

The Newcastle upon Tyne Hospitals NHS Foundation Trust

Patient Choice Directive Policy & Guidance

Effective: March 2010

Review: March 2012

1. Introduction

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 unable to return to their previous accommodation are re-housed in more appropriate extra care housing or other provision. Local policies and procedures and service provision should support maximum opportunity for rehabilitation and continued independence, which reflects the preferences of the great majority of patients. It should be recognised that when a transfer to a registered care home is the agreed outcome, proper opportunity for maximum rehabilitation has occurred.

For a minority of patients transfer directly from an acute setting to a care home may be the plan agreed by all involved.

Where a place is not available in the individual's preferred care home, remaining in an acute hospital setting is undesirable for the welfare of the patient. 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 to be used in conjunction with the [Hospital Discharge Policy](#) and is for use by all staff with responsibility for arranging the discharge of patients. The policy should not be presented in the last stages of discharge but be part of the information routinely delivered to patients and their carers when all professionals involved in the assessment identify the need for the patients move to a care home following admission to hospital. This prevents the development of expectation that the person may stay in the hospital setting indefinitely.

This policy 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. Policy Aim

The aim of this policy is to offer guidance to those staff with responsibility for arranging the discharge from hospital of patients who have been assessed by the multi disciplinary team (MDT) as having the need to move into a care home thereby reducing the length of time the person waits to be placed appropriately.

This policy has been developed and agreed by;
The Newcastle Upon Tyne Hospitals NHS Foundation Trust
Newcastle upon Tyne Adult and Cultural Services Directorate

3. Patient Group

Assessment has shown and the decision agreed by all health and social care professionals along with carers and relatives that the patient's needs cannot be met at home and therefore 24 hour care is required.

The placement will be funded either by the patient; Adult Services or the NHS (Continuing Care (CHC)).

4. Process (assessment and planning)

- All patients are to be treated fairly and without discrimination.
- Patients, relatives and carers must be fully involved in discussions and planning meetings regarding the discharge of the patient (with their consent).
- This process begins at admission. This adheres to the [Hospital Discharge Policy](#). However, patients and their families must not be given the impression that residential care is an option before the MDT has made its recommendation. Adult Services have developed a wide range of alternative services to enable people to remain at home for longer.
- [Hospital Discharge Policy](#) includes guidance set out in the [National Service Framework for the Older Person](#).
- The Patient remains in receipt of an appropriate standard of care while all assessments are completed (include Continuing Health care and Mental Capacity Assessment if indicated) and where practicable, agrees with the decision for transfer to a care placement.
- If the patient is unable to contribute to the assessment the wishes and views of their relatives and carers must be sought. It is essential that staff determine at admission whether the patient has; a Living Will, an Advance Decision; a Power of Attorney or is under a Safeguarding Order and the contact details of those persons who manage any of these.
- If the patient lacks capacity and has no person to represent their views an IMCA can be appointed by referring to www.dh.gov.uk/imca or by telephoning 'IMCA, Skills for People' on 0191 2817322.
- The need for Continuing Care must be considered and referral for assessment made if appropriate (see 'Continuing Care' in the 'Discharge Directory' on the intranet; <http://intranet/DischargeDirectory/Continuing%20Care.htm> If it is agreed the person does not fulfil the CHC criteria this, as with all assessment outcomes must be clearly documented in the patient's medical records.
- 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.

5. Process (assessments complete)

- The multi disciplinary team agree the patient is no longer in need of NHS care and that discharge to a care home is necessary.
- It is expected that the patient will move into a suitable placement within twenty one days of the decision that a care home placement is necessary and that this is communicated to all involved early in the assessment process.

- A copy of the leaflet 'Your Move' which details the process and the timescale to be given to the patient for viewing by themselves and their carer / relative / advocate at the time of decision that 24 hour care is needed.
- It may be necessary for the patient to move into an alternative placement until a vacancy in the home of their choice becomes available. It is recommended that two homes which can meet the care needs of the patient are chosen.
- Assistance will be given by the social worker who has been involved in the assessment process or their deputy in their absence. They will ensure that the patient has all the relevant information to enable them to choose an appropriate home. This will include details of the patient's care needs, financial details, lists of homes able to meet such needs.
- At this point the patient becomes delayed in their transfer of care and this should be notified in the Monday survey by completing the report form and faxing to 31372 or by telephoning 27474 with the patients' details.

6. **Guidance to be followed if a placement has not been secured within 2 weeks following completion of assessment**

In the event that a placement has not been identified the Social Worker should ensure that all appropriate actions have been taken.

When the MDT is certain the key principles have been met , that the patient's eligibility for CHC has not altered and 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 is available the following actions to be taken.

- **Ward manager** – arranges a meeting (Review meeting) with all involved (see guidelines for Case conference; appendix 1) within 5 days of the expiry of the first 2 week deadline. Any written communications to the family to be sent by recorded delivery. This to be clearly documented in the patients medical and nursing records.
- **At the meeting** – ward manager to advise that the patient no longer requires an NHS bed and that an alternative arrangement must be made.
- **The ward manager** should then confirm the following points;
 - ✓ The patient is fit for discharge from hospital and that all members of the MDT agree.
 - ✓ The inadvisability of remaining in hospital (health care acquired infection, loss of independence)
 - ✓ Confirm the defined time period within which a suitable care home is to be found.
 - ✓ Ensure that all necessary information and support is available to the patient and all involved in the choosing of a placement to enable an appropriate choice be made.
 - ✓ Confirm with the Social Worker 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 placement.

If an appropriate placement is not available and Adult Services have funding responsibility for the patient, then the reimbursement process should be instigated 21 days following the MDT decision date. Non-local authority

funded patients who will be funding their own placements are the responsibility of the NHS and the reimbursement process does not apply.

7. Guidance to be followed in the event that a suitable placement with a vacancy has not been identified within 7 days of the review meeting

- If, after the extended time period there are no indications that discharge is imminent, the ward manager should inform the Directorate Manager or their deputy.
- The Directorate Manager should convene the Final Review Meeting and invite the patient, family or advocate to attend in order to finalise the discharge plans with the Directorate Manager. This should be confirmed in writing and posted by recorded delivery.
- This meeting should take place within 2 working days of the expiry of the extended period (maximum 3 weeks from completion of assessments).
- The Hospital Adult Services Team Manager (if Social Services are involved) and The Discharge Liaison Facilitator may 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, the Directorate Manager must advise that the Trust will instigate legal proceedings to ensure that the patient is discharged to an appropriate placement.
- The details of this meeting must be sent to all attendees and include the Consultant and relative/carer/advocate.

8. Action to be taken if a placement is not identified within 7 days.

A meeting should be convened to discuss, assess risk and plan the patients discharge to a care facility which meets their assessed need.

Attendees should include the;

- Directorate Manager
- Adult Services Team Manager.
- N.U.T.H Legal Services Officer.
- N.U.T.H Executive/Deputy.

8.1 Process to apply to Patients choosing a residential/Nursing Care Home

- All assessments completed by medical staff, nursing staff, allied health professionals, social workers and extended team as need indicates.
- Has the team considered and documented the mental capacity of the patient?
- Consider screening for Continuing Health Care and document outcome.
- All agree the patients needs can be met ONLY in a care home environment
- The patient/carer/family/advocate agrees that a care home is required.
- Ward manager/social worker inform the patient/carer/family/advocate of the expectation that a placement will be found within 21 days and at this point notify Patient Services of the delay in discharge through the delayed discharge reporting procedure and a copy of the leaflet 'Your Move' be given to them. The social worker to give those involved in choosing a placement a list of homes which could meet the needs of the patient,
- The social worker to maintain contact with the family/carers/advocate for progress reports.

- If the patient is to fund their own care home placement the social worker should still be able to help with the process unless there is family or carers who are capable and willing to do so, if this is the case it must be documented as to who will help with the choice.
- If no placement has been identified 14 days after M.D.Fit date then the review process begins; **see section 6 for guidance.**

9. 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 Emergency Care Facilitator and the Discharge Liaison Facilitator on behalf of the Patient Services Manager.

These will be reported on a weekly basis by the Social Services Team Leaders and presented on a quarterly basis at the Discharge Review Group.

Author; Patient Services Manager

Guidelines for Management of Case Conferences (NHS Staff)

Pre Case Conference Planning

- Agree at M.D.T the need for a case conference
- Agree who is to be chair person
- Agree the persons required to attend
- Role of Chair person; to arrange the date/time and venue of the case conference. The Chair person will then issue the invitations to the professionals and appoint a minute taker.

Case Conference

- Introduction of attendees
- Apologies received/(minutes from any previous meetings)
- Outline the purpose of the case conference
- Views of the patient (may be given by an informed person)
- Views of the main carer (may be given by an informed person)
- Views/reports from professionals involved
- Outcomes and actions agreed
- Any other business
- Any further meetings needed to be arranged by Chair Person

“YOUR MOVE”

(To be used in conjunction with the Patient Choice Directive Policy)

Moving on from hospital

This leaflet is for you, your relatives and carers. It supports the information you need to make your decision once you are ready to be discharged to a Residential or Nursing care Home.

Since you were admitted to hospital, you and the team involved in your care have been working together, with you to assess your needs for health and social support when you leave hospital.

It is now agreed by all that your needs may be best met in a Residential or Nursing Care home.

We understand that this decision is a major one and one that involves important and significant changes for you, your family and carers.

Advice and Guidance for choosing a home.

Social Workers will offer you advice and guidance about planning your discharge from hospital. This will involve discussing your care needs with you and your family or carers and giving you written information about the homes that can meet those needs.

Social workers will also advise you regarding any questions related to funding your placement that you may have.

Timescales

You will, of course continue to receive care and support while making your choice of home but we must stress the importance of finding a care home which will meet your needs without undue delay.

Therefore we will ask you and your family or carers to make a choice of two care homes that are both suitable and available within twenty one days of the date it was agreed your care needs could only be met in a Residential or Nursing Care home.

