Appendix 1

Reviewed and Updated Version March 2008 for the Multi-Agency Discharge Steering Group

Joint Protocol for the Transfer of Care under the Community Care (Delayed Discharge) Act 2003

An Agreement between:

Leeds City Council

- Social Services
- Housing Services

Leeds Teaching Hospitals NHS Trust

Leeds Primary Care Trust

Harrogate and District NHS Foundation Trust

Mid Yorkshire Hospitals NHS Trust

1. Purpose

1.1 This protocol is intended to eliminate all delays in the transfer of care of acute patients:

- It sets out the principles of reimbursement and the health economy agreement on the expenditure for purposes of joint investment.

- It ensures that people are cared for in the most appropriate environment.

- It recognises that a whole system agreement is necessary to eliminate delayed transfers of care.

1.2 Whilst the major focus is upon acute beds the protocol also supports the 4 hour A&E standard and ensures best use of overall bed capacity, which in turn supports a well organised admission and discharge process.

1.3 This protocol recognises that systems and processes may be slightly different for out of Leeds hospitals, however the principles remain the same.

2. Principles

The protocol is based on the following principles:

- That joint working and the sharing of responsibility across agencies is key to eliminating delayed transfers of care.

- All health and social care organisations are committed to a whole systems approach, whereby responsibility for effective patient care and the discharge process is a shared responsibility across organisational boundaries.

- Planning patients' transfer/discharge should commence on or before the day of admission to hospital.

- The transfer of care process will focus on the persons needs and both they and their carers should be involved and kept informed of what is happening at all times.

- The management (including assessment) of a person's health and social care needs should be a single process. Duplication of effort is time consuming for professionals and frustrating for patients.

- That people will receive the right type of care in the right place at the right time.

- A commitment to the development of community resources to avoid inappropriate hospital admissions and to prevent A&E being used as the main gateway to health and social care services.

- Optimum use of bed capacity resources

- Acute hospital beds are for people with acute medical care needs. People who do not have acute medical care needs should not be admitted to acute beds and those who have acute medical care needs on admission should be transferred as soon as they are medically fit and safe for discharge.

- On transfer from acute care the first consideration should be for the patient to return home, safely and with the appropriate support. If necessary a transitional/interim placement will be offered whilst appropriate support or adaptations are put in place.

- Only in exceptional circumstances should patients transfer directly to long term residential or nursing home care. In the majority of cases the community care assessment should be completed in a non acute environment.

- Reimbursement is a catalyst for change not an excuse for more bureaucracy.

3. Definitions

Whilst the principles apply to all patients the legislation only applies to patients in receipt of acute care. Acute care is:

"Intensive medical treatment provided by or under the supervision of a consultant which is for a limited time after which the patient no longer benefits from that treatment".

Reimbursement may apply to all delayed acute adult patients who qualify for services under the NHS and Community Care Act 1990 – irrespective of their age.

4. For the purposes of this protocol acute care does not include any of the following:

- Care in respect of which the patient has given an undertaking to pay (or for whom such an undertaking has been given)

- Maternity care, that is care of expectant and nursing mothers

- Mental health care (defined as psychiatric services or other services provided to a patient for the purposes of the prevention, diagnosis or treatment of illness where the person primarily responsible for arranging those services is a consultant psychiatrist).

- Palliative care

- Intermediate care (a structured programme of care provided for a limited period of time to assist a person to maintain or regain the ability to live in his home)

- Care provided for the purposes of recuperation or rehabilitation.

4.1 Patients whose primary reason for admission to hospital is an acute physical condition but where there is a secondary condition relating to mental health or learning disability **are** included in the reimbursement category.

4.2 Patients receiving non acute care or rehabilitation within an NHS hospital and those waiting to transfer from acute care to Intermediate Care services **will not** be counted for purposes of reimbursement.

4.3 Non acute care will be determined by the individual patient's needs.

4.4 However, the principles of the discharge process will apply to non-acute care equally and the joint assessment process will address **all** delays.

5. Liability under the Community Care (Delayed Discharges) Act

5.1 Adult Social Care Authorities will be deemed liable to make delayed discharge payments where they have the **sole** responsibility for the delay in discharge of acute patients in the following circumstances:

See Appendix 1 for list of codes and definitions

- Where notice of a patient's case under Section 2 of the Act and notice of proposed discharge under Section 5 (3) have both been given and are in force.

- The Adult Social Care Authority has not carried out an assessment of a patient's needs with a view to identifying any community care services that need to be made available in order for it to be safe for the patient to be discharged.

- The Adult Social Care Authority has not made available for the patient a community care service which it decided under Section 4 (2) (b) to make available to him

- The Adult Social Care Authority has not carried out an assessment of needs of any carer identifying services which:

  a) May be provided under Section 2 of the Carers Disabled Children Act 2000 and

  b) Needs to be made available to the carer in order for it to be safe to discharge the patient

- The Adult Social Care Authority has not made available services which may include:

- Equipment and Adaptations

  Where social care equipment is awaited from the Leeds Equipment Service or adaptations to a patient's home are required before the person can return home.

5.2 Housing/Homelessness

Vulnerable people of no fixed abode, asylum seekers (where the local authority has duties under the Human Rights Act, National Assistance Act, and NHS Community Care Act) are the responsibility of the local authority from which the patient was admitted and the appropriate Adult Social Care Department will be held accountable for any delays in the assessment or provision of service.

Leeds City Council, Neighbourhoods and Housing will provide a specialist assessment service and will provide advice and support to health and social work professionals involved in the discharge process, where it has been identified that the patient is unable to be discharged to their current home, or where discharge to their current home would prove detrimental to their heath. Primarily this will be achieved through referral via EasyCare to the Medical Rehousing Team (see **Appendix 8**). In the interim discharge processes and, if necessary, the Escalation Policy will apply.

If a patient is waiting for accommodation only, rather than for adaptations to existing accommodation or other community care services to be arranged or provided by the local authority, then reimbursement will not apply, as housing is not a community care service.

5.3 Self Funders

Where an assessment and/or arrangement to place or provide community services is undertaken by Adult Social Care this means that Adult Social Care are liable, under reimbursement, even though the person may fully fund their own care.

Self funding patients and their families/carers refusing to participate in finding discharge placements into permanent/interim/transitional care will be subject to the implementation of the **Escalation Policy** (see below and **Appendix 2**).

5.4 Community Intermediate Care Beds/Community Unit - Seacroft V Ward

Assessment for Community Intermediate Care (CIC) tier beds will be determined by Leeds PCT. Patients assessed as suitable for a Community Intermediate Care Beds will be offered a placement from a city wide bed base. Patients cannot refuse a CIC bed based on the geography of the placement. Every effort will be made to ensure placement close to the patient's home, however, remaining in an acute hospital bed is not an option and a vacancy in a CIC bed in other areas of the city will be pursued.

Patient's refusing discharge to a CIC bed will be subject to the Escalation Policy (Appendix 2). Patients awaiting access to Community Intermediate Care Beds/services are not currently liable for reimbursement.

5.5 **Choice**

Remaining in an acute hospital bed is **not** an option. Adult Social Care are liable, under reimbursement, for patients who remain in an acute bed whilst waiting for a care home of their choice. In these circumstances the patient will be moved to an interim placement. If they refuse to move from the ward then the **Escalation Policy** will apply (see appendices for Choice, Escalation Policy and patient information details).

