Health and Wellbeing Board 27 August 2014

Title of paper:	**South Nottinghamshire Health and Social Care Community- Leaving Hospital Directive Policy & Guidance**	
Director(s)/ Corporate Director(s):	**Alison Michalska, Corporate Director for Children and Adults**	**Wards affected: All**
Report author(s) and contact details:	**Gemma Poulter, Interim Health Integration Manager, Nottingham City Council, tel: 0115 8763495**	
Other colleagues who have provided input:	**Robert Heywood, Director of Operations, Nottingham University Hospitals NHS Trust; Maria Principe, Director of Cluster Development and Performance, Nottingham City CCG**	
Date of consultation with Portfolio Holder(s) (if relevant)	**5th August 2014**	

Relevant Council Plan Strategic Priority:	
Cutting unemployment by a quarter	☐
Cut crime and anti-social behaviour	☐
Ensure more school leavers get a job, training or further education than any other City	☐
Your neighbourhood as clean as the City Centre	☐
Help keep your energy bills down	☐
Good access to public transport	☐
Nottingham has a good mix of housing	☐
Nottingham is a good place to do business, invest and create jobs	☐
Nottingham offers a wide range of leisure activities, parks and sporting events	☐
Support early intervention activities	✓
Deliver effective, value for money services to our citizens	✓

Summary of issues (including benefits to citizens/service users):

The South Nottinghamshire Leaving Hospital Policy is a joint health and social care strategy to reduce the pressures on the acute hospital.

Pressure on our emergency services continues to be high. We have seen an increase in patients aged over 65 being admitted to our hospital who are staying longer. A combination of factors has impacted on hospital performance, notably insufficient flow and capacity at QMC where the hospital is too often operating at near-full capacity.

The hospital is determined to improve the timeliness of emergency care that patients receive, and to do this with commissioning and other provider partners across South Nottinghamshire. The hospital has plans to open additional beds at NUH by October and increase capacity in the Emergency Department by the beginning of next year.

Health and social care community services need to continue to work with the hospital to ensure patients are transferred from acute care to the community in a timely manner. This will help to maximise efficiency and flow at the acute hospital enabling more people to receive acute care in a timely and dignified manner.

This policy will enable patients to be discharged from acute hospital beds to community care as soon as they are medically stable. Timely hospital discharge will enable patients to have their needs met in an appropriate community setting in which care is more specialised towards increased opportunities for maximising independence and ensuring people are supported to return home.

Recommendation(s):	
1	To approve and support the intention of the policy which will enable patients requiring recuperation to receive this in an appropriate community setting.
2	To support Nottingham City's intention as a health and social care community to promote independence through early intervention.
3	To support the intention of the policy to improve efficiency and flow at the acute hospital by releasing hospital beds for those in need of urgent medical care.

1. REASONS FOR RECOMMENDATIONS

- To enhance the health and social care community's ability to successfully respond to routine and extraordinary pressures at the acute hospital.
- To improve health and social care outcomes for patients medically fit for discharge from acute care.

2. BACKGROUND (INCLUDING OUTCOMES OF CONSULTATION)

An acute hospital is not the most appropriate place for a patient to be once they have recovered from an illness to a point where they can be clinically described as medically fit for transfer to other places of care. Such places may be community hospitals, nursing homes, residential care, or health and social care in the patient's own home. Widespread evidence shows that recovery and rehabilitation from illness is more successful and long-lasting in the most appropriate setting.

The impact of delayed transfers of care on patient flow at the acute hospital is significant, resulting in reduced capacity to deal with the demand for admissions for in-patient treatment. This is particularly difficult at times of extraordinary demand such as during a flu pandemic or an extremely cold winter.

The South Nottinghamshire Leaving Hospital policy has been developed in order to significantly reduce the numbers of delayed transfers of care thereby improving patient flow at the hospital. It is the product of partnership working across the health and social care community in order to provide suitable alternatives to hospital beds for patients who are ready for discharge but are waiting for a placement in their home of choice or whilst a home care package in their own home is being organised.

