University Hospitals of Morecambe Bay NHS Foundation Trust

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Scope: This policy applies to patients who meet the following criteria: the *comprehensive* assessment agreed by health and social services shows that the patient can be discharged from hospital, and needs a placement in a care home and this placement will be funded by either the patient, by health or by Social Services	**Classification:** Organisational
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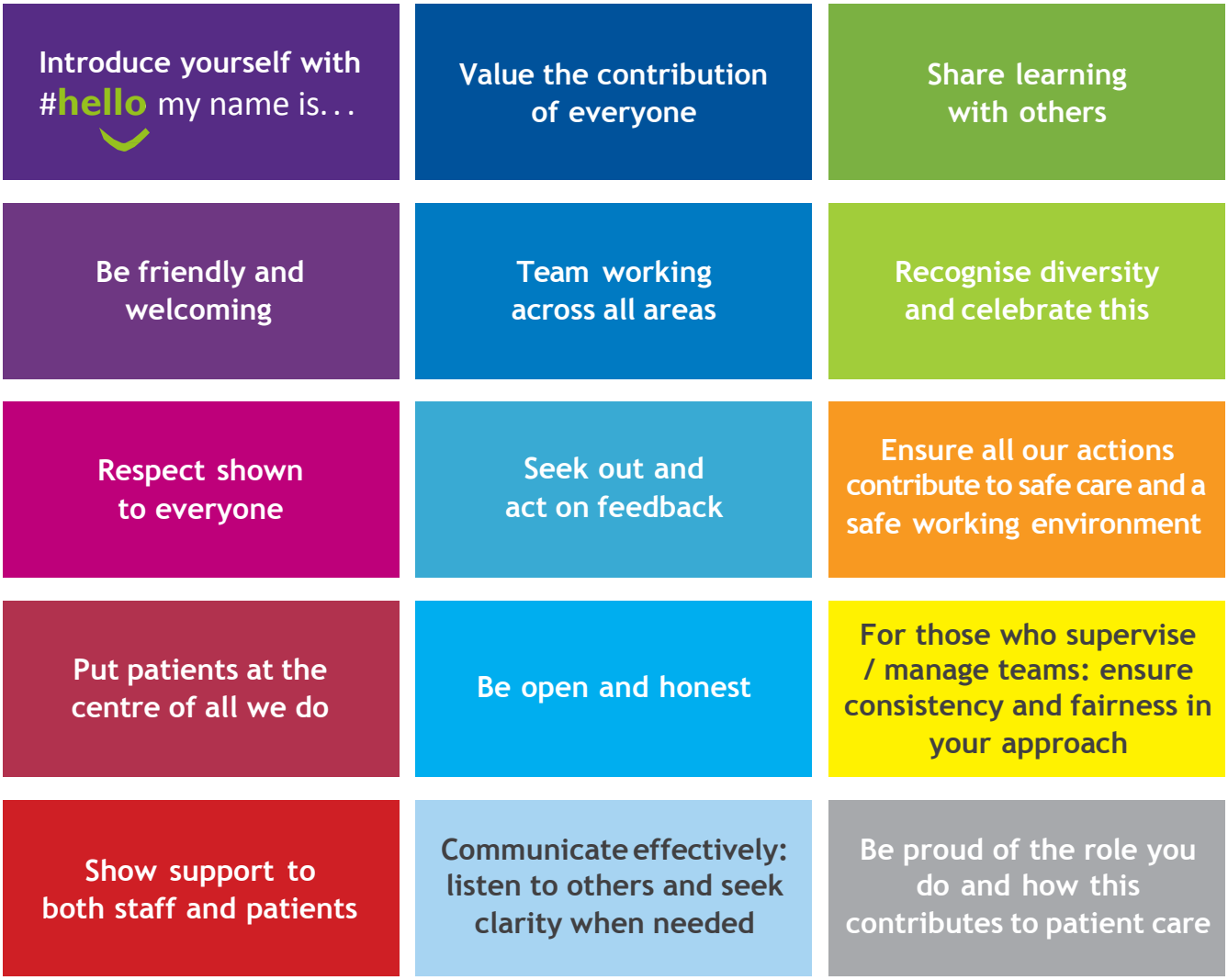
BEHAVIOURAL STANDARDS FRAMEWORK

To help create a great place to work and a great place to be cared for, it is essential that our Trust policies, procedures and processes support our values and behaviours. This document, when used effectively, can help promote a workplace culture that values the contribution of everyone, shows support for staff as well as patients, recognises and celebrates the diversity of our staff, shows respect for everyone and ensures all our actions contribute to safe care and a safe working environment - all of which are principles of our Behavioural Standards Framework.

Behavioural Standards Framework – Expectations 'at a glance'



1. SUMMARY

1.1 This policy sets out the framework for Discharge Planning for adults within University Hospitals of Morecambe Bay NHS Foundation Trust.

1.2 This policy defines how the Trust will manage choice throughout a patient's hospital stay with regard to discharge planning, particularly at the point that a patient no longer requires the level of care provided by the Trust. The Trust will make every effort to discharge patients to the destination of their choice but not to the detriment of equitable and fair access to services for all patients. Therefore where the destination of choice is not available the Trust will with partner organisation endeavour to identify alternative providers or an interim alternative.

1.3 The overarching aim is to reduce delays in the appropriate transfer of care or discharge of patient's, through early engagement and support, and the implementation of a fair and transparent escalation process.

1.4 Discharge planning should start at the point of admission, involving the patient in conjunction with any relevant family or carers (dependent on the patient's wishes and/or capacity) and should ensure that people are cared for in an environment that can meet their needs. Discharge requirements for each patient are assessed on an individual basis.

1.5 If a patient is deemed to lack capacity regarding a place of discharge decision, the decision will be made in the patient's best interests. Where the patient has no relevant family or carers who can be consulted, the Trust will use an Independent Mental Capacity Advocate (IMCA) service to ensure that the patient is supported and represented in respect of such a decision made in their best interests.

1.6 The NHS is under an obligation to only use hospital beds for those who need specific hospital services due to their physical or mental illness. If beds are occupied by people waiting for arrangements outside the hospital to be made to meet their assessed needs, including waiting for a place in a chosen home to become available, this effectively denies access to these hospital beds for people who need them.

1.7 Those responsible for arranging discharge care for patients have the difficult task of finding the right balance between the rights of the patient and the often competing pressure to release a hospital bed. This policy is designed to offer guidance to support them and the patient through this process.

1.8 This policy is to be used in conjunction with the Hospital Discharge and Transfer 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 available to patients and their carers on admission to hospital. This prevents the development of expectation that the person may stay in the hospital setting indefinitely.

2. PURPOSE

2.1 To provide guiding principles and outline roles, responsibilities and accountability for discharge planning of adult patients within the Trust.

Key Principles:

• Discharge planning process is ‘person centered’ ensuring respect and dignity.
• Ensure patients and relatives are well informed.
• Ensure patients and relatives are able to make informed choices about their onward care.
• Ensure good quality discharges are not compromised by bed pressures in hospital.
• Ensure that patients are treated in the most appropriate setting to meet their needs;• Recognising that as their needs change so may the setting.

2.2 The aim of this policy is to recognise the right of a patient to be cared for in the setting which is most appropriate to meet their assessed needs and which takes into account their preferred choice of accommodation. It aims to reduce the length of time a patient has to wait in an acute hospital bed prior to transferring to a more appropriate environment. It is not in a patient’s interest to remain in an acute hospital setting after an episode of ill health and the patient has the right for his/her assessed needs to be met promptly, whether by the Local Authority, the NHS, or by assisting them, or their families, to arrange their future care.

2.3 The consequences of patients remaining in a hospital bed when medically fit for discharge are:

- Patients are exposed to the unnecessary risk of hospital acquired infections.
- The wait for beds to become avaliable at specific nursing or residential homes causes frustrating waits for patients and relatives leaving them feeling unsettled.
- The delay in the transfer increases patients’ dependence, as the continued acute care environment is not designed to best meet the patients’ care needs.
- The inappropriate use of acute hospital beds puts additional pressure on the whole health care system in meeting both emergency and elective targets.

2.4 When a multidisciplinary assessment indicates that care in a nursing or residential home
is the most appropriate place to meet all of the patient's care needs, the patient, their advocate, family and/or carers should be assisted and supported to choose a suitable and available home of their choice. It is not appropriate nor in their best interests to remain in an acute hospital bed until such time as a bed in a particular home becomes available and transitional arrangements will need to be agreed and arranged to meet the patient’s needs.

3. SCOPE

This policy applies to patients who meet the following criteria:

- The comprehensive assessment agreed by health and social services shows that the patient can be discharged from hospital, needs a placement in a care home and this placement will be funded by either the patient, Health and/or by Social Services.