5.6 There will be no liability for delayed discharge payments from Adult Social Care in the following circumstances:

Where a patient does not agree to be referred to Social Services and they plan to make their own care arrangements on discharge. If discharge is not achieved in a timely manner, and within the prescribed timescales the **Escalation Policy** will be instigated, see appendices for details.

- When the discharge assessment process is awaiting the contribution of a health care professional/clinician (e.g. consultant psychiatrist). However, it is expected that all contributions to the assessment will be completed and available in a timely manner. Should there be an unreasonable delay in the process the issue will be immediately brought to the attention of the Lead Director.

- The non availability or delay in accessing non acute health services; primary health care services, palliative care services or intermediate tier services. Any unreasonable delay in accessing services will be brought to the attention of the Lead Director.

- Where there is a disagreement within the multi-disciplinary team that a patient is either not fit or safe to discharge. These patients will transfer into the Medically Unwell (M1) category and the Section 5 will be held in abeyance until the patient is well.

- Where Adult Social Care has arranged and funded an alternative placement or community care service but the patient or their relative refuses to allow them to leave an acute hospital bed. In this instance the **Escalation Policy** will be activated.

- Where the patient is eligible for Continuing Health Care funding and services.

- Where notices under Section 2 and Section 5 (3) of the Act have not been properly served and / or are not still in force pursuant to regulation 4 and 5 of the Delayed Discharge (England) Regulations 2003.

- Where circumstances set out in Regulation 9 apply. In these instances the decision on reimbursement will be dependent upon the decision of the Appeals Panel. (See 20.2).

5.7 Liability for delayed discharge payments commences the day after the relevant day as referred to in Section 5 (6) of the Act and Regulation 8 (1) of the Delayed Discharge (England) Regulations 2003

5.8 Notice under Section 2 and Section 5 (3) shall be deemed to have been served pursuant to Regulation 10 of the Delayed Discharge (England) regulations 2003

5.9 The period of reimbursement will end on the day that the Local Authority has completed the assessment and/or made available the resources to meet assessed needs or if, according to the MDT, the patient is no longer fit for transfer. Patients discharged before 11am will be treated as though discharged the preceding day.

5.9.1 Once reimbursement has been triggered every day a patient is delayed in acute care is counted.

6. Information Sharing

6.1 The pan-Leeds information sharing policy will apply to all aspects of this protocol. This is based on the premise that information on a person can only be shared if they give their informed consent.

7. Multi Disciplinary Assessment

7.1 A patient is ready for transfer when:

- A clinical decision has been made that the patient is ready for transfer AND
- A multi-disciplinary team decision has been made that the patient is ready for transfer AND
- The patient is safe to discharge/transfer

7.2 A multi-disciplinary team in this context includes nursing and other health and social care professionals, who are caring for a patient in an acute setting.

7.3 An MDT assessment requires a minimum of three members; a clinician a therapist and a Hospital/Community Social Worker/Joint Care Manager.

7.4 See appendix 4 for flowchart with triggers for S2 and S5 documentation.

8. NHS Continuing Care

On 1st Oct 2007 a new National policy came into effect called the National framework for NHS continuing healthcare and NHS – funded nursing care. This introduces three new national tools to aid decision making.

8.1 It is important that the NHS can demonstrate that it has been considered
whether a patient may be eligible for NHS Continuing Health Care (CHC)funding prior to an assessment notification being issued?

8.2 To fulfil this need a **NHS Continuing Healthcare Needs Checklist** should be completed by any member of the professional Multi Disciplinary Team. This will indicate whether there is a need for full eligibility consideration by the PCT. The outcome of this screening process should be notified to the patient and documented in the patients' records.

8.3 Where full assessment is indicated the **Checklist** should be sent to the Discharge Referral Point (DRP) along with the;

- SAP Contact Assessment,
- Specialist Nursing Assessment,
- Fax Cover Sheet
- S2 notification.

The case will then be allocated to the appropriate care manager and Continuing Care Team. A care manager can be a Joint Care Manager, a Hospital Social worker or a Community Social Worker.

8.4 Where a full assessment is **not** indicated MDT members, including ward staff, should be aware that if a patient's health condition deteriorates prior to discharge the above **Checklist** process should be repeated and the original Section 2 withdrawn.

8.5 The Care Manager will then facilitate the completion of the national **Decision Support Tool** taking account of all the MDT assessment information, including all relevant clinical information provided by ward staff, as evidence to inform the recommendations.

8.6 Where indicated the **Decision Support Tool** recommendation will be presented to the next City wide CHC Panel to determine a patient's eligibility for CHC funding.

8.7 Where a patient has a rapidly deteriorating condition, which may be entering a terminal phase, an urgent referral for care planning should be made. This will require the completion of a **Fast Track Tool** by an authorised clinician.

8.8 The discharge planning process, including any choice directive or escalation issues, should proceed as normal whilst CHC eligibility is determined.

8.9 At any point in the process the patient or their representative can appeal the decision and ask for a review. The CHC team will offer advice and support in this circumstance.

The National Framework document and decision support tools are available on Leeds Health Pathways, or they can be found at:

http://www.dh.gov.uk/en/Policyandguidance/SocialCare/Socialcarereform/Continuingcare/index.htm

9. Transfer / Discharge Assessments

9.1 The SAP Contact Assessment, along with the Specialist Nursing Assessment, is used to share information about the patient and their needs on transfer/discharge. The assessment will then continue in the most appropriate setting which may be the person's own home, an interim care arrangement or an intermediate care service.

9.2 The transfer/ discharge assessment should include carers needs but as these will relate specifically to the patients discharge, a more detailed assessment may be required as part of the ongoing assessment process.

10. Medical Transfer of Care

10.1 Patients considered by the Multi Disciplinary Team to be ready and safe to transfer will do so subject to a continuity of medical care. This will follow the current practice i.e. :-

- If a patient is relocated, but remains within their practice area, they will be retained on their own GP's list.

- If a patient is relocated, outside of their practice area, they will be a temporary resident and included on the list of a G.P. in the host area.

- If a patient is relocated for longer than 3 months then they should transfer to a G.P. in the new area

10.2 Communication relating to the continuity of medical care will follow the existing practice and procedures.

10.3 The G.P. practice responsible for a patient's care would normally be identified to the hospital by the patient / relative / carer. In the event of there being a difficulty the acute hospital should contact the West Yorkshire Central Services Agency (WYCSA) Tel 0113 295 2500, who would have the responsibility to arrange GP cover in order to ensure a safe discharge.

11. Process Unplanned Admissions:

11.1 Discharge planning begins on a patient's admission to hospital.

11.2 On admission the Senior Nurse/Lead Nurse on the ward will complete the admission details using Single Assessment Process (SAP) documentation (or the local alternative for out of Leeds hospitals) and begin to identify any potential need for services on transfer/discharge.

11.3 The patient's admission details will, with their consent, be forwarded to the relevant PCT Discharge Referral Point (DRP) and/the Adult Social Care Communication Centre (CCC), based at the Seacroft site.