3. OTHER OPTIONS CONSIDERED IN MAKING RECOMMENDATIONS

Doing nothing, but this would result in continued delayed discharges of patients medically fit for transfer which lead to poor health and social care outcomes for these patients and which reduces efficiency and flow at the hospital. Continued delayed discharges would additionally have a significant financial cost since additional beds would be necessary to meet demand for acute care.

4. FINANCIAL IMPLICATIONS (INCLUDING VALUE FOR MONEY/VAT)

This policy facilitates more efficient and effective use of acute hospital beds. It also delivers better outcomes for patients who are at reduced risk of contracting infections and of becoming dependent on care when discharged into appropriate community settings as soon as they are medically fit for transfer. This in turn could result in financial savings for health and social services and for patients themselves, many of whom make a financial contribution to the cost of their social care services.

5. RISK MANAGEMENT ISSUES (INCLUDING LEGAL IMPLICATIONS AND CRIME AND DISORDER ACT IMPLICATIONS)

Effective communication is central to the success of managing choice on hospital discharge and should be supported by the whole health and social care community. Regular communication across the system, in the form of leaflets, posters and verbal communication will reinforce the message that once patients are clinically ready for discharge they cannot continue to occupy an inpatient bed. A communication strategy will be agreed and initiated by all partner agencies to reduce the potential for misunderstanding, a lack of clarity or failure to adhere to this policy or implement it effectively and fairly.

Nottingham City Council has a Quality Improvement Forum which oversees quality and standards in residential care homes. Our intention in implementing this policy would be to encourage patients being discharged to residential care to choose homes of good quality. Due regard will be given to the Mental Capacity Act throughout.

6. EQUALITY IMPACT ASSESSMENT

Has the equality impact been assessed?

Not needed (report does not contain proposals or financial decisions) ☐

No ☐
Yes – Equality Impact Assessment attached ✓

Due regard should be given to the equality implications identified in the EIA.

7. LIST OF BACKGROUND PAPERS OTHER THAN PUBLISHED WORKS OR THOSE DISCLOSING CONFIDENTIAL OR EXEMPT INFORMATION

None

8. PUBLISHED DOCUMENTS REFERRED TO IN COMPILING THIS REPORT

None

APPENDIX 1

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 that 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 patients 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 persons 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.

APPENDIX 2

Equality Impact Assessment

Name and brief description of proposal / policy / service being assessed
South Nottinghamshire Leaving Hospital Directive Policy and Guidance

There is significant demand for acute hospital beds in Nottingham and delayed discharges from the acute hospital impact negatively on the effective admission and treatment of citizens in need of acute medical treatment and care. A “delayed discharge” occurs where a citizen has been assessed by their doctor as medically stable and in no further need of in-patient treatment in the acute hospital. Citizens’ discharges from hospital are most frequently delayed due to a lack of immediate availability of care packages or placements in their preferred residential or nursing home.

The pressure at the acute hospital has been assessed and monitored on a weekly basis via agreed joint health and social care strategies and health and social care representatives are involved in these The Leaving Hospital policy is informed by the findings of this group. The policy enables citizens who are medically fit to be discharged to an interim residential or nursing home whilst waiting for their preferred placement to be available.

An 8 week Interim bed pilot was completed from May 2014 to the end of June 2014 during which all eligible were offered the opportunity to move to an appropriate residential or nursing home for interim care until their placement of choice was available. There has been no charge to citizens transferred to interim care during the length of the pilot, however the Leaving Hospital policy allows for a maximum of 2 weeks in interim care without charge for self-funding citizens and any subsequent charges will be at a rate commensurate with their assessed contribution to the cost of their preferred support package. The policy also includes an explicit procedure for engaging with citizens (& their families) who refuse to leave the acute hospital despite having been assessed as medically fit for transfer.

