LEAVING HOSPITAL POLICY

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Prepared by:

- NHS Dorset Clinical Commissioning Group
- Dorset HealthCare University NHS Foundation Trust
- Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust
- Bournemouth, Christchurch and Poole Council
- Poole Hospital NHS Foundation Trust
- Dorset County Hospital NHS Foundation Trust
- Dorset Council
- Dorset Clinical Commissioning Group

REVIEW, REVISION

This policy will be reviewed November 2022 by the Dorset System Resilience Group (or suitable alternative).

CONSULTATION AND APPROVAL PROCESS

This policy was developed locally by a collaboration of partners with input from people working across the system, both locally and nationally.

This policy was signed off by the members of the Urgent Emergency Care Board the membership of which consists of Executives from all Health and Social Care organisations in Dorset.

MONITORING COMPLIANCE AND EFFECTIVENESS

Monitoring will take place in accordance with the framework set out in Appendix 5.

Local monitoring (at each acute hospital and community hospital) will include an audit of:

- Information provided to patients
- Patients' understanding of the information received (Appendix 2, step 2)
- Staff training
- Case study review of a sample of patients who exceed 21 day length of stay, and the application of this policy

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1. OVERALL SUMMARY

Background

1.1 The overarching aim of the policy is to ensure timely discharge of patients leaving hospital, through early engagement, support and the implementation of a fair and transparent escalation process.

1.2 This policy supports timely, effective discharge from any inpatient/community hospital setting, to an appropriate setting to meet a patient's ongoing needs . It is relevant to all adult inpatients (over the age of 18) in Dorset NHS hospitals who are required to return home or to an alternative setting with or without community support.

1.4 This policy applies equally to all patients who are assessed as ready to leave hospital whether they need ongoing NHS or social care and irrespective of who may be funding the care. This includes patients who are responsible for funding their own care.

1.5 For the purposes of this policy the term 'patient' is used to refer to the individual receiving treatment, but where they lack capacity for discharge planning may include their carer or appointed representative (such as a Lasting Power of Attorney or Deputy).

1.6 Early patient participation, engagement and communication are central to the process to enable the patient to leave hospital in a safe and timely manner.

1.7 This policy is in line with current NHS policy and best gractice guidance and supports existing guidance on effective discharge.

1.8 The changes brought about by the implementation of the Care Act 2014, are reflected in this policy.

2. PURPOSE

2.1 The purpose of this policy is to ensure that choice is managed 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 effectively for those people who require inpatient treatment and that a clear process is in place for when patients remain in hospital longer than is clinically required.

- NHS inpatient beds across Dorset will be used appropriately and efficiently for those people who require treatment within that service.
- There must be no lack of clarity about the need to accept an alternative care provider and/or location that is able to meet the patients assessed need at the point of being ready to leave hospital
- Planning for effective transfer of care, in collaboration with the patient, their representatives and all MDT members will commence at or before admission, e.g. prior to elective procedures.

- Where a patient is unable to express a preference and has nobody who can reliably represent their views, an advocate will be consulted on their behalf.

2.3 When the patient lacks capacity to make decisions about discharge from hospital then the application of the policy should be adapted as detailed in Appendix 1, following the Mental Capacity Act 2005.

2.4 If a patient has been assessed as ready to leave hospital it is not appropriate or desirable that they remain in hospital due to the negative impact this can have on their physical and mental health outcomes.

3. PRINCIPLES

3.1 Where it is the patient's preference and where appropriate, all possible efforts should be made to support people to return to their pre-admission location.

3.2 People should be provided with information, advice and support in a form that is accessible to them as early as possible before or on admission and throughout their stay.

3.3 Many patients will want to involve others to support them, such as family or friends or carers. 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.

3.4 If a patient is not willing to accept any of the available, appropriate alternatives, then it may be that they are discharged, after being advised of the risks and consequences of doing so.

3.5 Patients do not have the right to remain in hospital longer than clinically required.

4. MANAGING EXPECTATIONS OF PATIENTS

4.1 By the time the patient is clinically ready for transfer of care they and/or their representative should understand that they cannot continue to occupy the inpatient bed.