4. POLICY

4.1 Responsibilities / Duties

4.1.1 The Multidisciplinary Team (MDT)

This is a team of professionals who have been involved in the treatment, care and assessment of patients during their in-patient stay. This may also include professionals

who will be involved in the care of the patient after they have been discharged from hospital.

4.1.2 The Consultant Or His/Her Representative will be responsible for:-
Setting an estimated discharge date (EDD) in conjunction with the MDT assessment and recommendation ensure that a clear management plan is documented and communicated to facilitate timely discharge.

4.1.3 The Ward Manager will be responsible for: -
A) Ensuring the patient, their relatives and carers are kept informed and involved in transfer of care planning.
B) Ensuring that patients have access to discharge information on admission 'Being Discharged From Hopsital' A guide for you, your family and friends.
C) Ensuring that all ward staff complete discharge planning referrals in a timely manner.
D) Making the relevant member of the Discharge Team aware of any information surrounding
actual or potential delays relating to nursing or residential home placements.
E) Ensuring that specialist assessments are carried out and should this not happen escalate the situation to the Divisional Matrons and Discharge Team.

4.1.4 The Divisional Matrons will be responsible for: -
A) Ensuring that the ward managersenables access to discharge information on admission 'Being Discharged From Hopsital' A guide for you, your family and friends.
B)Ensuring that Ward Managers monitor the transfer of care/discharge planning process.
C) Taking action to expedite specialist assessments when necessary and if this cannot be achieved, escalate to the Discharge Team, Discharge Lead, and the Divisional Assistant Chief Nurse.

4.1.5 The Discharge Team will be responsible for: -
A) Ensuring that the relevant discharge planning assessment/evidence is complete and sent to
the appropriate Clinical Commissioning Group (CCG).
B) Maintaining an up-to-date database of all patients where referrals to external agencies have been made.
C) Working with the Social Workers to ensure there is no delay in transfer of care and in the event that delays in the process occur that cannot be resolved at this level escalate to the Trust Discharge Lead.
D) Issuing letter one (Appendix 2) in the event that any delays are due to patient and/or relative choice of placement and maintaining records relating to this process.
E) Issuing letter two (Appendix 3) if by the 10th working day the discharge team and/or social worker have not been informed of the patients choice the discharge team will issue letter 2 reminding the patient/relative should they not choice a home within the next 3 working days an interim placement will be identified.
F) Issuing letter three (Appendix 4) which informs the patient, relatives, advocate or carers that transfer will take place to a nominated facility on the EDD.
G) Will be responsible for assisting the ward manager/nurse to plan discharge on admission by
ensuring delays in the patient process are minimised and escalating to all relevant services to ensure timely discharge.

4.16 The Trust Operational Discharge Lead will be responsible for: -
A) Ensuring that all policies and procedures relating to transfer of care are current and comply with local and national guidance.
B) Ensuring that appropriate training has been identified and madeavailable to all relevant Trust staff.
C) Monitoring the effectiveness of the transfer of care process.
D) Maintaining links with all Social Service departments and the whole MDT to resolve ongoing issues where possible. In the event that this cannot be achieved escalate the situation to the The Assistant Chief Nurse.
E) Accept confirmation that the patient information and letter one, two and three (Appendix 2, 3 &4) have been issued.

4.1.7 The Trust Executive Lead Is The Chief Operating Officer (C.O.O) and will have overall responsibility for: -
A) Ensuring best practice is adhered too.
B) Ensuring that delayed transfers of care are resolved in a timely manner.
C) Liaising with counterparts in other agencies to ensure resolution is reached.
D) Ensuing that the Home of Choice Policy has been correctly followed.

4.1.8 The Named Social Worker will be responsible for: -
A) Carrying out all relevant social care assessments and providing information relating to the
outcome of those assessments to the Discharge Team.
B) Ensuring that where appropriate social care funding is applied for in a timely manner to enable discharge to take place without delay.
C) Where the patient is supported by Adult Social Care, Liaising with the relevant Nursing or Residential placement to arrange for assessments
to take place in a timely manner.
D) Supporting the patient and family in identifying a Nursing or Residential home by supplying them with up-to-date information relating to appropriate homes and vacancies.

4.1.9 The Senior Social Service Officer will be responsible for: -
Ensuring that the named Social Worker has adhered to the policy.

4.2 Process (Assessment and Planning)

4.2.1 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.