Information used to analyse the effects on equality
The main users of health services are people aged 65 and over and over 80% pf people aged 70 and over suffer from a significant physical illness (in need of treatment-Nottingham City JSNA 2010). Department of Health figures published in 2001 highlight that older people occupy two thirds of hospital beds in the UK. People with long term health conditions (LTC) frequently have more than one condition. Around half of this population will have more than 1 major health problem and around one quarter will have 3 or more problems (British Household Panel survey 2001). The percentage of people with LTC rises with age. 32.8% percent of those aged 50 and over have a LTC, but 66.9% of those aged 80 and over have a LTC.

In all age groups under 80, the percentage amongst men is slightly higher than amongst women. The higher rate of women with LTC aged 80 and over may be because they have an older age profile than men in this group. There are approximately 34,800 over 65s living in Nottingham

city (11.66% of the population) and 18,165 of these have a LTC. 10, 000 of these live alone. It is predicted that the numbers of city citizens aged 85 and over will increase by 500 in 2015 due to improved survival rates in that age group, particularly amongst men. The top 1% of the population at highest risk consists of 3, 182 citizens of whom 84% were aged 65 and over. Women account for over 50% of this group which is expected since 60% of the over 65s population in Nottingham is female. 70% of citizens accessing adult social care are aged over 65.

The prevalence of people living with LTC in the county is similar to the national average and older people are three times more likely to have an emergency admission to hospital than any other age group (Nottinghamshire JSNA 2012). Figures highlight that the rates of hospital admission largely reflect levels of deprivation with those living in more deprived areas in the county having higher rates of emergency admission. The numbers of emergency admissions to hospital, both locally and nationally, have increased over the past 4 years.

There were 7649 citizens in receipt of social care services from Nottingham city council in the year 2013/2014 and the percentage of these by ethnicity is as follows:
White (including British/Irish/Gypsy or Irish Traveller/Other white): 90.5%
Mixed or multiple ethnicity: 0.1%
Asian or Asian British (including Indian/Pakistani/Bangladeshi/Chinese/Other Asian): 2.8%
Black/African/Caribbean/Black British: 6.4%
Other ethnic group (including Arab & any other ethnic group): 0.4%

An analysis has been undertaken to identify the numbers of citizens whose discharges from the acute hospital have been delayed due to delays in their care at home or placement of choice being available alongside an analysis of their age. Further analysis has been completed to identify the proportion of these who have accessed interim beds during the pilot to inform planning. Unfortunately, the acute hospital (which is responsible for collating the data on delayed discharges) does not have data regarding the ethnicity of citizens whose discharges are delayed.

There were 76 Nottinghamshire county and Nottingham city citizens who were assessed as having delayed transfers of care from the acute hospital from 19/12/2013 to 16/7/2014. The percentage of these according to age are as follows:
Age 85 or over: 61.8%
Age 75 or over: 32.9%
Age 65 or over: 4%
Age 18-65: 1.3%

There were 52 Nottingham city citizens who accessed interim care beds during the pilot and the percentage of these according to age are as follows:
Age 85 or over: 43.137%
Age 75 or over: 33.333%

Age 65 or over: 19.607%
Age 18-65: 3.92156%

The percentage of these by ethnicity are :
White British: 80.762%
White-any other White background: 1.923%
Black/Black British-Caribbean: 7.692%
Mixed-White & Black Caribbean: 1.923%
Asian/Asian British-Pakistani: 1.923%
Asian/Asian British-Indian: 1.923%
No valid ethnicity recorded: 3.846%

These findings are generally reflective of the general population.

22 Nottinghamshire County citizens accessed interim beds during the pilot & the percentage of these by age & ethnicity are detailed below:
Age 85 plus: 57.14%
75 plus: 33.3%
65 plus: 0%
18-65: 9.53%

95.24% of these were White British & 4.76% were White Irish.

Although from both the City and County findings are generally reflective of the both local authorities' general populations, more time is needed to gather and analyse data due to the small sample size available from the pilot. A clear strategy has been identified to do this on an ongoing basis in order to inform any future changes to communication about the policy or to the policy itself.

No consultation has been completed with citizens or carers in either local authority, but this will now be planned and completed within the next 6 months in order for views and information gathered to inform the first review of the policy. Details of consultation plans are identified below.