4.2 The Multi-Disciplinary Team (MDT) will work jointly to offer advice and support to the patient and/or representative and to involve them as appropriate to support leaving hospital. The MDT will maintain communication with patients and/or their representatives to manage expectations. It is important that the patient and/or their representative understand discharge planning.

5. FUNDING ARRANGEMENTS

5.1 This policy applies equally to all people regardless of funding arrangements and the nature of their ongoing care.

5.2 Those responsible for funding their own care will be offered the same level of advice, guidance and assistance regarding choice as those fully or partly funded by their local authority or the NHS.

6. CHOICE OF AVAILABLE CARE OPTIONS AND INTERIM CARE

6.1 A discharge plan should accommodate patient choice where possible and recognise the patient's autonomy to choose from available care options.

6.2 If a care option is identified that can adequately meet the patient's assessed care and support needs, transfer to this available option would be expected without delay.

6.3 The patient and/or representative will be given information about what would be involved if the patient requires community support.

6.4 Refusal to make a decision about available options or refusal to accept a single available temporary option, that meets the assessed need, must not lead to the patient remaining in the hospital.

6.5 It may be necessary for the hospital, in consultation with the funding authority to implement discharge to an alternative or interim location.

7. DISCHARGE PLANNING

7.1 The MDT will follow the Trusts' Discharge Policy to take a proactive approach in supporting patients to leave hospital.

7.2 The MDT will apply the key principles of the Mental Capacity Act 2005 when planning discharge wilth patients and/or representatives (see Appendix1).

7.3 Whilst the patient is still undergoing hospital treatment, the discharge plan will include establishing care needs after discharge in consultation with the funding authority and community services.

7.4 With elective admissions, discharge planning should start prior to admission but with unplanned admissions a collaborative discharge plan will start as soon as possible after admission.

8. ESCALATION PROCESS

8.1 Where the patient is ready to leave hospital and the patient or their representative is refusing, the escalation process (outlined in Appendix 2) will be implemented.

9. FINAL NOTIFICATION TO LEAVE HOSPITAL

9.1 If a patient refuses to leave hospital following all attempts to facilitate a discharge and has:-

- completed medical treatment
- received prior notification of the date for discharge
- a plan for safe discharge

the hospital should act in accordance with the Criminal Justice Act 2008, sections 119-120.

9.2 In all instances, this process should be led by a senior manager from the hospital

9.3 On issuing the Final Notiification to Leave Hospital Letter (Appendix 3), a summary of the discussion from the previous meeting with the patient or representative must be attached.

APPENDIX 1: HOSPITAL DISCHARGE AND MENTAL CAPACITY ISSUES

All staff are required to be familiar with and follow the Mental Capacity Act 2005 (the Act) together with the associated Code of Practice (the Code) which relate to adults aged 16 and over.

The Statutory Principles (Section 1 of the Act & Chapter 1 of the Code)

Staff must have regard, in particular to the five Statutory Principles of the Act as follows:

1. A person must be assumed to have capacity unless it is established that they lack capacity
2. A person is not to be treated as unable to make a decision unless all practicable steps to help him to do so have been taken without success
3. A person is not to be treated as unable to make a decision merely because he makes an unwise decision
4. An act done, or decision made, under the Act for or on behalf of a person who lacks capacity must be done, or made, in his best interests
5. Before the act is done, or the decision is made, regard must be had to whether the purpose for which it is needed can be as effectively achieved in a way that is less restrictive of the person's rights and freedom of action.

Assessing an individual's ability to make a decision (Section 3 of the Act & Chapter 4 of the Code)

A person lacks capacity in relation to a matter if at the material time he is unable to make a decision due to an impairment of, or disturbance in the functioning of the mind or brain (permanent or temporary).

An individual lacks capacity in relation to a decision if he is unable to

a) understand the information relevant to the decision *or*
b) retain that information *or*
c) use or weigh that information as part of the decision-making process *or*
d) communicate the decision

All practicable steps must be taken to help the patient make the decision themselves. Please refer to Chapter 3 of the Code for practical guidance on how to support people to make decisions for themselves and/or play as big a role as possible in decision-making.