Once your choice is made

- If it seems that the wait for a bed in your initial choice of home will be longer than one week we will support you in choosing an alternative accommodation until a vacancy becomes available in the home of your choice.
- If you are unable to identify a choice of care home within the time period or refuse the temporary accommodation available, the Trust will be required to take the necessary steps to arrange your discharge to an appropriate place of care.
- A summary of the hospitals discharge process used in these situations is included in this leaflet.
- A copy of the Trust policy, 'The Patient Choice Directive' can be accessed via the internet or the ward staff will be able to give you a paper copy on request.
- Trust staff will do their best to support and help you to move smoothly from hospital to Residential or Nursing Home within these timescales.

The Discharge Process and Timescales

Your medical condition has resolved, all assessments are complete and the Consultant and staff involved in your assessments agree, along with your relatives and carers that your care needs can best be met in a residential or nursing home.

The Trust requires you to choose accommodation which will be available within two – three weeks of agreeing your care needs.

If you are unable to make a choice within these timescales, the ward team will work with you to help you find an alternative, interim placement.

Discharge Review group January 2010

Dear -----

Re; -----

Your ----- was admitted to ----- on date and is currently an in-patient on ward X at ----- hospital.

Your ----- was assessed as medically fit for discharge on date and I understand that there has been an ongoing dialogue with you to establish the most appropriate nursing care home to which to admit her. It does appear that this dialogue has become somewhat protracted and I would therefore strongly urge you to resolve this matter as a priority as your ----- no longer requires a bed in hospital.

I would therefore be grateful if you would contact Sister -----, on ward x at ----- hospital who will be able to provide you with further advice and guidance in order to ensure that ----- is safely discharged from hospital.

Yours sincerely

Dear _____

date _____

Regarding _____.

Following the Case Conference which was held on _____ at ward _____ Hospital which you attended, it was agreed by the Multi disciplinary team who have been working with _____ that he/she was fit to be discharged from hospital and all in attendance including yourself agreed with this decision.

At this meeting you were made aware of the process the Trust expects you to follow and failure to support _____ in finding an appropriate placement may result in the Trust being forced to pursue the Patient Choice Directive Policy. As it is now 14 days since this agreement was reached we would like to invite you to meet with the same team as on _date, time and location to discuss the progress you are making in your selection of a suitable care home for _____.

Please contact _____ on telephone no; _____ on receipt of this letter to confirm your attendance on __ date, time and location

We look forward to hearing from you

Yours Sincerely,

THE NEWCASTLE UPON TYNE HOSPITALS NHS FOUNDATION TRUST
IMPACT ASSESSMENT – SCREENING FORM A

This form must be completed and attached to any procedural document when submitted to the appropriate committee for consideration and approval.

Policy Title:	The Newcastle upon Tyne NHS Foundation Hospitals Trust Patient Choice Directive Policy	Policy Author:	Dot Kyle – Patient Services Manager/Emergency care Lead
		Yes/No?	You must provide evidence to support your response:
1.	Does the policy/guidance affect one group less or more favourably than another on the basis of:		This policy does not discriminate against the individual on grounds of, nationality, race, gender, sexuality, religious belief, ethnicity, culture or disability.
	• Race	No	
	• Ethnic origins (including gypsies and travellers)	No	
	• Nationality	No	
	• Gender	No	
	• Culture	No	
	• Religion or belief	No	
	• Sexual orientation including lesbian, gay and bisexual people	No	
	• Age	No	
	• Disability – learning difficulties, physical disability, sensory impairment and mental health problems.	No	
2.	Is there any evidence that some groups are affected differently?	No	
3.	If you have identified potential discrimination, are any exceptions valid, legal and/or justifiable?	N/A	
4(a).	Is the impact of the policy/guidance likely to be negative? (If “yes”, please answer sections 4(b) to 4(d)).	No	
4(b).	If so can the impact be avoided?	N/A	
4(c).	What alternatives are there to achieving the policy/guidance without the impact?	N/A	
4(d)	Can we reduce the impact by taking different action?	N/A	

Comments:	Action Plan due (or Not Applicable): Not applicable
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Name and Designation of Person responsible for completion of this form: Dot Kyle, Patient Services Manager/Emergency Care Lead..... Date: 02032010.....

Names & Designations of those involved in the impact assessment screening process:..... Sue Cummings Discharge liaison facilitator.....

(If any reader of this procedural document identifies a potential discriminatory impact that has not been identified on this form, please refer to the Policy Author identified above, together with any suggestions for the actions required to avoid/reduce this impact.)

For advice on answering the above questions please contact Helen Lamont, Director of Nursing, or, Christine Holland, Senior HR Manager. On completion this form must be forwarded electronically to Steven Stoker, Clinical Effectiveness Manager, (Ext. 24963) steven.stoker@nuth.nhs.uk together with the procedural document. If you have identified a potential discriminatory impact of this procedural document, please ensure that you arrange for a full consultation, with relevant stakeholders, to complete a Full Impact Assessment (Form B) and to develop an Action Plan to avoid/reduce this impact; both Form B and the Action Plan should also be sent electronically to Steven Stoker within six weeks of the completion of this form.