11.4 The Senior Nurse/Lead Nurse will discuss the discharge process including the possibilities of transitional care with the patient and their carer and this will be reinforced through the provision of the LTHT Transfer/Discharge letter and other relevant information regarding the assessment, care planning and transfer/discharge process.

11.5 The patient and carer will be advised of the likely discharge/transfer date and timescales for completing the discharge process.

11.6 Where a patient is identified as likely to need support on transfer/discharge the Senior Nurse/Lead Nurse will submit a Section 2 notification to the relevant PCT Discharge Referral Point and Care Communication Centre as soon as possible after admission. This will require a transfer/discharge assessment, identifying needs and services to facilitate a safe transfer/discharge. Adult Social Care have a minimum period of three days to carry out an assessment and arrange services.

11.7 As a matter of good practice the assessment will be completed within 48 hours of notification and services arranged where appropriate. The outcome will be communicated to the patient and reiterated by the Senior Nurse/Lead Nurse.

11.8 Following confirmation by the multi-disciplinary team, that the patient is fit and safe for transfer/discharge, the Senior Nurse/Lead Nurse will submit a Section 5 notification to the relevant PCT Discharge Referral Point and/or Care Communication Centre giving notice of the proposed discharge date. The Senior Nurse/Lead Nurse will inform the patient and carer of this date.

11.9 The Section 5 notification will give a minimum period of 24 hours for services to be made available. For reimbursement purposes this period excludes the 48 hour minimum period for assessment.

11.10 Any patient/carer dispute regarding the planned transfer/discharge will be reported to the relevant PCT Discharge Referral Point and/or Care Communication Centre and referred in accordance with the **Escalation Policy** (see appendix 2).

11.11 All patients are monitored on a daily basis and the Senior Nurse/Lead Nurse will immediately inform the relevant Discharge Referral Point and/or Care Communication Centre of patients whose needs have changed. This will include those who now require an assessment under Section 2 notification and patients who have been referred and whose condition has deteriorated making them unfit for transfer / discharge, (this will be as a withdrawal of the Section 5 notification).

12. Specific Requirements for Planned Admissions

12.1 Where a pre-admission assessment identifies that a patient is likely to need social care support after transfer from acute care, the admission assessor has the responsibility to notify Adult Social Care, via the relevant Discharge Referral Point and Care Communication Centre of this need. This Section 2 notification must not occur earlier than 8 days prior to admission and not later than 3 days prior to transfer/discharge.

On receipt of the Section 2 notification the process will be as an unplanned admission.

13. Documentation

13.1 Transfers of care are subject to the Single Assessment Process (SAP). EASYcare (or a local adaptation of it) amended to include essential reimbursement data, will be used as the agreed Contact and Overview SAP documentation.

13.2 It is acknowledged that SAP will be introduced in stages across the patch (see list on cover); in the interim, systems will be deployed that are both compatible with SAP and create the minimum of disruption.

13.3 On admission a patient's details will be entered onto the Contact Assessment.

13.4 The Contact Assessment will be used by the ward as the formal notification under Section 2. This will require that the "Section 2" box is completed on the form which will be forwarded, along with the Specialist Nursing Assessment and the NHS Continuing Healthcare Needs Checklist, either as a fax or as an attachment to an e-mail to the appropriate Discharge Referral Point and Care Communication Centre.

13.5 Ward staff will complete the Ward Fax Cover Sheet, indication potential services required. This will be faxed to the relevant Discharge Referral Point and Care Communication Centre who will signpost appropriately.

13.6 The receiving team will contact the ward staff immediately on receipt of the referral information in order to provide a named contact and contact details.

13.7 The assessment of need will use the appropriate SAP documentation (Contact, Overview, Specialist or Comprehensive).

13.8 The proposed outcome of the assessment will be entered onto the computer held record system (ESCR), where this is not possible it should be e-mailed / faxed back to the Care Communication Centre (as a minimum requirement this will be the Care Plan Summary) who will record the information and inform the ward.

13.9 The Section 5 notification will be e-mailed / faxed by the ward staff to the Care Communication Centre / Discharge Referral Point who will inform the relevant Care Management Team or Service Provider of the discharge date and confirm the provision of a service.

13.10 For the purposes of reimbursement it is essential that all forms are **signed** and include the **date** and **time** of referral and are legible.

14. The Care Communication Centre

14.1 This service is located within LTHT and provides a centralised administrative function in relation to the requirements of reimbursement, brokering of Homecare, Bed Bureau for the independent sector (residential and nursing) and the processing of invoices in relation to these tasks. The team collate information from the five single Discharge Referral Points in the PCTs.

14.2 The Care Communication Centre is the clearing house for all documentation with regard to the above and is responsible for tracking the process flow and recording the details. It undertakes an administrative role in following but not determining care pathways. In this respect it acts as an extension of the bed management function.

14.3 The Care Communication Centre operates between 8.00am and 6pm, 5 days each week, closed weekends, Bank Holiday cover will be advised. CCC staff immediately search for a provider for the required service, placement of homecare.

14.4 For reimbursement purposes the Care Communication Centre should be advised, by care management teams and ward staff, of any delays / discrepancies in the discharge process and the reasons for these. This aids the reconciliation of the invoices with the activity.

15. Discharge Referral Points

15.1 The Discharge referral point (DRP) is primarily for Leeds residents being discharged from LTHT who require services to support them on discharge. There are separate care pathways for patients who are independent, reside outside the Leeds boundary, or for patients on wards with Trust funded social workers. Each Leeds PCT wedge has a separate contact number. The service is available Monday – Friday from 8am – 8pm, and 9am – 5pm at weekends and Bank Holidays.

The documentation used by the DRP is the SAP Contact Assessment documents, the Specialist Nursing Assessment and NHS Continuing Healthcare Needs Checklist. Further assessments may be required once the referral has been received. The referrer is asked to clearly indicate the reason for the referral and only fully completed documentation will be accepted.

The LTHT Discharge Information Pack contained within the LTHT Adult Discharge Policy (http://nww.lhp.leedsth.nhs.uk/common/guidelines) has been circulated to all teams and discharge advisors containing key contacts and specific referral pathways, including palliative care, NFA, restart existing packages, and readmission to care home.

16. Finance

16.1 The finance to support reimbursement will be managed in an open and transparent way and will be used to facilitate the timely discharge of patients who might otherwise be delayed.

16.2 All partners will be informed, in agreement and involved in the decisions made relating to use of reimbursement monies.

16.3 During 2006/07 a portion of reimbursement monies will be utilised to support the continuation of the Task Force and a member of the team of Discharge Advisors.

16.4 Information flow in respect of Section 5 notices and invoicing will be as detailed in **Appendix 7**

16.5 All organisations/partners are committed to a shared approach to managing discharge and as such will produce a Joint Investment Plan which details expenditure specifically targeted towards eliminating delayed discharges. Once completed and agreed, the JIP will replace the finance section of this document.

17. Education / Training

17.1 All relevant staff will be briefed on this protocol and the implications for their working practice. It will also be included in the ongoing induction for new starters within LTHT, Adult Social Care and the PCT. Specialised training will be provided as appropriate. Staff from out of Leeds hospitals will be briefed appropriately.

18. Patient Disputes

18.1 Where patients or carers are in dispute regarding an assessment and proposed outcome this will be dealt with under the **Escalation Policy**. This will require an immediate decision whether or not to "stop the reimbursement clock" and a follow up plan on how to resolve the issue. In all cases the patient will be expected to move to a more appropriate setting whilst the dispute is resolved.

19. Inter – Agency Disputes

19.1 Where there is a dispute between LTHT and Leeds Adult Social Care and /or the PCT, regarding reimbursement, that cannot be resolved as per Appendix 7, then the matter will be referred to the local dispute panel. The membership of this will be:

- Divisional General Manager - Medicine Division (LTHT)
- Head of Service Delivery (Adults) (Adult Social Care)
- Head of Intermediate Tier (Leeds PCT)

19.2 If the dispute cannot be resolved locally, it will be referred to the panel established and chaired by the West Yorkshire Strategic Health Authority. The decision of the panel is binding to all parties.

19.3 Disputes between Leeds Social Services and an out of Leeds hospital will be dealt with by appropriate director level staff.

20. Cross Boundary Issues

Leeds residents in out of Leeds acute hospital care but within England will be the responsibility of Leeds Social Services. In these circumstances the acute hospital involved should send the statutory notifications to the Care Communication Centre. It is the responsibility of the Care Communication Centre to direct any relevant referrals to the appropriate Discharge Referral Point.

Out of Leeds residents who are in acute care in Leeds Teaching Hospital Trust are the responsibilities of the Local Authority where the patient normally resides. In these circumstances the Care Communications Centre will instigate the assessment process and has the responsibility to notify and liaise with the relevant authority.

21. Appendices

- Delayed Discharge codes
- Escalation Policy
- Escalation Flowchart
- Flowchart for S2 and S5 process
- Patient information letter 1
- Patient letter 2
- Responsibilities on issue of Section 5
- Referral process to Housing Services

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Review February/March 2008 for Ratification

Sue Jones Discharge Taskforce LTHT
Margaret Faulkner Discharge Taskforce Adults Social Care
Leslie Petrie Leeds PCT

Appendix I

DELAYED DISCHARGE CODES

DELAYED DISCHARGE CODES

Version 1 - March 2008

Leeds Delayed Discharge Codes	Description of Delay	Reimbursement YES/NO		Links to National Delay Code
A1	Family not provided information for financial assessment	YES		A
A2	Unallocated case i.e. SW/Community SW/JCM	YES		A
A3	Assessment not completed by JCM/SW	YES		A
A4	Continuing Care Assessment not completed by SW/JCM		NO	A
A5	Ward Staff not completed their part of the assessment		NO	A
A6	Continuing Care Assessment not yet completed by health staff		NO	A
C1	Patient/Carer/Family choosing Residential home	YES		D1
C2	Awaiting Assessment by Residential home	YES		D1
C3	Agent not report patient on any waiting lists	YES		G
C4	Patient/Carer/Family choosing a Nursing Home replacement	YES		D2
C5	Awaiting Assessment by Nursing Home	YES		D2
E1	Home Care availability	YES		E
E2	Equipment – Social	YES		F
E3	Patient of no fixed abode		NO	I
E4	Home adaptations	YES		F
E5	Equipment – Health		NO	F
F1	Patient awaiting LA funding for chosen placement /Complex package of care	YES		B
I1	Awaiting action within LTHT (e.g. investigation, therapy. referral to consultant)		NO	N/A
I1a	Therapy (inc OT and Physio)		NO	N/A
I1b	Care Planning Meeting		NO	N/A
I1c	Review by another Consultant		NO	N/A
I1d	Investigations		NO	N/A
I2	Delayed in non-acute/rehab bed		NO	N/A
MI	Medically Unwell		NO	N/A
N1	Awaiting Continuing Care placement		NO	C
N2	Awaiting action by Hospital Trust outside Leeds		NO	C
N3	Awaiting action by Mental Health (including assessment)		NO	C
N4	Awaiting action by ICT (including assessment)		NO	C
O1	Disputed discharge e.g. family disagree with professionals		NO	H
O2	Professional disagreement		NO	H
O3a	Self Funding for Residential/Nursing Placement		NO	G
O3b	Self Funding for EMI Residential/Nursing Placement		NO	G
O3c	Declined Interim Placement whilst awaiting Home Care Package		NO	G
O3d	Declined Block Placement		NO	G
O3e	Legal issues/guardianship signing with Solicitor		NO	H
O3f	Carer/Family issues		NO	G
O4	Patient/Carer/Family exercising choice		NO	G
V1	Awaiting vacancy in Residential Care	YES		D1
V2	Awaiting vacancy in Nursing Home	YES		D2
V3	Awaiting vacancy in Residential EMI Care	YES		D1
V4	Awaiting vacancy in Nursing EMI Care	YES		D2
V5	Awaiting vacancy in Local Authority Part 3	YES		D2
V6	Awaiting interim placement (housing patient)	YES		D2
V7	Awaiting transfer to Residential Home	YES		D1
V8	Awaiting transfer to Nursing Home	YES		D2

All level codes mapped to National Sitrep codes A - I
These are:-
A – Awaiting completion of Assessment
B – Awaiting public funding
C – Awaiting further (non acute services) NHS Care (including ICT, Rehabilitation).
D – (i) Awaiting Residential Home Placement or availability
(ii) Awaiting Care Package in own home
F – Awaiting Community Equipment and Adaptations
G – Patient or Family Choice
H – Disputes
I – Housing – Patient not covered by NHS and Community Care Act

Appendix 2

Choice on Discharge (taken from LTHT Discharge Policy)

DISPUTED DISCHARGE/ESCALATION PROCESS

For the successful discharge/transfer of patients to take place it is essential that there is good communication in an appropriate format/language between all parties involved. Discharge planning is not a single event at the end of a stay in hospital but is a continuous process which begins on admission to the hospital, if not before. The Leeds Teaching Hospitals NHS Trust along with its partners in Primary Care and Social Services are committed to providing a high quality service for all patients.

With this in mind it is essential that the smooth transition from the hospital back into the community be achieved to allow access to the hospital for acutely ill patients who require its services.

For a small group of individuals the transition into the community becomes delayed for numerous reasons. This escalation policy is intended to aid the resolution of any difficulties that patients are experiencing with being discharged from hospital in a timely manner.

Where discharge planning does become problematic and the escalation plan is implemented patients, families and carers will be encouraged to seek an advocate (See Section 12 below) or appropriate independent advice.

11.1 **TYPES OF DISPUTES**

Discharge disputes which may require escalation fall into a number of categories. The examples given below are to guide staff when questioning the need for further support in discharging patients.

- Patients/families/carers repeatedly refuse offers of permanent/interim nursing/residential home placements.
- Patients who will be self funding and their families/carers refuse to participate in finding discharge placements for permanent/interim care.
- Patients refusing/delaying participation in financial assessments.
- Patients/families/carers refusing outcome of financial assessments/continuing care assessments, etc.
- Patients/families/carers refused Level 5 Continuing Care Funding and alternatives not accepted.
- Staff perceptions of individual's/families as being unreasonable in their behaviour and expectations.

12 *ESCALATION POLICY FOR DISPUTED DISCHARGES*

Discharge planning will continue throughout the stay in hospital whilst the patient is in receipt of treatment from the ward team.

12.1 If during this time it is identified that the patient will be unable to return directly (if at all) to their previous accommodation, the Social Worker / Joint Care Manager will work with the patient/family/carers and the multi disciplinary team (MDT) to identify a suitable alternative, with a current vacancy, including residential or nursing home placement.

12.2 The MDT reaffirms the procedure and process and gives the patient/family/carers a Confirmed Date of Discharge 12-24 hours prior to leaving.

For patients who have been assessed as fit for discharge and all arrangements are in place staff planning the discharge will complete a discharge planning check list and plan for a morning discharge. On St James University Hospital and Leeds General Infirmary sites patients will await final discharge arrangements in the Hospital Discharge Lounge.

12.3 If there is not an agreed discharge date the patient/family/carer will be provided with a letter regarding planning for discharge and support / advice services available for patients/family/carers.

12.4 If the patient/family/carer disputes the discharge arrangements or discharge date and members of the multi-disciplinary team feel they have explored all possibilities, the escalation process will be instigated. Escalation has been designed as a four stepped approach. This endeavours to support staff, patients and their carers/families in timely resolution of disputes.

12.5 **ESCALATION POLICY – LEVEL 1**

All multi-disciplinary attempts to facilitate discharge in conjunction with the Discharge Facilitation Team and relevant community staff have failed to elicit a discharge plan or date. The Team Leader for the Leeds Teaching Hospital's Discharge Facilitation Team will contact the Locality Matron and Matron for Specialty Medicine to advise of the situation both verbally and in writing. A way forward will be proposed with the Team Leader for Discharge Management enacting the plan on behalf of the Locality Matron.

The Team Leader for the Discharge Facilitation Team, Team Leaders for ASC*/JCM*/Community Services will meet with the patient, relatives/carers together within one week of referral. The escalation process will be explained. Information regarding assessments, within the bounds of confidentiality, can be explored. Discussion regarding options for on going care within local/national policies can be expected. The team can use this opportunity to re-iterate patient's rights including access to continuing health care review, independent advocacy and second medical opinions. The Team Leader for the Discharge

Management Team will keep accurate records of meetings and all other communications with patient and family.

If required advice regarding discharge and any proposed plans can be discussed with LTHT Risk Management Department.

If no resolution, ie no date for discharge, or discharge action plan made Escalation continues to Level 2.

***ASC/JCM may delegate roles to named discharge liaison staff, to act on behalf of Team Leaders. These individuals will have the authority to enact procedures for discharge for their organisations.**

12.6 ESCALATION POLICY – LEVEL 2

The Team Leader for the Discharge Facilitation Team will report to the Matron for Specialty Medicine, outlining the case, the action taken so far and the issues that still remain unresolved.

The Matron for Specialty Medicine will contact the family requesting an urgent meeting, and outlining the issues that need to be resolved. The meeting is to take place within a week of referral to Level 2. Adult Social Care* (Health Teams Manager)/JCM representatives (Team Manager Level*) will also attend the meeting if appropriate. If patient Advocacy/Independent Mental Capacity Advocates (IMCA) are required these should be present at the meeting.

If required advice regarding discharge and any proposed plans can be discussed with LTHT Risk Management Department.

Following the meeting the Matron for Speciality Medicine will write to the patient / family / carers to clarify the agreement reached or to explain the next steps in the process.

*** ASC/JCM may delegate roles to named discharge liaison staff, to act on behalf of Team Leaders. These individuals will have the authority to enact procedures for discharge for their organisations.**

12.7 ESCALATION POLICY - LEVEL THREE

The Matron for Speciality Medicine will send a report to the Divisional General Manager and Directorate Manager for Medicine. This report will be copied to the relevant PCT Director, and Service Delivery Manager (Adults) within Adult Social Care, outlining the case and the process which has taken place.

The Divisional General Manager for Medicine (who may delegate the to Directorate Manager) will decide on an outcome, or if further information is required contact the family requesting an urgent meeting and outlining the issues needing to be resolved. Any further meeting will take place within a week of referral to Level 3. Adult Social Care

Service Delivery Manager and /JCM representatives will also attend the meeting.

Following the meeting the Divisional General Manager will write to the patient/family/carers to clarify the agreement reached or to explain the next and final step in the escalation process. If no discharge outcome is arrived at then The Divisional General Manager for Medicine will brief the Chief Executive in order for him/her to decide on an outcome and discuss with partner agency colleagues.

12.8 ESCALATION POLICY - LEVEL FOUR

The LTHT Chief Executive or his/her representative will agree a course of action within a maximum of one week of receiving the Divisional General Manager's report. The LTHT Chief Executive will ensure any related agency is briefed and aware of the outcomes of all discussions.

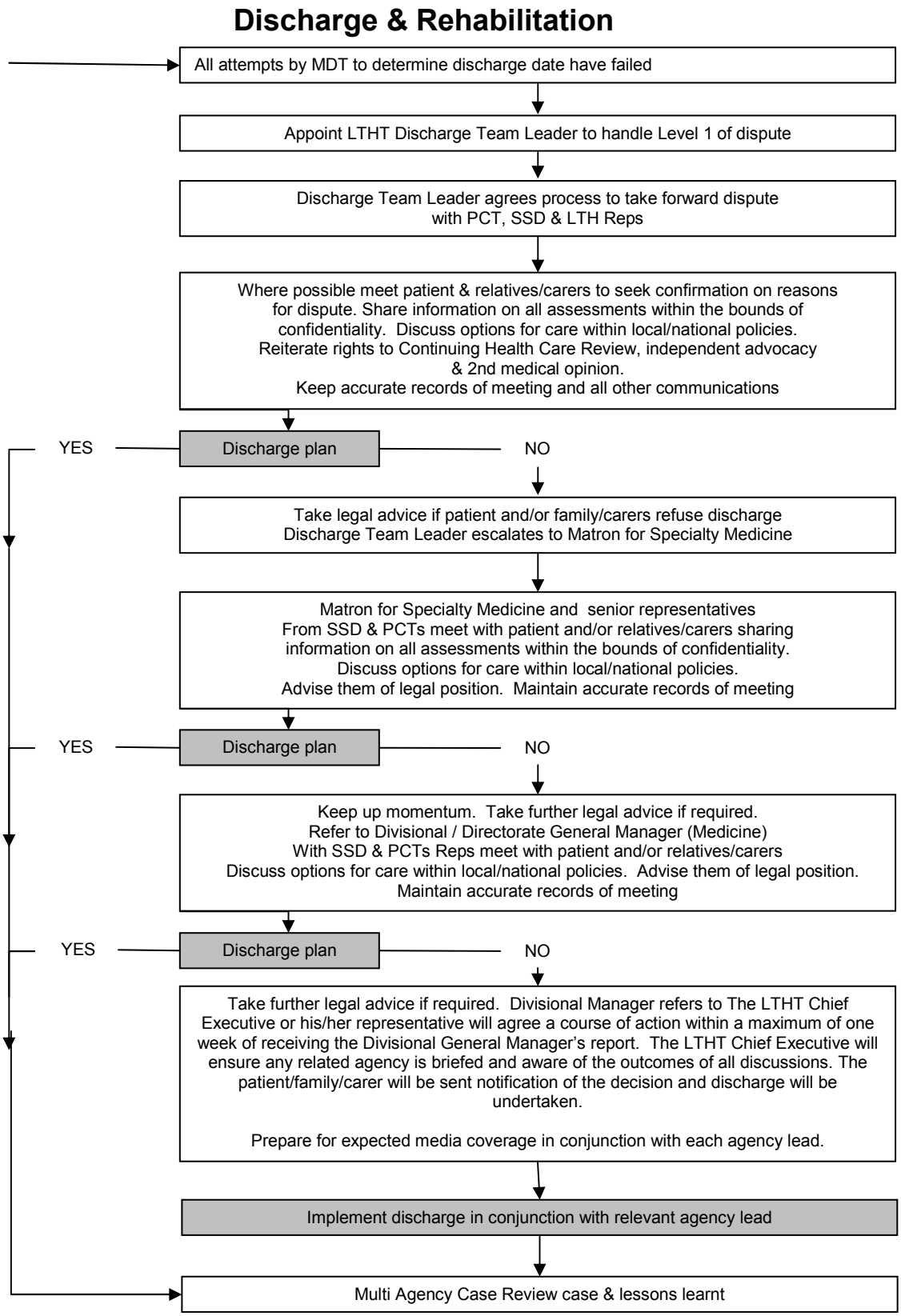
The family will be sent written notification of the decision, which has been reached.

All Agencies involved via their Chief Executives Office will prepare for relevant media coverage as the ultimate sanction will be to Discharge without patient/families/carers consent. Rarely this may involve the use of Security Staff or Police to support removal from LTHT premises.

It is anticipated that between each level of escalation report writing and briefing will take no more than 48 hours.

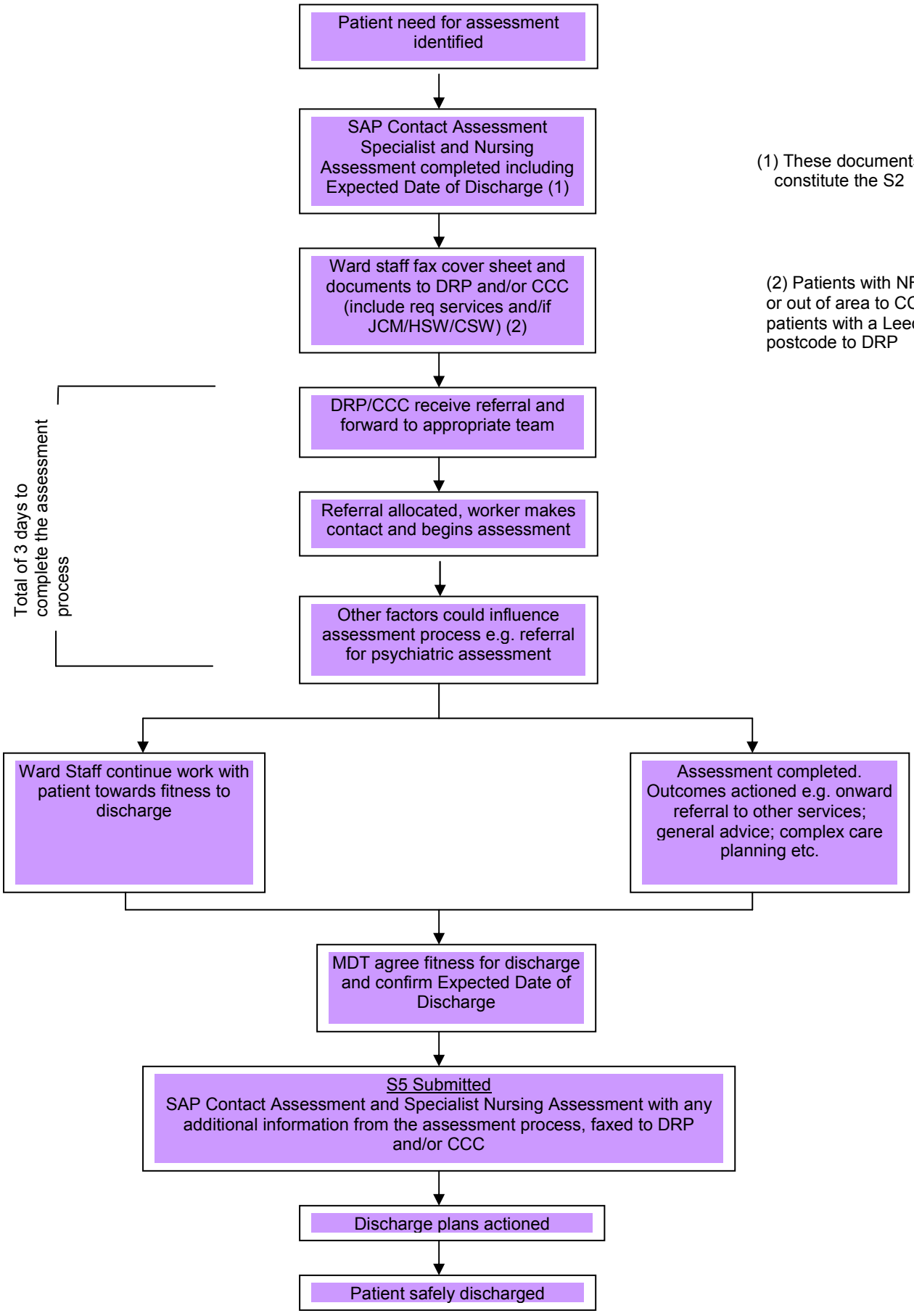
Appendix 3

Escalation Flowchart
(Discharge & Rehabilitation)



Appendix 4

Flowchart and Triggers for S2 and S 5



Appendix 5

Patient Information Letter 1

To be given to patient on admission and reiterated later

Dear Patient

Patient Information (Delayed Discharge Act 2003)

During your stay in hospital, health and social care services are here to help you and are required to follow national legislation on discharge planning.

This letter explains the policy that has been agreed by Leeds Adult Social Care, Leeds Primary Care Trust and Leeds Teaching Hospitals NHS Trust.

From the day of your admission into hospital we will ask you and your relatives/carer about your needs in order to support a safe discharge. When your consultant decides that you can be safely discharged from hospital, we will aim to move you as soon as possible. This could be to your own home or somewhere such as rehabilitation or a short stay unit in another hospital, residential or nursing home.

Most patients will be discharged straight home. Sometimes an immediate return home is not possible and you may need extra support. In these situations ward staff will arrange a referral to a social worker/care manager. The social worker/care manager will work with you and your family/carer so that the team in charge of your care can identify your needs and arrange the most appropriate help with your agreement.

If the assessment shows that you need residential or nursing home care to meet your long term needs, you and your family will be able to choose the home you wish to live in. **If this home does not have a vacancy and you choose to wait for a place to become available in your first choice home, you will be moved to a temporary place elsewhere which social services will arrange until your preferred choice is available, there may be a charge for this.**

Should you choose not to be referred to Adult Social Care or to fund your own care, then once you can be safely discharged from hospital you will be responsible for ensuring you have made appropriate arrangements and can be discharged.

If the assessment shows that you require a stay in a Community Intermediate Care bed (CIC bed in a residential/nursing home or the Community Unit - V ward at Seacroft) you will be advised of where a bed is available. You cannot refuse a CIC bed based on the geography of the placement and, whilst every effort will be made to place you in a CIC bed as near to your own home as possible, remaining in an acute hospital bed is not an option when CIC beds in other areas of the city are available.

If you have concerns about how you will manage after you are discharged, and ward staff have not yet discussed this with you, please speak with the Ward Sister or Nurse-in-Charge.

Dear

Your Choice of Care Home

The outcome of your assessment for your future care needs on discharge from hospital is that these can be met in a Care Home. Now that you no longer require an acute hospital bed we need to plan for your move to a care home placement.

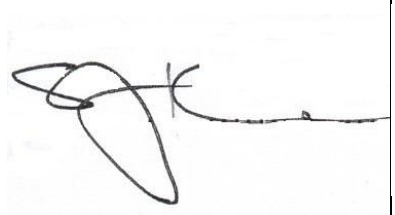
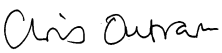
We hope your first choice of home is able to offer you a placement. However, many nursing and residential homes are full and you may be placed on a waiting list. If your chosen home is unlikely to have a bed within seven days of the issue of this letter we will plan for your discharge to an alternative care home placement, pending a vacancy becoming available in your home of choice.

This interim placement may be in any Care Home able to meet your care needs and with whom Adult Social Care Department has a contractual arrangement.

You will be financially assessed to contribute to the cost of care in any care home placement from the date of admission whether this is your home of choice or an interim arrangement.

If you have any queries about this advice please contact the social worker or care manager named above.

Yours sincerely

		
SANDIE KEENE Director Adult Social Services Leeds City Council	MAGGIE BOYLE Chief Executive Leeds Teaching Hospitals NHS Trust	CHRISTINE OUTRAM Chief Executive Leeds PCT

Dear

Advice on Transitional Placements

The assessment for your future care needs on discharge from hospital is that these can be met at home with the support of home care services.

As you no longer require an acute hospital bed and because the home care service is not available at the moment we need to plan for your discharge to a Care Home in what we call a transitional placement.

A transitional placement is a bed in a Care Home arranged by the Adult Social Care Department and provided to people who need a placement where their long term needs can be assessed and where support can be given to aid their recovery and independence.

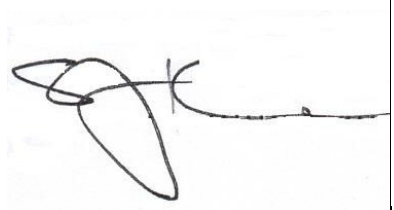
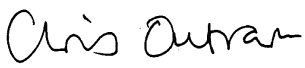
Such placements can also be used as a short term arrangement for people awaiting their home care service, so they can return to their own home once this is available.

If your home care service is still not available within seven days of the issue of this letter we will plan for your discharge to a Care Home.

There is no charge for this service for four weeks and within that time we will make every effort to have services in place for you to return to your home as soon as possible. Should your stay extend beyond the four week period then there will be a charge. You will be advised of this rate by your Social Worker/Joint Care Manager.

If you have any queries about this advice please contact the social worker or care manager named above.

Yours sincerely

		
SANDIE KEENE Director Adult Social Services Leeds City Council	MAGGIE BOYLE Chief Executive The Leeds Teaching Hospitals NHS Trust	CHRISTINE OUTRAM Chief Executive Leeds PCT

Appendix 7

LTHT, Leeds and Social Services Joint Protocol for Inter-Agency Responsibilities Upon the Issue of Section 5 (S5) January 2007

This protocol seeks to achieve inter-agency working to effect and expedite patient centred care.

It aims to ensure that a patient's discharge with social support is not delayed, but underpinned by the administration process which facilitates trusted and reliable flows of information.

1.1 Section 5 is faxed by the Ward within the Leeds Teaching Hospital Trust to the Care Communication Centre (CCC) or Discharge Referral Point (DRP). The Date of Section 5 issue is registered by CCC/DRP and on a daily basis date of issue and receipt is confirmed/cross-checked by Discharge Facilitation Administration Assistant. Cross checking includes reviewing the existence of a Section 2 to match the Section 5. The CCC/DRP will continue to inform the Discharge Facilitation Team of all S2s and S5s.

1.2 The Section 5 is dispatched by the CCC/DRP to the appropriate Care Manager. The Care Manager will issue a commencing Delay Discharge Code (Appendix 1), via a daily log sheet, sent to the Discharge Facilitation team by 10am each morning. This code will be logged by the Discharge Facilitation Team on the Delayed Discharge Database. *Community Social Workers will submit their coding via the appropriate PCT Joint Care Management Team. Hospital Social Workers will submit their coding via an independent daily log sheet.* **If the Discharge Facilitator does not agree with the commencing code, a telephone dialogue will be held to verify/determine a suitable code.**

1.3 Any disputes between Discharge Facilitator or Care Manager for patient coding will be referred to the Discharge Facilitation Team Leader and relevant Care Management Team Leader. If no agreement can be reached then escalation should be made to Matron for Specialty Medicine (Medicine) and Adult Services Manager (Hospital Services Adult Social Care). **NB If the Matron for Specialty Medicine and Adult Services Manager remain in dispute then escalation for arbitration is expected, as per the Joint Protocol for Transfer of Care, Interagency Disputes, Section 19.**

1.4 The Care Manager works with the appropriate external agencies and LTHT multi-disciplinary team to effect patient assessment and plan of care for a timely discharge. The Care Manager will continue to notify The

Discharge Facilitation Team of any perceived code changes. This will take place on a daily log sheet submitted to the Discharge Facilitation team by 10 am. *Community Social Workers will submit their coding via the appropriate PCT Joint Care Management Team. Hospital Social Workers will submit their coding via an independent daily log sheet.* The code will be logged on the Delayed Discharge Database and will record on an individualised reimbursement charge sheet (Appendix II). **If the Discharge Facilitator does not agree with the daily update coding, a telephone dialogue will be held to verify/determine a suitable code.**