4.2.2 If the patient lacks capacity to make this decision the wishes and views of their relatives and carers must be sought. It is essential that staff determine at admission whether the patient has 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.

4.2.3 This policy will only be implemented when 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, the Local Authority (Adult Services Care (ASC)) or the NHS (Continuing Health Care (CHC)) or a combination of the above.

4.2.4 All patients are to be treated fairly and without discrimination.

4.2.5 The MDT decision is made and an Estimated Date of Discharge (EDD) of within 10 working days has been set. Both must be documented in the discharge communication in the patient's records and the Discharge Teams database and all relevant information must be given to the patients and/or their relatives, advocates and carers (dependent upon the patient's wishes and/or capacity).

4.2.6 Patients, relatives, advocates and carers (as applicable) should be fully involved in discussions and planning meetings regarding the discharge of the patient. Where the patient has the capacity to make the decision in question such involvement must be with the patient's consent. Where the patient lacks such capacity such individuals should be involved in order make a decision in the best interests of the patient.

4.2.7 The named Social Worker and the Discharge Team will ensure that the patient is fully supported and has up to date information regarding the discharge planning process.

4.2.8 Patients and their families must not be given the impression that Nursing/Residential care is the only option before the MDT has made its recommendation. Adult Social Care has developed a wide range of alternative services to enable people to remain at home for longer.

4.3 Process (Assessments Complete)

4.3.1 The Discharge Team will issue letter one (Appendices 2) and place a copy in the patients' medical notes. This letter requests that the patient, relatives, advocate or carers identify a nursing or residential placement home within 10 working days of the receipt of the letter.

4.3.2 If by the 10th working day the relatives or carers have not informed the Social Worker and/or the Trust of their choices the Discharge Team member who issued letter 1 will inform the Discharge Lead and recommend that letter two (Appendices 3) be issued This letter reminds the patient, relatives, advocate or carer of the time frame and informs them that should they not identify a placement, one will be identified by the Trust/Social Services and transfer will be arranged.

4.3.3 Once letter two has been issued and a copy is placed in the patients' medical notes, the named Discharge Team individual/ Social Worker will identify a suitable Nursing or Residential placement with a vacancy and arrange for them to assess the patient in preparation for transfer.

4.3.4 If within 3 working days of the EDD the relatives, advocate or carers have not identified a placement or placement of their choice the Discharge Team will recommend to the Discharge Lead that letter three is issued. This letter informs the patient, relatives, advocate or carers that transfer will take place to a nominated facility on the EDD.

4.3.5 The ward staff will ensure the patient, relatives, advocate or carers are made aware

of the transfer details and transport will be arranged.

4.3.6 On the day of transfer the Consultant or his/her representative will ensure that the patient is fit for transfer and this will be clearly documented in the patients' notes.

4.3.7 Throughout this process it is the responsibility of the MDT to support the patient, relatives, advocate or carers where possible and to ensure that the patient has all the information and support they require.

See appendix 5

4.4 Training

4.4.1 All new staff will receive an overview of this policy during their hospital induction.

4.4.2 Existing staff will be provided training sessions with updates every 2 years and monitored via Training Mangement Sytem (TMS).

4.4.3 Trust leads will have the opportunity to gain training in changes to legislation.

5. ATTACHMENTS	
Number	**Title**
1	Being discharged from hospital A guide for you, your family and friends
2	Leaving Hospital (agreed needs)
3	Leaving Hospital (unable to confirm arrangements for you/your family members transfer to a Residential/Nursing Placement)
4	Leaving Hospital (unable to confirm arrangements for you/your family members transfer to Residential/Nursing care)
5	Discharge Flowchart
6	Equality and Diversity Impact Assessment Tool