	Could particularly benefit (X)	**May adversely impact (X)**	How different groups could be affected: Summary of impacts	Details of actions to reduce negative or increase positive impact (or why action not possible)
People from different ethnic	☐	☐	The policy will predominantly affect citizens aged 18	This policy is owned by local health and

groups			and over in a positive manner, but will have the most impact on citizens aged 65 and over. It enables their timely discharge from acute care to community care in the form of interim residential placement when their care package or residential placement of choice is not immediately available. Timely hospital discharge reduces the risk of contracting infections and of becoming dependant on care. It also maximises efficiency and flow at the acute hospital enabling more citizens to receive acute care in a timely and dignified manner. It will affect a slightly higher number of women than men due to their older age profile. Those living with LTC are classed as having a disability and, therefore, the policy will have a significant impact on citizens with disabilities. The potential negative impacts of this policy on citizens include the fact that a move to an interim placement could be distressing for some citizens, particularly for those with functional and organic mental health needs; interim care beds may not be immediately available in a citizen's home locality and this may increase their social isolation & limit the ability of their friends and family to visit them; citizens may be expected to contribute towards the cost of interim care if their placement in this setting exceeds 2 weeks.	social care agencies and multi-disciplinary colleagues working in the acute hospital have an excellent knowledge of the policy and of how it works in practice. All colleagues are committed to explaining the policy to citizens and their families at the earliest opportunity in order to plan for discharge from the point of admission. The offer of interim care will be made to all eligible citizens (and their carers) in order to facilitate discharge once they are medically fit. Specific information regarding the homes in which this is available will be provided verbally and in writing. Details of any potential cost to the citizen and of potential implications for citizens who refuse to leave hospital when medically stable will also be given in writing and verbally. All written information will be easy to read and available in a range of languages. Interpreters will be used to enable effective communication with citizens and families whose first language is not English. Distance from local community, family and friends will be considered by social care staff arranging interim placements and they will, wherever possible, ensure that citizens are not placed in homes which isolate them further from their informal support networks and will
Men, women (including maternity/pregnancy impact), transgender people	x	x		
Disabled people or carers	x	x		
People of different faiths/beliefs and those with none.	☐	☐		
Lesbian, gay or bisexual people	☐	☐		
Older or younger people	x	x		
Other (e.g. marriage/civil partnership, looked after children, cohesion/good relations, vulnerable children/adults)	☐	☐		

				ensure that family & friends are able to access homes using public transport. Financial assessments will be completed with all citizens in order to determine their assessed contribution towards the cost of their placement where this exceeds the maximum cost free period. The assessment takes into account income, assets, debts & outgoings to ensure that citizens are only asked make an appropriate contribution. Mental Capacity tests will be completed with all citizens who appear to lack capacity to make a decision about interim care. Best interests' decisions will be made in partnership with citizens, relatives and friends and advocates for all citizens who are assessed as lacking capacity to make this decision. A series of consultation strategies will be initiated jointly by the city and county councils and NUH with citizens and carers over the next 6 months. These will take the form of short questionnaires to be given/sent to all eligible citizens and their carers (irrespective of whether they accept interim care) to seek their views. Telephone or face to face interviews will be available for those who are unable to complete a questionnaire independently A citizen and carer

				consultation event will be held in October/November 2014 facilitated by all agencies in order to share information on the policy and to seek citizen and carer views. Information gathered through these methods will be collated and analysed by January 2015 and will inform formal review of the equality impact assessment. Formal review of the equality impaxt assessment will be completed every 6 months in order to identify and implement any necessary changes to reduce any identified adverse impacts.

Outcome(s) of equality impact assessment:

No major change needed ☒ Adjust the policy/proposal ☐ Adverse impact but continue ☐ Stop and remove the policy/proposal ☐

Arrangements for future monitoring of equality impact of this proposal / policy / service:

Review to be completed in 6 months time and then annually thereafter. Equalities information to now be included in the existing reporting completed by the hospital discharge teams to inform reviews.

Approved by (manager signature): Gemma Poulter	Date sent to equality team for publishing: