Patient Choice Policy

For use:	Colchester Hospital Anglian Community Enterprise Essex County Council North East Essex Clinical Commissioning Group
For use by:	All staff involved in discharge plans for patients
For use for:	This policy defines the process North East Essex Health and Adult social care organisations will follow to manage choice throughout a person's inpatient stay with regard to discharge planning, particularly at the point they no longer require inpatient care.
Document owner:	Direction of Choice policy adapted to meet multiagency requirements by representatives from: • Colchester Hospital (CHUFT) • Adult Social Care (ECC) • Anglian Community Enterprise (ACE) • North East Essex Clinical Commissioning Group (NEECCG)
Approval Committee	Colchester Hospital NHS Foundation Trust Executive Team Essex County Council Adult Social Care Legal Team ACE Management Executive Committee North East Essex Clinical Commissioning Group Adopted by A&E delivery Board
Status: (date approved)	November 2017

Contents

1. POLICY STATEMENT

This policy defines the process North Essex and local authority adult social care departments will follow to manage choice throughout a person's inpatient stay with regard to discharge planning, particularly at the point they no longer require inpatient care.

The overarching aim is to reduce delayed transfer of care, through early engagement, support and the implementation of a fair and transparent escalation process.

Introduction

Patients should only remain in hospital when there is a clinical need for them to be there. This policy supports people's timely, effective discharge from an NHS inpatient setting, to a setting which meets their diverse needs and is their preferred choice amongst available options. It applies to all adult inpatients in Colchester Hospital University NHS Foundation Trust and Anglian Community Enterprise (ACE) settings, and needs to be utilised before and during admission to ensure that those who are assessed as medically safe for discharge can leave hospital in a safe and timely way.

This policy supports existing law and guidance on effective discharge, such as the 2015 NICE guidance 'Transition between inpatient hospital settings and community or care home settings for adults with social care needs, the Care Act 2014 and the Care and Support Statutory Guidance (Dept of Health, 2017) and is based on existing good practice.

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

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

In the event that a person who, for whatever reason, fails to leave hospital when they are ready to do so, we will work together in line with our respective statutory frameworks, wider legal obligations, and relevant NICE guidelines, to ensure discharge is achieved. All system partners will work together to support the hospitals and patients to achieve timely discharge ensuring all options are exhausted prior to discharge or eviction of patient by the hospitals if necessary. It applies to all adult inpatients in NHS settings operated by the parties adopting this policy from the point of admission to the point of discharge, or eviction.

Purpose of policy

The purpose of this policy is to ensure that discharge is managed appropriately and consistently throughout the discharge planning process, with all parties clear about their respective roles and responsibilities

This guidance supporting this policy sets out a framework to be operated by all parties to this policy to ensure that NHS inpatient beds will be used appropriately and efficiently, the relevant guidance and statutory frameworks are applied, and that a clear process is in place to ensure that no one remains in hospital unless they have a clinical need to be there.

Scope of the policy

This policy applies equally to people regardless of the funding arrangements for and the nature of any ongoing care.

Those self-funding care will be offered the same level of advice, guidance and assistance to make a choice about their future care and support as those fully or partly funded by their local authority or NHS Continuing Healthcare (CHC), although it is likely that some of the content of that advice will need to differ.

2. PRINCIPLES, ROLES AND RESPONSIBILITIES

SUPPORTING PEOPLE TO MAKE DECISIONS

Patients will be;

a) provided with information advice and guidance to ensure that they are fully informed about what they can expect both during their stay in hospital and at the point of discharge;
b) supported, as appropriate, to make decisions about their future care; made aware that they cannot remain in hospital longer than there is a clinical need for them to be there;
c) Informed that if they fail to leave hospital when clinically ready to do so and, where applicable, have refused an offer of social care support, the hospital will take any necessary action to ensure they are discharged.

Role of the Social Care Authority staff

It is the responsibility of the social care authority staff to ensure that in accordance with the Care Act 2014, the Care and Support (Discharge of Hospital Patients) Regulations 2014 and Annex G, of the Care and Support Guidance, they have assessed a person's care and support needs ('needs assessment') and made an offer to meet those needs which have been assessed as eligible.

Refusal of an offer of support from the Social Care Authority

Where an offer to meet the assessed eligible needs has been offered and that offer has been refused by the patient or patient's representative, the social care authority staff will inform the hospital for them to take action in line with their own policy and procedure to ensure discharge. Appendices include a template letter to be issued by Essex Social Care staff in the event of patient refusal of care.

Role of the Clinical Commissioning Group

The CCG is responsible for the commissioning of services for patients to meet their needs in and outside of the acute hospital setting including community services and mental health services. The CCG provides overarching support to facilitate complex discharge, ensuring that where a patient is ready to leave the acute hospital, that all relevant statutory agencies have been involved in line with relevant national guidance. In addition, along with NHS England, to ensure that appropriate primary care services are available to the patient.
It is also responsible for considering whether a patient is eligible for Continuing Healthcare ('CHC')

Role of the hospital

The acute hospital is wholly responsible for the care and support of the adult from the point of admission to the point of discharge, and, is responsible, in line with relevant legislation and national guidance, for ensuring the adult is discharged from hospital at the point at which there is no clinical need for them to be there, subject to the Care and Support (Discharge of Hospital Patients) Regulations 2014 and supporting statutory guidance set out in Annex G of the Care and Support Guidance (see link in section 5, evidence base). Appendices include a template letter regarding eviction of patients following exhaustion of all options by appropriate system partners.

Colchester Hospital staff

Chief Executive Officer
The Chief Executive is the Accountable Officer and as such has overall accountability and responsibility for ensuring safe and effective systems are in place for patient discharge and that staff are fully informed and skilled to carry out their responsibilities

Director of Operations
The Director of Operations has accountability for the effective and appropriate management of patient discharge arrangements that follows the clinical decision to discharge

Medical Consultants
The Medical Consultant has overall responsibility for ensuring that the patient is medically fit for discharge. It is the responsibly of the doctor to specify when a patient is medically fit for discharge and this will be documented in the medical notes. The actual date of discharge will depend on this and other factors as determined by the Multidisciplinary Team. When confirmed, the actual date of discharge will be clearly documented in the patient's notes and

on the Discharge Planning Documentation. This will be used in conjunction with this policy

MDT (Multi-Disciplinary Team)
The multi-disciplinary team on the ward is responsible for planning and implementing timely and appropriate referrals to other professionals, taking into account the predicted date of discharge and recognising relevant requirements **in advance** of the process e.g. agreeing the patient is ready for transfer and that this is recorded in the medical notes as "Health Complete". This is statutory requirement under the Community Care (Delayed Discharges) Act 2003. This team will communicate and support the patient and family in following this Policy supporting them to make the transition out of hospital.

Matrons
The appropriate Matron responsible for the ward will ensure that

- Ward staff and the MDT are proactively planning discharge with all patients by undertaking all necessary procedures; updating patients and families and reporting progress on a daily basis to the site office.
- Conversations with families around the Direction of Choice policy
- Choice letters are provided, where relevant, to support the Health and Social Care Team.
- They manage any situation that could lead to non-compliance with this policy and if appropriate escalate any concerns

Sisters/Ward Managers
Sisters/ward managers are responsible for proactive discharge planning on admission and ensuring that

- The patient and /or carer receive Standard discharge information on admission
- The patient and /or carer receive daily updates on their care and treatment and planned date of discharge,
- The discharge hub team are updated on developments promptly
- Patients are discharged when medically fit for discharge, preferably in the morning
- Any delays, or concerns are escalated to the matrons and site team.

Integrated Discharge Team Manager
Is responsible for overall management of Complex discharges and the Integrated Discharge Team. They will

- Review each patient daily and update on progress
- Maintain a record of progress and be the point of contact for all DTOC activity

Role of Anglian Community Enterprise

Managing Director
The Managing Director is the Accountable Officer and as such has overall accountability and responsibility for ensuring safe and effective systems are in

place for patient discharge and that staff are fully informed and skilled to carry out their responsibilities

MDT (Multi-Disciplinary Team)
The multi-disciplinary team on the ward is responsible for planning and implementing timely and appropriate referrals to other professionals, taking into account the predicted date of discharge and recognising relevant requirements **in advance** of the process e.g. agreeing the patient is ready for transfer and that this is recorded in the medical notes as “Health Complete”. This is statutory requirement under the Community Care (Delayed Discharges) Act 2003. This team will communicate and support the patient and family in following this Policy supporting them to make the transition out of hospital.