6. OTHER RELEVANT / ASSOCIATED DOCUMENTS	
Unique Identifier	**Title and web links from the document library**

7. SUPPORTING REFERENCES / EVIDENCE BASED DOCUMENTS **References in full**	
Number	**References**
1	
2	
3	

8. DEFINITIONS / GLOSSARY OF TERMS	
Abbreviation or Term	**Definition**
Patient	An individual who has been admitted for NHS inpatient services. References to interactions with a patient should be taken to include the person in hospital and/or their representative as appropriate.
CHC	Continuing Health Care
Discharge Process	Transition planning for the patient's move from a hospital, whether to primary care, an acute hospital or to a specialist tertiary care setting.
EDD	Estimated date of discharge is an multidisciplinary team decisionwhich highlights when the patient is most likely to be ready for safe discharge.
Interim Care	A provisional placement that is suitable and able to meet the patient's assessed needs whilst they wait for their preferred option.
IMCA	Independent mental capacity advocate, who will represent patients assessed as lacking capacity under the Mental Capacity Act 2005 to make important decisions, such as change of accommodation, and who have no family and friends to consult.
MDT	Multidisciplinary team of health and social care professionals involved in the care and assessment of patients.
Medically stable/fit	No longer requiring inpatient care or treatment at that hospital, so ready for discharge or transfer to another setting
Self-funder	A person who financially meets the full cost of their social care needs, whether because their financial capital exceeds the threshold for adult services funding or because they or a representative choose to pay for their care.
Social care assessment	The assessment of a person's social care needs that all adult patients are entitled to, regardless of financial status. A social care professional will help identify suitable care and assist with discharge from hospital if asked.

9. CONSULTATION WITH STAFF AND PATIENTS	
Name	**Job Title**
Pauline Turner	Discharge Lead
Pamela Manson	Discharge Cooridnator
Tracey Ashton	Discharge Cooridnator
Debra Allen	Complex Case Manager
Alison Mulligan	Complex Case Manager
Richard Parker	Legal Services Adviser (Temp)
Lancashire Clinical Commissioning Group	CCG

10. DISTRIBUTION PLAN	
Dissemination lead:	Pauline Turner, Discharge lead UHMB
Previous document already being used?	No
If yes, in what format and where?	
Proposed action to retrieve out-of-date copies of the document:	N/A
To be disseminated to:	All ward staff, Discharge teams, management
Document Library	
Proposed actions to communicate the document contents to staff:	Include in the UHMB Weekly News – New documents uploaded to the Document Library

11. TRAINING

Is training required to be given due to the introduction of this procedural document? *Yes

Action by	Action required	Implementation Date
Pauline Turner	Full Ward Based staff training	May 2015

12. AMENDMENT HISTORY

Version No.	Date of Issue	Page/Selection Changed	Description of Change	Review Date
1.1	04/10/2017	Page 3	BSF page added	01/04/2018

Appendix 1: Being discharged from hospital A guide for you, your family and friends

Being discharged from hospital

A guide for you, your family and friends

This information is intended to help you, your family, your carer or your friends understand how your discharge or transfer from hospital takes place. We want to make sure that this happens as smoothly and efficiently as possible.

Our aim is to support you to plan your discharge as soon as you are well.

Hospitals are the right place to be when you are in need of specific medical or surgical treatment. However, when your treatment has been completed it is important that your discharge is not delayed for the following reasons:

- There is a risk of you acquiring an infection in hospital, so leaving at the earliest opportunity makes this less likely.
- Some people find it hard to return home the longer they remain in hospital.
- Hospital beds are needed for people who are unwell, and who may be waiting in the Accident and Emergency department for urgent treatment.
- Operations may have to be cancelled if beds are not available.

Planning your discharge

We would like to work together to:

- Assess what your needs are likely to be when you are ready to leave.
- Involve the relevant health and social care professional who can help in meeting those needs such as social workers, occupational therapists, physiotherapists and district nurses as well as carer's, family and friends.
- The ward staff and your GP have access to a wide range of community support staff to help you.

Delays in leaving hospital

Sometimes making arrangements for people to receive care and support at home, finding a 24 hour care placement or providing specialist equipment or adaptations can take a while. It is not possible to wait in hospital until these services become available.

Where necessary the nursing staff or other members of the multidisciplinary team will support you to look at available options such as a rehabilitation package in a community hospital, an alternative placement or reablement in your own home. This is in Line with the Trust Home of Choice Policy.

If there are problems with your housing situation we will help you contact a housing options case worker to work with you and facilitate your return home.

When do I go home?

Your planned date of discharge will be based on the progress you make whilst in hospital. A doctor or nurse will tell you your discharge date and any follow up arrangements that are necessary. We will work towards this date as much as possible and in the meantime we will expect you to begin making arrangements for your discharge. If you or your family have any concern please bring them to our attention as soon as possible.

Transport home

On the day of your discharge you should expect to be discharged as early as possible. Please inform your Discharge Nurse as soon as possible if you need help organising transport home.

Confidentiality

Staff may have to talk to people who are involved in your care to make sure that a full assessment of your needs is carried out. Everyone working for the NHS and social services has a legal duty to keep information about you confidential.

University Hospitals of Morecambe Bay NHS Foundation Trust Discharge Policy

We want to support you and your family throughout your stay in hospital. However, once you are ready to be discharged, if your individual care choices are delaying the process, you may first need to move to a place that is not your first choice until your preferred option is available.

When you are discharged, you and your GP will receive a summary of your care and treatment and details of your medication. The ward staff will also give you any specific information relating to your ongoing care.

Help and Advice

If your have any further questions about your condition, treatment or procedure, then please speak with the ward manager or nurse in charge. If your questions are relating to your discharge the ward staff will be able to signpost accordingly.

Please double click on the icon to open

Being discharged from hospital admissic

Appendix 2: Leaving Hospital (agreed needs)

Dear

Leaving Hospital

We are pleased that you/your **(delete as appropriate)** family member are now ready to leave hospital, as confirmed by your/their medical Consultant. Your/Their **(delete as appropriate)** health and social care assessment has been completed and the Nurses, Doctors and other members of the multi-disciplinary team have discussed and agreed with you and/or your **(delete as appropriate)** family what your/their **(delete as appropriate)** needs will be when you/they **(delete as appropriate)** are discharged.

As you are aware, it is recommended that your/their **(delete as appropriate)** current needs would be best met in a Nursing/Residential **(delete as appropriate)** placement. You will receive support from both your/their **(delete as appropriate)** Social Worker and Trust Staff in identifying an appropriate placement.

As I am sure you understand there is a great demand on acute hospital beds and with this in mind we need to put a time limit on the time taken to choose an appropriate placement. Therefore the hospital expects that a suitable placement be identified and discharge takes place within 10 working days of the date of this letter. This date will be_____

If you are unable make a choice within the agreed timescale the Trust/Social Services will identify a facility that can appropriately meet you/your family member's needs. This action does not take away your/their **(delete as appropriate)** right of choice and you/they **(delete as appropriate)** can move to another facility as soon as a placement of choice is available.

Please note that because of the potential heavy demand on hospital beds, you/they **(delete as appropriate)** may be required at any stage in this process to transfer at short notice to an alternative placement.

We recognise that this letter may cause you some anxieties. If you wish to talk things through with someone who can help and support you please talk to the Ward Manager an ask him/her to put you in touch with the Discharge Team.

Communications in the first instance should be with **(Please add contact name and number)**
Thank you for your co-operation.

Yours Sincerely
Discharge Team

Appendices 2

Letter One

Dear

Leaving Hospital

We are pleased that you/your **(delete as appropriate)** family member are now ready to leave hospital, as confirmed by your/their medical Consultant. Your/Their **(delete as appropriate)** health and social care assessment has been completed and the Nurses, Doctors and other members of the multi-disciplinary team have discussed and agreed with you and/or your **(delete as appropriate)** family what your/their **(delete as appropriate)** needs will be when you/they **(delete as appropriate)** are discharged.

As you are aware, it is recommended that your/their **(delete as appropriate)** current needs would be best met in a Nursing/Residential **(delete as appropriate)** placement. You will receive support from both your/their **(delete as appropriate)** Social Worker and Trust Staff in identifying an appropriate placement.

As I am sure you understand there is a great demand on acute hospital beds and with this in mind we need to put a time limit on the time taken to choose an appropriate placement. Therefore the hospital expects that a suitable placement be identified and discharge takes place within 10 working days of the date of this letter. This date will be_____

If you are unable make a choice within the agreed timescale the Trust/Social Services will identify a facility that can appropriately meet you/your family member's needs. This action does not take away your/their **(delete as appropriate)** right of choice and you/they **(delete as appropriate)** can move to another facility as soon as a placement of choice is available.

Please note that because of the potential heavy demand on hospital beds, you/they **(delete as appropriate)** may be required at any stage in this process to transfer at short notice to an alternative placement.

We recognise that this letter may cause you some anxieties. If you wish to talk things through with someone who can help and support you please talk to the Ward Manager an ask him/her to put you in touch with the Discharge Team.

Communications in the first instance should be with **(Please add contact name and number)**
Thank you for your co-operation.

Yours Sincerely

Discharge Team

Appendix 3: Leaving Hospital (unable to confirm arrangements for you/your family members transfer to a Residential/Nursing Placement)

Dear

Leaving Hospital

I understand that you have so far been unable to confirm arrangements for you/your **(delete as appropriate)** family members transfer to a Residential/Nursing placement.
I am writing to you to confirm that the expected date of discharge agreed with you remains unchanged as _____.

If we have not received confirmation of your/their **(delete as appropriate)** placement of choice within the next 3 working days you/they will be transferred to an appropriate placement identified by the Trust/Social Services. This will be funded by the funding stream identified during the Continuing Healthcare process. Patients who are identified as self-funding their own care or who will be contributing to care costs will be liable for their own costs from date of admission.

This action does not take away your/their **(delete as appropriate)** right of choice and you/they**(delete as appropriate)** can move to another facility as soon as the placement of choice has a vacancy.
I have today requested that your/their **(delete as appropriate)** Social Worker/Discharge Team Individual begin sourcing an appropriate placement and to arrange for that facility to carry out an assessment.

I realise that these decisions are difficult and should you wish to talk things through with someone who can help and support you, please contact the Ward Manager an ask him/her to put you in touch with the Discharge Team.

Communications in the first instance should be with **(Please add contact name and number)**

Thank you for your co-operation.

Yours sincerely

Discharge Team

Letter Two

Dear

Leaving Hospital

I understand that you have so far been unable to confirm arrangements for you/your **(delete as appropriate)** family members transfer to a Residential/Nursing placement. I am writing to you to confirm that the expected date of discharge agreed with you remains unchanged as _____.

If we have not received confirmation of your/their **(delete as appropriate)** placement of choice within the next 3 working days you/they will be transferred to an appropriate placement identified by the Trust/Social Services. This will be funded by the funding stream identified during the Continuing Healthcare process. Patients who are identified as self-funding their own care or who will be contributing to care costs will be liable for their own costs from date of admission.

This action does not take away your/their **(delete as appropriate)** right of choice and you/they**(delete as appropriate)** can move to another facility as soon as the placement of choice has a vacancy.
I have today requested that your/their **(delete as appropriate)** Social Worker/Discharge Team Individual begin sourcing an appropriate placement and to arrange for that facility to carry out an assessment.

I realise that these decisions are difficult and should you wish to talk things through with someone who can help and support you, please contact the Ward Manager an ask him/her to put you in touch with the Discharge Team.

Communications in the first instance should be with **(Please add contact name and number)**

Thank you for your co-operation.

Yours sincerely

Discharge Team

Appendix 4: Leaving Hospital (unable to confirm arrangements for you/your family members transfer to Residential/Nursing care)

Dear

Leaving Hospital

I understand that you have been unable to confirm arrangements for your/your family members transfer to Residential/Nursing care **(delete as appropriate)**.

I am now able to confirm that an interim placement has been secured for you/your relative at---------- starting on---------- and transfer there will take place on that date. This will be funded by the funding stream identified during the Continuing Healthcare process. Patients who are identified as self-funding their own care or who will be contributing to care costs will be liable for their own costs from date of admission.

Their address is as follows:

Insert Address

Whilst you/they **(delete as appropriate)** are there you/they will be able to continue to view other homes to identify a place of your/their choice.

If you wish to talk things through with someone who can help and support you, please contact the Ward Manager an ask him/her to put you in touch with the Discharge Team.

Communications in the first instance should be with **(Please add contact name and number of the ward)**

Thank you for your co-operation.

Yours sincerely

Discharge Team

Letter Three

Dear

Leaving Hospital

I understand that you have been unable to confirm arrangements for your/your family members transfer to Residential/Nursing care **(delete as appropriate)**.

I am now able to confirm that an interim placement has been secured for you/your relative
at---------- starting on---------- and transfer there will take place on that date. This will be funded by the funding stream identified during the Continuing Healthcare process. Patients who are identified as self-funding their own care or who will be contributing to care costs will be liable for their own costs from date of admission.

Their address is as follows:

Insert Address

Whilst you/they **(delete as appropriate)** are there you/they will be able to continue to view other homes to identify a place of your/their choice.

If you wish to talk things through with someone who can help and support you, please contact the Ward Manager an ask him/her to put you in touch with the Discharge Team.

