

**1 October 2014****Agenda Item: 5****REPORT OF THE CLINICAL LEAD, RUSHCLIFFE CLINICAL  
COMMISSIONING GROUP****LEAVING HOSPITAL POLICY****Purpose of the Report**

1. To provide members with information about the Leaving Hospital policy being applied across the south of the County.

**Information and Advice**

2. The Leaving Hospital policy (see Appendix A) has been developed as a joint strategy between the NHS organisations and the local authorities across the south of the county, including the city. The purpose of the policy is to ensure that patients in an acute hospital, their families and carers, and members of the public are aware of the expectation that the patients will be required to leave hospital once they have been deemed medically fit for discharge.
3. At times, patients seek an extended stay in hospital whilst they are recovering from an illness or whilst their ongoing care and support is being arranged or if they are waiting for a place at a care home of their choice. However, it is widely recognised that an acute hospital is not the most appropriate place for patients once they have received the required treatment and are clinically medically fit for discharge. Evidence shows that patients have a higher level of success of recovery, and for regaining their independence, once they are out of hospital and in another setting such as a community hospital, nursing or residential care home or are back in their own home with the appropriate level of care and support from health and social care services.
4. Over the past few years emergency services, including acute hospitals, have experienced a significant increase in demand. Demographic pressures arising from an aging population and increasing numbers of people with complex health and care needs means that the demand for these services will continue to increase.
5. Within Nottingham University Hospitals, and particularly at QMC, there are a number of factors which, when combined, result in their having to operate at near-full capacity for long periods of time and experiencing difficulties in meeting the increased demand within existing resources. One of the areas of concern is the ability to move patients out of hospital once they are medically fit for discharge. Without timely discharges, a hospital is not able to maintain patient flow, which then impacts on its ability to meet its performance targets within its emergency department. South Nottinghamshire is under considerable

performance scrutiny from NHS England and the Trust Development Agency (TDA) due to the national 95% Early Discharge target (seen and discharged within 4 hours) being consistently missed.

6. In order to alleviate some of the pressures within the hospital, Nottingham West Clinical Commissioning Group (CCG), Nottingham North and East CCG and Rushcliffe CCG have made additional funding available to invest in some interim care provision, both in terms of short term placements within care homes for up to two weeks at a time, and in additional home care services which are being provided by Crossroads. The services are accessed for elderly patients where they are deemed medically fit for discharge but are in need of further care and support to enable them to recover. The services are also being provided for patients who are awaiting the availability of a long term placement in a care home of their choice. This is enabling the timely discharge of a number of frail elderly people who would otherwise remain in an inpatient bed unnecessarily.
7. The aim of the South Nottinghamshire Leaving Hospital policy is to reduce the length of stay of patients where they are ready to be discharged from hospital. The policy will provide clear information for patients and their families and carers in relation to their hospital stay. They will be provided with information about the timely discharge from acute care to community care, including the availability of alternative or interim care where required, whilst they wait for their care package to be set up or whilst they wait for a care home of their choice if not immediately available. The individuals will have their needs met in an appropriate community setting in which care is focussed on supporting people to regain their independence and to return home wherever possible. The impact will be to improve the health and social care outcomes for individuals once they are medically fit for discharge from acute care.
8. Effective communication is central to the success of managing choice on hospital discharge and is being supported by the whole health and social care community. Regular communication across health and social care services in the form of leaflets, posters and verbal communication will reinforce the message that once patients are clinically ready for discharge they will not be able to continue to occupy an inpatient bed. If they require further care, they will be moved to an alternative community setting where their care needs can most appropriately be met. A communication strategy will be initiated by all partner agencies to reduce the potential for misunderstanding or failure to adhere to this policy and to ensure it is implemented effectively and fairly.

## **Statutory and Policy Implications**

9. This report has been compiled after consideration of implications in respect of crime and disorder, finance, human resources, human rights, the NHS Constitution (Public Health only), the public sector equality duty, safeguarding of children and vulnerable adults, service users, sustainability and the environment and ways of working and where such implications are material they are described below. Appropriate consultation has been undertaken and advice sought on these issues as required.

## **RECOMMENDATION/S**

- 1) That members note the report.

**Dr Jeremy Griffiths**  
**Clinical Lead, Rushcliffe Clinical Commissioning Group**

**For any enquiries about this report please contact:**

Nicola Lane, Public Health Manager. Tel: 0115 977 2130. Email: nicola.lane@nottsgov.uk

### **Constitutional Comments**

10. This report is for noting only.

### **Financial Comments**

11. There are no financial implications contained within the report.

### **Background Papers and Published Documents**

Except for previously published documents, which will be available elsewhere, the documents listed here will be available for inspection in accordance with Section 100D of the Local Government Act 1972.

- None

### **Electoral Divisions and Members Affected**

- All



**SOUTH NOTTINGHAMSHIRE HEALTH AND SOCIAL CARE COMMUNITY**

**LEAVING HOSPITAL DIRECTIVE POLICY & GUIDANCE**

**1. BACKGROUND**

Most people return home after a period of acute care, some after a period of intermediate care. Increasingly, in line with the policy of supporting independent living, those who are immediately unable to return to their previous place of residence are offered more appropriate extra care housing or other provision.

The South Nottinghamshire health and social care community is working together to develop a model of 'transfer to assess'. The objective of this is to ensure that patients who are having a supported transfer of care from the hospital move within 24 hours of being medically safe for transfer to a suitable environment for them to receive further assessment of their long term needs.

Where a place is not available in the individual's preferred residential or nursing care home or there is a wait whilst packages that will support the citizen from returning home are put in place, remaining in an acute hospital setting is undesirable both for the patient and for other patients trying to access care within that hospital. There are particular risks of increasing dependency and acquiring infections. In addition the acute care provision is needed for those with acute care needs.

This policy is needed to support the timely, effective transfer of care of medically fit patients, ready for discharge from an NHS inpatient setting who need to move into a care home. It is to be used in conjunction with the Hospital Discharge Policy and is for use by all staff with responsibility for arranging the transfer of care for patients. It is based on direction given by the Department of Health in the document, 'Discharge from Hospital: Pathway, process and practice (2003) and 'NHS Responsibility for meeting Continuing Health Care Needs' (HSG (95)5)

**2. AIM AND OBJECTIVES**

The aim of this policy is to reduce the length of time a patient waits in an acute hospital bed whilst waiting to be transferred to a care home of choice. In particular the policy aims to

- a) Be patient centred, aiming to improve the welfare of the patient and minimise frustration and distress.
- b) prevent the development of expectation that a person may stay in the hospital indefinitely
- c) offer guidance to staff who have responsibility in arranging the transfer of care from hospital of those patients who need to move to a care home
- d) ensure that there is a clear escalation process in place for when patients remain in hospital longer than is clinically required
- e) ensure NUH inpatient beds will be used appropriately and efficiently for those who require that service.

### **3. PATIENT GROUP**

The policy needs to apply to patients who meet the following criteria:

1. The patients' needs cannot be adequately provided for in their usual place of residence
2. The agreed initial assessment shows that the patient can be discharged from hospital, requires a nursing home or residential care home (and this placement will be funded by either a patient, Adult Social Services or the NHS) or requires care at home, but is waiting for the package to be ready
3. The patient has identified a preferred home, or is having difficulty in identifying one.
4. The patient is unwilling to be discharged until a preferred placement is available
5. An interim, or alternative long term placement exists which meets the patients assessed needs.

### **4. UNDERLYING PRINCIPLES / STANDARDS**

- All patients should be treated fairly and without discrimination
- Patients, relatives and carers should be fully involved from the beginning in the discharge planning process which should be initiated when the patient is admitted to hospital. This adheres to the Hospital Discharge Policy.
- If the patient is unable to contribute to the assessment the wishes and views of their relatives and carers must be sought.
- The patient, their relatives, carers or advocate should be informed at the outset of planning that while every effort will be made to transfer the patient to the home of choice, if the home has no vacancy an interim arrangement will need to be made.
- Patients would only be expected to make one move before entering the care home of their choice
- If the patient is awaiting a care home, the patients name will remain on the list for their preferred choice whilst they are discharged to an alternative or interim location.

### **5. MANAGING CHOICE**

#### **5.1 Communication to patients**

Communication is central to the policy for managing choice on hospital discharge. This policy should be supported by the whole health and social care community – ensuring regular communication across the system (through posters, leaflets etc.) to reinforce the message that once patients are clinically ready for transfer they cannot continue to occupy an inpatient bed.

Interactions with patients and or representatives will need to acknowledge and offer support with any concerns, whilst reinforcing the message that everyone will work towards the patients discharge from hospital. At the time of admission, all patients must understand that once they are clinically ready for transfer of care they cannot continue to occupy the inpatient bed. See Appendix 1 and 2. All patients must understand that they will be supported by a social worker and given relevant information to help them choose an interim placement (where a choice is available) until a vacancy becomes available in the home of their choice.

#### **5.2 Support for patients who lack capacity to make decisions**

If the patient has been assessed as lacking capacity to make decisions around their transfer of care and is unable to contribute to the assessment, a best interests decision must be made. Under the Mental Capacity Act, s4(7), the decision maker has a duty to take into account the views of significant others where it is practical and appropriate to do so (see paragraph 5.49 of Mental Capacity Act Code of Practice (p84) for who should be consulted when working out someone's best interests).

It is essential that staff determine at admission whether the patient has, an Advance Decision to Refuse Treatment (ADRT), statement of wishes and feelings, a Lasting Power of Attorney for Health and Welfare or Property and Affairs or is under a Safeguarding protection plan and the contact details of those persons who manage any of these instruments.

In circumstances where a patient lacks capacity and has no 'significant other' able to contribute to a Best Interests decision, then an Independent Mental Capacity Advocate (IMCA) must be appointed if the decision for transfer of care necessitates a change in the venue of care from that pertaining at admission and is likely to be effective for a period longer than 28 days (Mental Capacity Act 2005; MCA Code of Practice, Chapter 10).

### **5.3 Escalation process**

When the Multi-disciplinary team is certain the key principles have been met, that the patient's eligibility for Continuing Healthcare has not altered and that the patient or their relative/carer/advocate on the patient's behalf refuses to leave hospital to an address other than the care home of choice then the following escalation process must begin.

- Responsible Consultant to meet with patient, family and MDT to advise that the patient no longer requires an Acute Care NHS bed and that an alternative arrangement must be made.

The following points should be confirmed:

- The patient no longer requires the services of an acute hospital and that the MDT decision is to transfer their care
- The inadvisability of remaining in hospital for the patient (i.e. that the acute hospital environment is no longer of benefit)
- Ensure that all necessary information and support is available to the patient and all involved in the selection of appropriate venues of further care.
- Confirm with the Social Worker or advocate that an appropriate placement which is able to meet the person's care needs is available within the area.
- Explain to the patient and carers that a further period of up to seven days from the date of the meeting is available in which to find an appropriate venue for further care.

If, after a further 5 days there are no indications that transfer of care is imminent, the Ward Manager should inform the responsible provider Head of Service.

- The Head of Service should convene the Final Review Meeting and invite the patient, family or advocate attending in order to mandate and action the transfer of care plans. This should be confirmed in writing and posted by recorded first class delivery.
- This meeting should take place within 2 working days of the expiry of the extended period (maximum 2 weeks from completion of assessments).

- The Hospital Adult Services Team Manager (if Social Services are involved) should be invited to attend. It is recommended that a 'minute taker' be appointed.
- If it becomes apparent at this meeting the patient/relative/advocate, do not intend finding a placement immediately, it should be advised that the Trust may instigate legal proceedings to ensure that the patient is transferred to an appropriate placement.
- The details of this meeting must be sent to all attendees including the responsible Consultant, relative/carer/advocate, Trust Legal team, Executive Directors

If there is no agreement to a placement within this meeting, then a meeting should be convened to discuss, assess risk and plan the patients transfer to a care facility which meets their assessed need, where necessary taking legal action to ensure this happens.

Attendees should include Head of Service, Director of Operations, General Manager or Clinical Lead, Adult Services Team Manager and NUH Legal Services Officer.

## **6. MEETING THE COSTS**

For self- funding patients who are waiting for a care home of choice, they will not be required to pay for an interim placement for a maximum of 2 weeks.

Where the cost of interim accommodation is higher than the usual cost paid by Social Services due to a shortage of care homes, market conditions or other commissioning difficulties the person and/or third parties should not be asked to pay more towards their accommodation than s/he would normally be expected to contribute.

## **7. MONITORING AND REVIEW**

This policy will be monitored by an on-going programme of weekly audit of the delayed discharges reported by the ward staff as being delayed due to 'awaiting placement in care home' or 'patient or family choice' by the Care Co-ordination team manager.