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- The patient and /or carer receive daily updates on their care and treatment and planned date of discharge,
- The discharge hub team are updated on developments promptly
- Patients are discharged when medically fit for discharge, preferably in the morning
- Any delays, or concerns are escalated to the **Integrated Care Manager**

3. PROCESS FOR MANAGING CHOICE ON HOSPITAL DISCHARGE

3.1 STAGE 1 – GIVE STANDARD INFORMATION

3.1.1 The discharge planning process is led by a named registered health or social care professional (thereafter referred to as the discharge coordinator). This discharge coordinator supports the patient and/or representative in liaison with all those currently involved in the patient's care. They also ensure that those who need to be involved after discharge are contacted at the earliest opportunity to discuss the patient's needs and that responsibilities are transferred on discharge. Issues relating to the mental capacity should be considered at this point and any information relevant to discharge will be provided to the CCH or the social care authority in line with the Data Protection Act.

3.1.2 All parties will record plans, communication with the patient and/or representatives, referrals and actions in the patient's record on a daily basis.

3.1.3 The locally agreed discharge-planning information leaflet will be given to all adult patients on admission by the discharge coordinator or another member of the multidisciplinary team (MDT), this should be discussed with the patient (and/or representative). For elective admissions the leaflet may be given prior to admission. If appropriate, the leaflet may be given to the patient's representative and an Easy Read leaflet may be given to the patient.

3.1.4 The discharge coordinator ensures that the patient and/or representative are aware of the policy and process for managing choice on hospital discharge, and of the circumstances in which a move to alternative or interim accommodation or care might be necessary. All communications reinforce the expectation that patients will leave the hospital as soon as their need for inpatient treatment ends.

3.2 STAGE 2 – ASSESSING NEED - REFER FOR SERVICES TO SUPPORT DISCHARGE

3.2.1 If the patient is likely to have ongoing health or social needs after discharge the discharge coordinator ensures timely referral to other services and that the managing choice pathway is followed and recorded (see appendices).

3.2.2 Any referral to the social care authority must be made through an assessment notice which the discharge coordinator will prepare (see appendices)

3.2.3 Should a patient be referred for assessment of eligibility for continuing health care, the discharge coordinator will contact the integrated discharge team to begin the process

3.2.4 The discharge coordinator explains expectations to the patient and/or representative and may offer factsheet 1 if appropriate to minimise confusion (see appendices).

3.2.5 The organisation arranging care ensures the patient and/or their representative and the discharge coordinator are informed of all currently available options.

3.2.6 Withal parties will follow - the Mental Capacity Act 2005, a patient who lacks capacity to make decisions regarding the discharge process will be supported through a best interests decision making process. This will likely involve their family and relevant professionals. A patient may have registered power of attorney or a court appointed deputy who is empowered to make this decision on their behalf and in their best interests.

3.3 STAGE 3 – OFFER OPTIONS AND PREPARE FOR DISCHARGE

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

3.3.2 Social care is not a free service and those receiving it will be financially assessed to see what, if anything, they will contribute towards the cost of their care. Patients who may be eligible for social care services will be informed of this at the earliest opportunity.

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

3.3.4 Social care can only offer available options when considering how to meet the patients assessed needs. If there is currently at least one available option, the patient cannot remain in hospital to wait for further choices and must decide whether to accept the offer by the local authority to meet their needs on that basis. This placement can be on a short term or temporary basis pending further options becoming available. The person offering care will endeavour to meet the patient's and/or representative's wishes regarding specific concerns about the appropriateness of a temporary arrangement if concerns are brought to their attention.

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

3.3.6 The discharge coordinator clarifies expectations and may give or send factsheet 2 if appropriate to minimise confusion later on (see appendices).

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

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

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

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

3.4 STAGE 4 – AVAILABLE CARE DECLINED

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

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

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

3.4.4 If discharge arrangements are not agreed, the discharge coordinator escalates to the ward lead (usually ward sister/charge nurse) for support. The local process to escalate delayed transfers of care (DTOC) is followed throughout the Managing Choice process. The ward lead starts the formal process. All parties continue to encourage patients to make their own choices throughout this process.

3.4.5 If discharge plans are not agreed after a suitable option has been offered the ward lead or deputy consults any specialist staff involved and escalates to the matron/service manager for support. The ward lead or deputy invites the patient and/or representative to a formal meeting, to discuss plans for discharge.

3.5 STAGE 5 – FORMAL MEETING AND FORMAL LETTER 1

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

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

3.5.3 If the patient has declined an offer of social care support, the social care team will formally write to them. The letter will also be proved to the hospital. At this point social care will have no further in the discharge unless the patient subsequently seceded to accept the offered care and support.

3.5.4 The ward lead or deputy gives or sends formal letter 1 to the patient and/or representative at or soon after the formal meeting, even if the patient and/or representative did not attend. An example letter is provided in the appendices but the letter can be amended as required dependent on circumstance (see appendices).

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

3.5.6 The MDT continue to work with the patient and/or representative to try and arrange an appropriate means of meeting the patient's care needs at the point of discharge. The allocated social care or ward staff the process of making arrangements for a patient to transfer to an identified care provider or location on the agreed date.

3.6 STAGE 6 – LEGAL PROCESS AND FORMAL LETTER 2

3.6.1 If no agreement has been reached regarding discharge arrangements after stages 1 – 5, and transfer arrangements are challenged by the patient and/or representative, the local director or senior manager supports the matron/service manager to continue plans for transfer to an interim location or alternative care provider.

3.6.2 The matron/service manager, supported by the director or senior manager consults local Trust/Organisation advisors regarding legal proceedings and escalates as required to ensure discharge from hospital, in order to safeguard the health and wellbeing of this and other patients.

3.6.3 The social care and ward staff involved provides details of a suitable interim option.

3.7 STAGE 7 - ESCALATION PROCESS

3.7.1 Responsibility for the discharge process in relation to patients will remain with the Nurse in Charge on the ward. They will undertake or delegate as appropriate the task of gathering MDT assessments to inform decisions about needs on discharge. They will work in liaison with the discharge hub.

3.7.2 The discharge hub will offer the appropriate level of guidance and support and will consult the Nurse in Charge as needed. All staff will proactively chase progress with the discharge.

3.7.3 The MDT will aim to undertake considerable discussion with the patient and/or representative prior to initiating formal 'managing choice' meetings. Emphasis in discussions will be placed on accessing available support, clarification of

the process and the need to transfer to an interim placement or alternative provision if the preferred option is not available.

The director or senior manager sends formal letter 2 to notify the patient and/or representative that legal advice will be sought and discharge instigated to the named interim option (see appendices).

4. LEGAL RESPONSIBILITIES AND RIGHTS

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

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

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

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

	authority, in some circumstances (but no right to remain in hospital when medically fit for discharge while preferred choice is awaited) Right to respect for family life and to not be treated in an 'inhuman or degrading' way	Human Rights Act 1998 s6 in relation to Articles 3 and 8 of the European Convention of Human Rights
Carer	Right to carer's assessment / support and choice about caring i.e. willingness to provide care	Care Act 2014 s10

5. EVIDENCE BASE

Annexe G of The Care and Support Statutory Guidance Issued Under The Care Act 2014

https://www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance#AnnexG

6. MONITORING COMPLIANCE AND AUDIT

This policy will be monitored by an on-going programme of weekly validation of Delayed Transfers of Care. This process is undertaken within the IDT team for all patients identified as being delayed during the week. All patients delayed due to 'awaiting placement in care home' or 'patient or family choice' will be reviewed and the IDT Manager will identify any patients for further review.

7. DISSEMINATION, IMPLEMENTATION AND ACCESS TO THE DOCUMENT

This document has been approved by CHUFT, ACE, CCG and ECC and is available on each respective organisations intranet and has been adopted by the A&E Deliver Board. All relevant staff are notified via email, of the document updates and any amendments. This policy will be reviewed at least every 3 years.

APPENDIX 1 – CHOICE PROCESS

Stage 1 Start discharge planning discussions and give 'Leaving Hospital leaflet' and choice letter 1a	**Stage 2** Refer to service required to support discharge (factsheet 1 given)	**Stage 3** Offer available discharge service and provide factsheet 2	**Stage 4** Start formal process if available service declined and arrange formal meeting	**Stage 5** Hold formal meeting to minimise delay and send choice letter 1-E	**Stage 6** Establish best option and issue choice letter 2 before instigating discharge
Start to discuss discharge planning with patient and/or representative shortly after admission Explain process for reviewing estimated date and time of discharge Issue letter 1A and 'leaving hospital leaflet' Identify any issues regarding capacity and who will be the decision maker	Refer to required service e.g. another hospital, social services, community mental health team or NHS continuing health care when patient is ready to have needs assessed for discharge. Where the referral is social services, an assessment notice must be provided.	Discuss discharge plans with patient and or representatives regularly. Ensure assessments to clarify needs are complete. Explain to patient that they must accept an available discharge option, either as interim or permanent plan. Manage patient expectations regarding available options and that they will be discharged home if deemed not suitable for care.	If there is reluctance to accept the option/s offered ward representative and care professional discuss concerns and encourage to reconsider Clarify rationale for transfer to interim option if their preferred option unavailable. Agree urgent date for formal meeting if discharge plan still not agreed	Formal meeting held (even if representative doesn't turn up) Information and support provided Issue choice letter 1B-E clarifying discussions what follow up arrangements have been made and rationale for transfer to alternative/interim care. Ward notify social care/CHC of expected ready date and request an interim option.	If transfer arrangements are disputed consult trust legal advisors. Send letter 2 to explain that discharge to alternative will be arranged in line with the managing choice policy. Note: if social care has been refused their involvement has ceased at this stage.