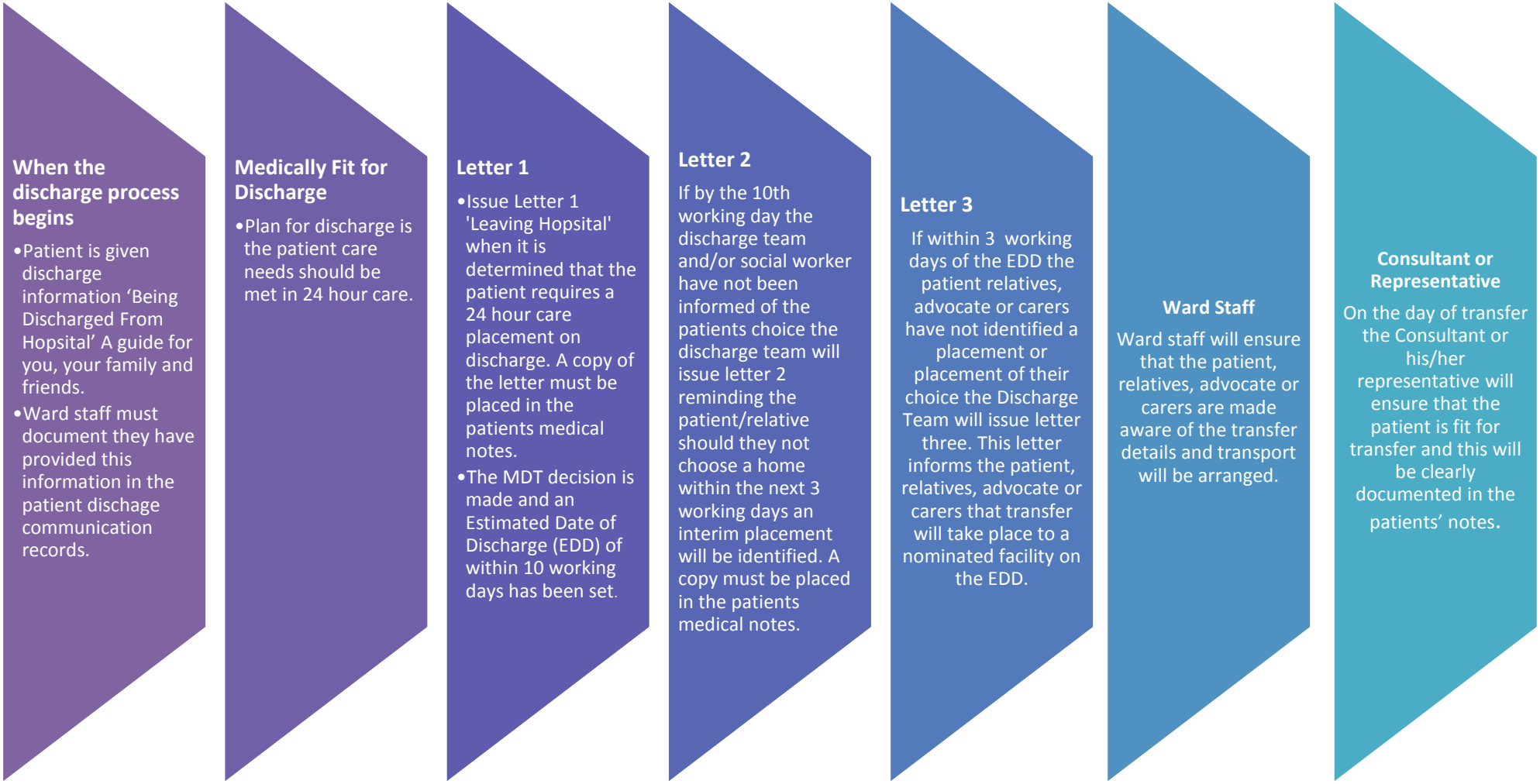
Communications in the first instance should be with **(Please add contact name and number of the ward)**

Thank you for your co-operation.

Yours sincerely

Discharge Team

Appendix 5: Discharge Flowchart



Appendix 6: EQUALITY & DIVERSITY IMPACT ASSESSMENT TOOL

		Yes/No	Comments
1.	**Does the policy/guidance affect one group less or more favourably than another on the basis of:**		
	• 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 disabilities, 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 there any exceptions - valid, legal and/or justifiable?**	No	
4.	**Is the impact of the policy/guidance likely to be negative?**	No	
4a	**If so can the impact be avoided?**	No	
4b	**What alternative are there to achieving the policy/guidance without the impact?**	No	
4c	**Can we reduce the impact by taking different action?**	No	

If you have identified a potential discriminatory impact of this procedural document, please refer it to the HR Equality & Diversity Specialist, together with any suggestions as to the action required to avoid/reduce this impact.

For advice in respect of answering the above questions, please contact the HR Equality & Diversity Specialist, Extension 6242.