registered under the Care Standards Act 2000), it will be necessary for the registered manager of the care home to apply for DoLS authorisation from the relevant DoLS team, which will be the team from the area where the person is ordinarily resident, rather than the area in which the care home is located. Wherever possible, the application for DoLS authorisation should be made in advance of the hospital discharge, (and can be made up to 28 days in advance) but equally, the discharge should not be delayed by this process. The practitioner arranging the placement must advise the care home about the requirement to make an application for DoLS authorisation and also make the relevant DoLS team aware, so that they can chase the application if necessary.

If the person is going to be discharged into their own home or another unregistered setting (e.g. extra care housing, supported living) it will be necessary to make an application to the Court of Protection to authorise the DoL, as these settings do not fall within the DoLS regime. Under these circumstances, the practitioner arranging the care package should seek immediate legal support to commence this process. Again, wherever possible the application should be made in advance of discharge.

Where the person objects to their accommodation / proposed accommodation

People under a DoLS authorisation have the right to have their authorisation reviewed and can appeal against their authorisation to the Court of Protection. Where the person is objecting to a DoLS authorisation, it is expected that their DoLS representative (including paid representatives) will appeal on their behalf. Legal aid is available for this where appropriate.

Where the practitioner arranging the placement is aware that the person is objecting, or likely to object, it is likely that an application to the Court of Protection should be made prior to discharge. Under these circumstances the practitioner should seek further advice or legal support as a matter of urgency.

Interim Placements

It is widely accepted that people should not remain in hospital any longer than is necessary, and on this basis, it may be necessary to make use of interim care home placements as a stepping stone to more permanent care arrangements.

Where there is no objection or disagreement to these arrangements, a thorough mental capacity assessment and robust best interest determination (preferable using a "balance sheet" approach*) will be sufficient to make the required arrangements, following the guidance above in relation to any potential DoL.

Where a family member or carer disagrees with the proposed accommodation whether permanent or interim:

There is a crossover between the MCA and the Care Act that must be considered in these situations. Family members / carers will have been consulted as part of the best interest determination process. The decision maker has to take family / carer views into account, but is able to make a decision contrary to their wishes when determining what is in the person's best interests. LAs and CCGs are able to meet a person's needs in the most effective way possible, so the way in which a person's needs are met, in their best interests, may not be in line with family / carers expectations. The views of family/significant others will be taken into account as part of the best interest determination. Any objections or disagreements will be negotiated within this process. In the event of an ongoing dispute about the best interest decision that cannot be resolved further legal advice will need to be sought.

Where the family / carer would prefer to be making the care arrangements for the person, perhaps in their own home, but this is being refused as a result of Safeguarding concerns or other reasons, in addition to any complaints procedure, it will be necessary to deal with the dispute using the principles of the MCA. This would mean attempts to resolve via use of advocacy, mediation, meetings etc. but if unsuccessful an application to the Court of Protection is likely to be necessary, to make a declaration about what is in the person's best interests.

* Balance sheet – a list of pros and cons relating to the decision that needs to be made

Family / Carers with Lasting Power of Attorney or Deputyship for Health and Welfare

Under these circumstances the attorney or deputy has decision making power, so a best interest determination is not required, although an attorney or deputy must demonstrate they are acting in the person's best interests when making the decision. Neither an attorney nor deputy can authorise a DoLS, so the processes described above must be followed according to the particular situation. However, an Attorney or Deputy can object to an authorisation under the DoLS regime, under which circumstances an authorisation cannot be granted.

A person with health or welfare attorney or deputyship cannot insist that a Local Authority or Clinical Commissioning Groug meets the person's needs in a particular way or setting. However, any objections or disagreements between an LPA and the LA/CCG about discharge destination whether permanent or temporary will be negotiated within this process. In the event of an ongoing dispute that cannot be resolved, legal advice will need to be sought.

If there are concerns that the attorney or deputy is not acting in the best interests of the person, the Office of the Public Guardian can be asked to look into the matter.

In the event of an unresolvable dispute between an LPA with health and welfare, an application to the Court of Protection can be considered, as they are able to make final determination as to what is in the person's best interests, which all parties need to abide by.

Appendix 9 Legal Issues around Reluctant Discharge

Legal Issues around reluctant discharge

Issues to cover when holding a meeting or writing a letter from our local legal advisors if a patient or their family has failed to leave the hospital after Formal Letter 1 and 2 have been sent:

- We must ensure that there is a suitable placement that meets the person's needs at the point when we sent Formal Letter 2. This is because the person may wait for their long-term placement of preference but they may not do so in hospital.
- An interim placement only has to meet needs not preferences. This is quoted both within the Delayed Discharge Act and the Choice Directions.

  (Community Care (Delayed Discharge) Act 2003 paragraph 96, 97-100.

  Local Authority Circular (2004) 20, paragraph 7.1, 7.2 and 2.5.12)

At this point we would meet with the family or the patient themselves, if they are not prepared to attend meetings we would write to them from our local legal advisors; we would need to cover the following:

- You or your relative are now medically stable and do not require the services of an acute hospital bed.
- Continuing to stay here exposes you to hospital acquired infection, a reduction in your independent living skills, e.g. ability to live independently, and loosens previous social networks that you had supporting you, and prevents another person, who does need acute hospital treatment, from accessing it.
- You do not have to move permanently to another placement from an acute hospital bed, however, legislation indicates that you may not wait, blocking an acute hospital bed, while your placement of preference becomes available.
- You need to make arrangements to move to an interim placement or to return home if your family wish to support you while you wait for that placement to become available.
- To this point, we have consulted, discussed and supported you and you have been offered both permanent and interim placements (these need to be listed) which you have declined giving these reasons…….
- We now need to set a timescale by which you or your relatives inform us of plans to leave the hospital.
- If we do not receive those plans within X days we will have no choice but to revert to legal action which could result in a county court judgement against your family members or you if you refuse to leave hospital. We would also put in a claim for costs.
- It is with great reluctance that we would move to this, however, we have to ensure equitable use of the service we have here, which is that those in need of acute hospital treatment should be able to access it.

We need to give patients and families a clear idea of what to do if they cannot achieve the timescale you are asking from them, but make it clear that to hear nothing implies that they will fulfil the request within that timescale. We need to be meticulous in our recording of all conversations, verbal, telephone, letters, memos. At the same time as being compassionate and understanding, we need to be clear and give a consistent message from all staff. We need to be clear that we will not tolerate any intimidating or abusive actions or behaviour.

NHS
Torbay and South Devon
NHS Foundation Trust

Appendix 10: MANAGING EXPECTATIONS (CHOICE) FOR HOSPITAL DISCHARGE FLOW CHART

Clearly document all discharge conversations in the patient notes, sign, name and date.

ON ADMISSION

Give patient "PATIENT INFORMATION ON ADMISSION" leaflet and discuss with patient +/ representative.
Set Estimated Date of Discharge (EDD).

ON ADMISSION

Give patient "PATIENT INFORMATION ON ADMISSION" leaflet and discuss with patient +/ representative.
Set Estimated Date of Discharge (EDD).

DISCUSS WITH PATIENT +/ REP

- Expectation that patient will accept interim arrangements, or make their own arrangements if home or service of choice is not available at time of discharge
- Remaining in hospital once medically fit/ safe to transfer is not an option.

ASSESS ONGOING NEEDS

If patient is likely to have ongoing health/ social care needs after discharge, MDT to complete referral clearly describing needs to be met.
Offer a Carers assessment if necessary.

Discuss process and potential options with patient +/ representative.

PREPARE FOR DISCHARGE

Patients should be reminded that:

'You do not have to move anywhere permanently that you do not wish, but, you are unable to wait here while waiting for your service of choice'

HDT to advise patient +/ representative & MDT about available suitable care providers at earliest appropriate stage.

STAGE 1- FORMAL MEETING 1 & FORMAL LETTER 1

If timely discharge plans have not been identified/ patient has declined suitable service, the ward manager/ deputy or senior therapist will invite the patient +/or representative to formal meeting 1 to discuss discharge plans.

If patient still declines offer give/send formal letter 1 to the patient +/or rep.
File a copy of the letter in the patient records and record in notes that the letter was hand delivered/ sent via Royal Mail and date.
If after formal meeting 1 discharge destination has not been agreed escalate to Matron.

STAGE 2- FORMAL MEETING 2 & FORMAL LETTER 2

If no agreement has been reached within 2 calendar days of formal meeting 1, the matron will meet with the patient +/ or representative for formal meeting 2.

This meeting is to discuss plans for transfer to an alternative available option or interim care whilst a permanent option is sought.

The Matron /HDT Lead/ Associate Director of Nursing and Professional Practice/ Associate Director of Operations will give/send formal letter 2 to the patient and/or representative at/after the meeting. A copy of the letter should be included in the patient notes.
The MDT will work with the patient and/or representative and will agree a discharge date as soon as appropriate following formal meeting 2.

STAGE 3- LEGAL PROCESS & FORMAL LETTER 3

The Associate Director of Nursing and Professional Practice/ Associate Director of Operations or appropriate representative will send formal letter 3 to notify the patient and / or representative that legal advice will be sought to facilitate discharge.

Consult local Trust advisors regarding legal proceedings.

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:	2473		
Document title:	Managing Expectations (Choice) and Managing Discharge of Patients from Hospital		
Purpose of document:	This policy and operational guidance defines how Torbay and South Devon System (Torbay & South Devon NHS Foundation Trust, NHS Devon Clinical Commissioning Group and Devon County Council adult social care department) will 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.		
Date of issue:	27 March 2020	**Next review date:**	27 March 2023
Version:	1	**Last review date:**	
Author:	Associate Director Nursing & Professional Practice		
Directorate:	Trustwide		
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 Associate Director of Nursing Medical Director Chief Nurse		
Date approved:	26 February 2020		
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:
27 March 2020	1	New	Care and Clinical Policies Group Associate Director of Nursing and Professional Practice Medical Director Chief Nurse

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.

NHS South Devon and Torbay Clinical Commissioning Group

NHS Torbay and South Devon NHS Foundation Trust

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

Policy Title (and number)	Managing Expectations (Choice) for Hospital Discharge	Version and Date	1 March 2020
Policy Author	Associate Director of Nursing and Professional Practice		

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

Consider any additional needs of carers/ parents/ advocates etc, in addition to the service user
[2] Travelers may not be registered with a GP - consider how they may access/ be aware of services available to them
[3] Consider any provisions for those with no fixed abode, particularly relating to impact on discharge
[4] Consider how someone will be aware of (or access) a service if socially or geographically isolated
[5] Language must be relevant and appropriate, for example referring to partners, not husbands or wives
[6] Consider both physical access to services and how information/ communication in available in an accessible format
[7] Example: a telephone-based service may discriminate against people who are d/Deaf. Whilst someone may be able to act on their behalf, this does not promote independence or autonomy

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.