APPENDIX 2

CHOICE PATHWAY FORM

Affix patient label Patient name Address Date of birth Hospital no/NNN	Hospital Ward Discharge Co-ordinator Ward Sister General Manager / Matron

STAGE & ACTION	Date	Initial/sign
1 – START DISCHARGE PLANNING ON ADMISSION (every patient) **Leaving hospital leaflet** discussed with patient/representative **Letter 1A** given to patient Patient informed of EDD and that they will be told when it is revised		
2 – REFER FOR SERVICE Patient referred for assessment if required **Factsheet 1** given to patient/representative if wished Patient expectation managed regarding availability of preferred option		
3 – OFFER SERVICE OR CARE (options offered): **Factsheet 2** given to patient/representative if wished **Letter 1B** given to patient		
4 – AVAILABLE OPTIONS DECLINED by (name and relationship): Reason given for decline:		
5 – Formal meeting held to discuss interim transfer (invited/attendees): **Choice Letter 1C (or) D (or) E** given to patient/representative from Senior Nurse		
6 – INSTIGATE DISCHARGE TO INTERIM OPTION Alternative or interim discharge location sourced: **Choice Letter 2** given to patient/representative from Senior Manager		
END: Reason process terminated (start new form if process re-started):		

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

APPENDIX 3

FACTSHEET 1

DISCHARGE PLANNING FACTSHEET 1

REFERRAL AND ASSESSMENT

Dear Sir or Madam

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

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

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

If on assessment it is deemed that you do not need care, once you are medically fit you will be discharged home.

If you would like a copy of this factsheet to be given to someone else or you have any questions please speak to the discharge co-ordinator or the nurses caring for you. Please do not hesitate to ask if you have any questions.

With best wishes for a speedy recovery

The team caring for you at this hospital

On behalf of NHS healthcare and local authority services in North Essex

This factsheet does not have to be used but can be photocopied and given to inpatients and/or their representatives. When a patient has been assessed under the Mental Capacity Act 2005 as not having capacity to make decisions about their discharge, this factsheet can be given to a representative, such as their next of kin

APPENDIX 4

OPTIONAL FACTSHEET 2

DISCHARGE PLANNING FACTSHEET 2

ACCEPTING AN AVAILABLE OPTION

Dear Sir or Madam

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

Your recent assessment shows that you will need support or treatment elsewhere. A member of the team caring for you will advise you of currently available options. If you have not had this information yet, please let us know.

If your preferred choice has no current vacancies, you will be asked to move to a temporary option that is available whilst you wait for your preferred choice to be ready. If you need treatment at another hospital but your preferred hospital is full, you will have to transfer to a hospital that can offer you a bed.

It is not possible for you to remain at this hospital when you are ready for discharge or transfer because a medical professional has deemed that you no longer require care and treatment in an acute hospital. Staying in hospital will increase your risk of catching a hospital acquired infection and of becoming increasingly less independent. The team caring for you at this hospital will help make arrangements for your discharge as soon as a suitable option is available.

If you would like a copy of this factsheet to be given to someone else or you have any questions please speak to the discharge co-ordinator or the nurses caring for you. Please do not hesitate to ask if you have any questions.

With best wishes

The team caring for you at this hospital

On behalf of NHS healthcare and local authority services in North Essex

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APPENDIX 5

Please stick patient address label here

Date: ……..

CHOICE LETTER 1A

Dear Mr/Mrs/Miss/Ms

We would like to welcome you to our hospital and let you know that our dedicated staff will be working hard to ensure you receive the best care and treatment possible and to make sure that your stay here is as comfortable and safe as possible.