Where the patient is assessed not to have the mental capacity to make the decision in question, the decision must be made in their best interests.

Best Interests (Section 4 of the Act & Chapter 5 of the Code)

All relevant circumstances must be considered, including whether the patient might regain capacity.

The individual must be encouraged to participate as fully as possible in any decision affecting him.

The individual's own past or present wishes and feelings, beliefs and values must be taken into account. Certain prescribed people must also be consulted (set out at section 4(7) of the Act).

A determination of what is in a person's best interests must not be made solely on the basis of a person's age, appearance, condition or aspects of behaviour that might lead to unjustified assumptions.

Deprivations of Liberty Safeguards (DOLS)

A deprivation of liberty will occur where the individual is under continuous supervision and control and is not free to leave.

Where the discharge of a patient without mental capacity potentially involves a deprivation of liberty, the appropriate authorisations must be sought.

Independent Mental Capacity Advocate (IMCA)

An "un-befriended" individual without mental capacity who is facing a long-term change in accommodation or a potential deprivation of liberty is entitled to the services of an IMCA.

APPENDIX 2: LEAVING HOSPITAL PROCESS

Provide standard information and support in line with SAFER

1

- SAFER CARE BUNDLE:
- **S - Senior** Review. All patients will have a senior review before midday by a clinician able to make management and discharge decisions.
- **A – All** patients will have an **Expected Discharge Date and Clinical Criteria for Discharge**. This is set assuming ideal recovery and assuming no unnecessary waiting.
- **F - Flow of patients** will commence at the earliest opportunity from assessment units to inpatient wards. Wards that routinely receive patients from assessment units will ensure the first patient arrives on the ward by 10am.
- **E – Early discharge. 33%** of patients will be discharged from base inpatient wards before midday.
- **R – Review**. A systematic MDT review of patients with extended lengths of stay (> 7 days – 'stranded patients') with a clear 'home first' mind set.

- Commence discharge planning on admission
- Continue discharge planning discussion at daily MDT meetings
- Determine if patient has mental capacity
- Inform patient who will be the main contact in respect of discharge planning on the ward
- Provide patient with Leaving Hospital Leaflet and support to understand the information
- Refer to support services and advocacy if required
- Set out an expectation in respect of date of discharge

Assess needs and prepare for discharge

2

- The patient should be able to answer:
- What is wrong with me?
- What is going to happen now, later today and tomorrow to get me sorted out?
- What things do I need to be able to do to get home?
- How will I contribute to discussions and plans about what needs to happen in order for me to get home?
- When should I expect to be going home, assuming that my recovery is on track?

- Liaise with health and care services to arrange to have their needs assessed for discharge when medically stable
- Discuss available and appropriate options with patient/ representatives. It is important to establish what families and their communities can do to support a patients discharge in the first instance before formal care services are considered.
- Explain the MDT decision-making process with patient/ NOK or Carer, offer the opportunity for a meeting if further clarification is required
- If the patient/representatives have a reason why the proposed care option does not reasonably meet their needs, a rationale must be provided. The MDT must consider and establish whether the option is suitable in meeting the assessed need.
- If there are ongoing disagreements about discharge plans that are proving difficult to resolve a family/MDT meeting should be arranged
- Ensure assessments to clarify care needs and carers' needs are completed.

Available care declined proceed to formal process

3

- If options offered are declined then a formal meeting should be arranged
- If no agreement has been reached regarding discharge, and/or transfer arrangements after stages 1-2 then the ward should implement the trusts escalation process as outlined in the Discharge Procedure/ Policy.
- The MDT continue to work with the patient/ representatives to try and arrange an appropriate means of meeting the patient's care needs at point of discharge
- Support the patient to reconsider, respond to concerns and offer advice, support and encouragement
- Clarify rationale for transfer to alternative or interim option
- A senior manager supports the MDT to facilitate a solution and/ or informs the patient/ representatives of the trusts intention to discharge the patient in line with the Pan Dorset Leaving Hospital Policy. The Leaving Hospital leaflet will be reissued and an explanation given
- A formal letter is sent outlining the legal process for leavng hospital

APPENDIX 3: FINAL NOTIFICATION TO LEAVE HOSPITAL

Our reference:
To:

Date:

Dear <Name>

FINAL NOTIFICATION TO LEAVE HOSPITAL

Your date to leave hospital is: xxxxxxxxx

The hospital has offered you all necessary support and guidance to enable your safe and appropriate discharge.

You have been informed of your responsibility to finalise other arrangements if you would prefer not to accept what has been proposed.

We have now reached the stage where you are required to leave hospital.

Should you remain in hospital after the date above, the Trust will take legal action to facilitate discharge and may seek to recover its legal costs for doing so from you.

[enc. summary of formal meeting]

APPENDIX 4: PATIENT LEAFLET (UNFORMATTED)

This leaflet is intended to help you, your family or representative understand how we will support you to leave hospital (also known as discharge from hospital).

Preparing to leave hospital (you may be returning home or moving on to other care settings)

It is important we start talking about leaving hospital soon after your admission. This is so we can see if you need any additional help or if you may need to consider alternative care and support. The team of doctors, nurses and therapists can work with you, and those who support or represent you, to work through the possible different options for you.

It is important to understand that **you will only be able to stay in this hospital for the time needed** to complete your course of acute treatment and care.

Your expected date of discharge is the date you are well enough to leave hospital and your hospital treatment will have been completed.

It is important that you only stay in the acute hospital for as long as clinically necessary. There is research that states **staying in an acute hospital for longer than necessary may be detrimental** to your long term health and wellbeing.

Being at home or in an alternative community setting may be the best place to continue recovery or receive ongoing treatment once an illness requiring hospital care is over.

You may wish for family, friends or representatives to help support you in getting ready to leave hospital. This may include attending meetings in the hospital with your consent. If the person is absent or unable to be involved, you may wish to arrange for somebody else who can help support you with your plans to leave hospital.

Our commitment to you…..

The team of clinicians looking after you will:-

- involve you in all the decisions about your care and treatment
- aim to tell you your date for leaving hospital within 48 hours of admission
- give you the information and support to make the best decisions to help with your return home. This may include helping you to understand your care needs, the process of assessing your needs and the options available to you. The process of assessment should always take place away from the acute hospital setting. The team looking after you will explain how this can happen.

You should always ask staff to explain to you:

- what is the medical problem you have
- what the plan is to investigate or treat your condition
- what options are available to you
- what impact your care and treatment may have on you, including any ongoing plan for when you leave hospital
- any follow up care, what this is, who will provide this and where it will happen

What is important for you to consider?:

- What family or support do you have to help you leave hospital, what can they help with?
- If you had paid for care before you came into hospital, this may need to be restarted
- What support can you call upon to help transport you home? Who will transport you home?
- Who can check you're okay once your home, if needed?
- Do you have food and drink for when you get home? Who can help you with this?
- Do you have your keys for your home? Who can let you in if you don't?
- You need to make sure you have all you belongings and medication before you leave.

It is important that you ask the staff looking after you if you have any worries or concerns about any of these things. They can help you sort some of these issues out if needed.

Your GP and, if necessary, the community team such as nurses and therapists, will be sent information with details of the treatment you have received during your stay in hospital, including any changes to medication.

Making Decisions

If you are unable to make decisions about leaving hospital or ongoing care and support (if you lack capacity to do this), and you have appointed a Lasting Power of Attorney, they can help you make the decisions or can make the decisions for you.

If you do not have a Lasting Power of Attorney, then any decision will be made in your best interests and hospital staff or social work staff will need to consult with people who know you well, such as family, friends or carers, to make the decision.

If you do not have family or friends to consult, then the hospital will ask for an Independent Mental Capacity Advocate to be appointed to help establish and represent your views where at all possible.

What if I am unable to return home?

Most people who have been unwell and in hospital will be able to return home; however, some people may require further care after their hospital stay which may be provided in different settings in the community.

If you are not able to return home, an alternative or temporary setting will be identified that can adequately meet your assessed care, housing and support needs. You may receive a choice of options, but this may not be possible in all instances, particularly for temporary arrangements.

We will require you to **make a decision as soon as possible** to allow all necessary arrangements to be made and avoid you staying in hospital longer than you need to.

Transferring to a temporary or alternative setting will enable you to continue your recovery in more peaceful settings with privacy and dignity.

If you are leaving hospital to continue treatment, rehabilitation and assessment, you will receive support from a range of services in the community. This will be discussed with you as part of your plan for leaving hospital.

You have the right to complain at any point of the process if you are not happy with the information and support provided, or with the options being made available to you. A member of the hospital will be able to advise you on how you can complain and your local Healthwatch (0300 111 0102) organisation can also help.

Ward: ……. …….Phone Number……..

Consultant:……..

Ward Sister:……

Expected Date of Discharge:……

An easy-read version of this leaflet is available.

Appendix 5: Audit – Leaving Hospital Policy (2019) – being tested (November/December 2019)

<table>
<tr><td>Aim:</td><td>1. To reduce length of stay by enabling patients to leave hospital as the earliest possible opportunity
2. To ensure that information is provided at the earliest point, from admission, to manage patient and family expectations</td></tr>
<tr><td>Objectives:</td><td>1. Patients receive and understand key information provided to them to help with planning their discharge
2. Planning for discharge begins on admission with the patient/family representative.
3. Patients are well-informed of plans and Multi-disciplinary teams are able to address concerns and issues as early as possible.
4. To contribute towards a reduced length of stay for super-stranded patients</td></tr>
<tr><td>Standards:</td><td>
<table>
<tr><th>Criteria</th><th>Lead</th><th>Target</th><th>Audit Frequency</th><th>Source of Evidence</th></tr>
<tr><td>All patients are given the Leaving Hospital leaflet within 48 hours of admission</td><td>Ward Manager</td><td>100% for all stranded patients (LoS >7 days)</td><td>All adult inpatient wards, every 3 months

Audit sample: min 20% of inpatients on selected day</td><td>Paper/electronic patient record</td></tr>
<tr><td>All patients are well informed of their plan for discharge and are able to answer:-
1. What is the medical problem you have
2. What the plan is to investigate or treat your condition
3. What options are available to you
4. What impact your care and treatment may have on you, including any ongoing plan for when you leave hospital
5. Any follow up care, what this is, who will provide this and where it will happen</td><td>Ward Manager/Clinical Lead/Department Manager</td><td>90% of stranded patients (LoS of >7 days) are able to provide evidence for each</td><td>All adult inpatient wards, every 3 months

Audit sample: min 20% of inpatients on selected day</td><td>Inpatient survey, paper/ electronic patient record (including minutes of meetings)</td></tr>
<tr><td>Clinicians have undertaken appropriate training to support implementation of the Leaving Hospital policy</td><td>Ward Manager/Clinical Lead/Department Manager</td><td>100% adult inpatient multidisciplinary teams, hospital social care link workers, in-reach workers</td><td>Annually</td><td>Attendance sheets, training records</td></tr>
<tr><td>Retrospective review of patients to audit application of the Leaving Hospital policy (selected patients with a Length of stay of 21 days+)</td><td>Ward Manager/Clinical Lead/Department Manager</td><td>100% patients audited demonstrate evidence of leaving hospital policy</td><td>20% of patients exceeding 21 day length of stay, every 3 months</td><td>MDT case study of patients, paper/ electronic patient record</td></tr>
</table>
</td></tr>
<tr><td>Performance:</td><td>To achieve the target levels set out in ‘Standards’.
Balancing measures are to contribute towards the:-
• reduction in patients with a length of stay of 21 days+ (Long Length of Stay Patient Tracking List)
• reduction in the average length of stay attributed to patients who have been in hospital for 21+ days (Super-Stranded Patient Ambition)
• improvement in friends and family feedback</td></tr>
<tr><td>Review:</td><td>Through Trust Clinical Governance Groups, reporting through to system-wide Long Length of Stay Delivery Group (or equivalent)</td></tr>
</table>