Any disputes regarding on-going coding will be dealt with as per point 1.3

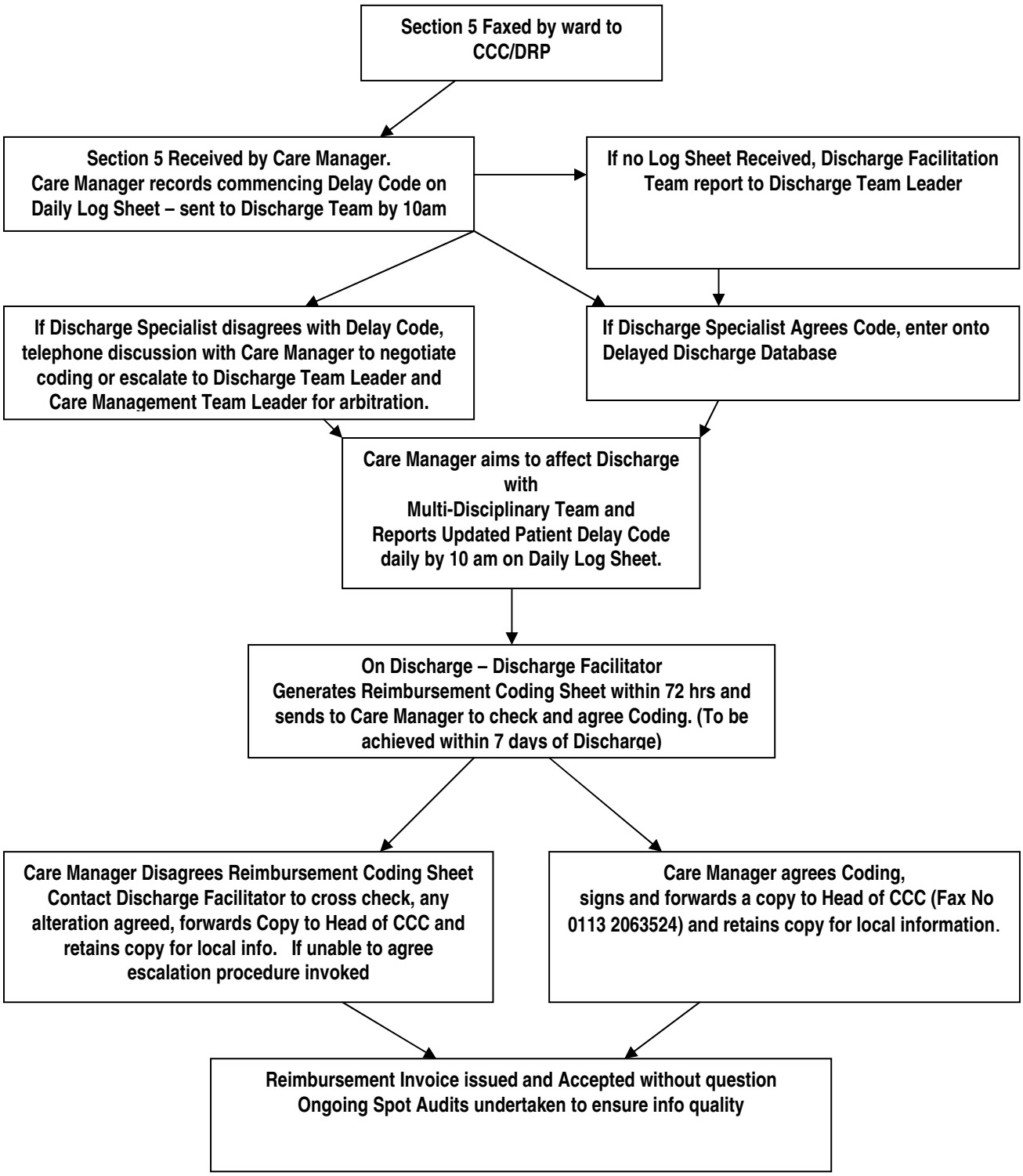
At the point of Discharge, if a patient has incurred a reimbursement charge the Discharge Facilitation Team Administration Assistant will fax the Care Manager a copy of the Individualised Reimbursement Coding Sheet checked and signed by the Discharge Facilitation Team. All Delay Codes for the patient, whether reimbursable or non reimbursable, will be clearly displayed and dated. The Care Manager must crosscheck his/her records and sign to confirm this information is correct for invoicing purposes. This must occur within 72 hours of discharge and be forwarded to the Head of CCC (on Fax Number 0113 2063524). If the Care Manager disagrees then he/she must contact the Discharge Facilitator and liaise to review the patients' coding period. This must occur within 7 days of issue. Any agreed changes must be made and an altered Reimbursement Coding Sheet signed by the Discharge Advisor and Care Manager. The Care Manager will forward the amended Reimbursement Coding Sheet to Head of CCC (on Fax Number 0113 2063524) to hold pending any queries regarding charges. If Care Manager and Discharge Advisor are unable to agree coding then escalation will occur as per 1.3.

1.5 For LTHT the Discharge Facilitator will forward the original or altered copy via LTHT channels to advise finance of changes. Within LTHT reimbursement information is sent to the PA for the Directorate Manager of Medicine for monthly collation and thereby forwarded to LTHT Finance for invoice issue.

1.6 Reimbursement invoices should at this stage be issued quarterly by the Trust Based on the Reimbursement Coding Sheet and accepted as true with spot audits established to ensure information/data quality.

Reviewed January 2007
Next Review January 2008 for Ratification March 2008

Reviewed by:
Sue Jones Matron Discharge LTHT
Diane Massey Discharge Matron Leeds PCT on behalf of Discharge Facilitation Team


Section 5 Faxed by ward to CCC/DRP
Section 5 Received by Care Manager. Care Manager records commencing Delay Code on Daily Log Sheet – sent to Discharge Team by 10am
If no Log Sheet Received, Discharge Facilitation Team report to Discharge Team Leader
If Discharge Specialist disagrees with Delay Code, telephone discussion with Care Manager to negotiate coding or escalate to Discharge Team Leader and Care Management Team Leader for arbitration.
If Discharge Specialist Agrees Code, enter onto Delayed Discharge Database
Care Manager aims to affect Discharge with Multi-Disciplinary Team and Reports Updated Patient Delay Code daily by 10 am on Daily Log Sheet.
On Discharge – Discharge Facilitator Generates Reimbursement Coding Sheet within 72 hrs and sends to Care Manager to check and agree Coding. (To be achieved within 7 days of Discharge)
Care Manager Disagrees Reimbursement Coding Sheet Contact Discharge Facilitator to cross check, any alteration agreed, forwards Copy to Head of CCC and retains copy for local info. If unable to agree escalation procedure invoked
Care Manager agrees Coding, signs and forwards a copy to Head of CCC (Fax No 0113 2063524) and retains copy for local information.
Reimbursement Invoice issued and Accepted without question Ongoing Spot Audits undertaken to ensure info quality

Private & Confidential

Discharge Facilitation Team
Inpatient Placement Service
B Floor Medical Out Patients
Leeds General Infirmary
Leeds
LS1 3EX

Fax:
LGI – 0113 3922660
SJUH – 0113 2066404
www.leedsteachinghospitals.com

Date: 16 March 2009

Dear Colleague

Your patient has recently been discharged from Leeds Teaching Hospitals Trust and during their hospital stay a reimbursement charge has been incurred.

As per the LTHT Leeds and Social Service Joint Protocol for Inter Agency Responsibilities upon the Issue of a Section 5, dated May 2006, I enclose a copy of the Individual Patient Reimbursement Charge Sheet signed by the relevant Discharge Specialist Worker.

As per protocol you are obliged to check the codes allocated by the Discharge Management Team for your patient. If you are in agreement with these please sign, retain a copy for your records, and forward a copy to the Head of CCC on Fax Number 0113 2063524.

If you are unable to agree the codes allocated by the Discharge Management Team please contact them on 66391 (for St James) or 26891 (for LGI, Chapel Allerton and Wharfedale) within 7 days of the charge sheet being issued. Any agreed changes must be made and an altered reimbursement sheet signed by the Discharge Specialist Worker and yourself. Once signed by both parties, retain a copy for your records, and forward a copy to the Head of CCC on Fax Number 0113 2063524.

On going coding disputes about codes should be escalated as per the protocol retained within your department.

Any further questions, please do not hesitate to contact the Discharge Management Team on the numbers above.

Discharge Management Team
Leeds Teaching Hospitals Trust
Enc

APPENDIX 8 Medical Re-Housing Flowchart