Your individualised care/treatment plan will include your discharge plan and Estimated Day of Discharge. This will be discussed with you and the person you have nominated to be involved with your discharge planning. It is important that as soon as possible following your admission, you inform us of an actual or potential problem relating to your discharge so that we can begin to make appropriate plans with you.

There are many risks associated with delaying your discharge which a member of staff will be happy to discuss with you. When our multidisciplinary team has agreed that your treatment has been completed and that you will no longer benefit from remaining in our hospital, you will be discharged as planned. Patients that have no identified care needs will not be able to remain in the acute hospital due to circumstances regarding housing, accommodation or their finances.

Most people who are admitted to our hospitals will complete all their care and treatment with us and then be discharged home. However some patients may be ready to leave hospital and may not be able to return to their home. For example, they may need more time to recover, they may need a care package or alternations to their own home. In these cases, discharge to an appropriate, alternative care setting will be arranged.

We need to ensure that we have enough available beds in our hospitals so that all acutely ill patients can be admitted and treated as quickly as possible. For this reason we will aim to discharge you before 10am on your day of discharge.

If you have any concerns or questions regarding your discharge plans or the contents of this letter, please speak with the discharge co-ordinator or ward sister/charge nurse.

Yours sincerely

Nick Hulme, Chief Executive Colchester Hospital University Foundation Trust

Lynne Woodcock, Managing Director Anglian Community Enterprise

Ward contact name &
phone number

.....

*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***.**

APPENDIX 6

Please stick patient address label here

Date: ……..

Dear Sir or Madam

CHOICE LETTER 1B

Notification of plan to transfer to another hospital

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

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

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

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

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

Ward contact name &
phone number .....

Yours sincerely

Matron/Senior Nurse – Discharge Services
On behalf of NHS and local authority services in North Essex

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

APPENDIX 7

Please stick patient address label here

Date: ……..……

Dear Sir or Madam

CHOICE LETTER 1C

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

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

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

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

Please discuss discharge plans with the nurse in charge of your ward. You will have to either transfer to the temporary care home offered by your care manager or to inform us of an alternative arrangement to leave the hospital without further delay. If we do not hear from you we will make arrangements for transfer to the temporary care home as soon as possible.

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

Ward contact name & phone number .....

Care manager name & number .....

Yours sincerely

Matron/Senior Nurse – Discharge Services
On behalf of NHS and local authority services in North Essex

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

APPENDIX 8

Please stick patient address label here

Date: ……..

Dear Sir or Madam

CHOICE LETTER 1D

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

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

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

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

Please discuss discharge plans with the nurse in charge of your ward. You will have to either transfer to the temporary care home found by your care manager or to inform us of an alternative arrangement to leave the hospital without further delay. If we do not hear from you we will make arrangements for transfer to a temporary care home as soon as possible.

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

Ward contact name & phone number .....

Care manager name & number .....

Yours sincerely

Matron/Senior Nurse – Discharge Services
On behalf of NHS and local authority services in North Essex

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

APPENDIX 9

Please stick patient address label here

Date: ……..

Dear Sir or Madam

CHOICE LETTER 1E

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

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

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

Please discuss discharge plans with the discharge co-ordinator or nurse in charge of your ward. If you do not wish to transfer to the temporary location found by your housing or care manager you will have to inform us of an alternative location, so that you can leave the hospital without further delay. Otherwise, we will make arrangements for transfer to the temporary location as soon as possible.

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

Ward contact name: .....

Ward contact phone number .....

Care or housing manager name .....

Care or housing manager number .....

Yours sincerely

Matron/Senior Nurse – Discharge Services
On behalf of NHS and local authority services in North Essex

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

APPENDIX 10
Our reference:
To:

Date: ……..

Dear Sir or Madam

CHOICE LETTER 2

FINAL NOTIFICATION – DATE OF TRANSFER TO ALTERNATIVE CARE

I am writing further to the letter you were recently sent, informing you of proposed arrangements for your discharge. This hospital has offered you all necessary support and guidance to enable your safe and appropriate discharge. You have been informed of your responsibility to finalise other arrangements if you would prefer not to accept what has been proposed.

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

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

If you would like further information or support regarding discharge arrangements please speak to the General Manager. 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 (within 24 hours) without your involvement. Please do not hesitate to ask if you have any questions.

Discharge destination: ……

Address: ……

……

Tel number: ……Date of transfer/discharge……..

Discharge coordinator name & contact number: ……

Yours sincerely

General Manager/Assistant Director
On behalf of NHS and local authority services in North Essex

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.

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