University Hospitals of Morecambe Bay
NHS Foundation Trust

Document Type: **Standard Operating Procedure**	**Unique Identifier:** CORP/SOP/062
Document Title: **Morecambe Bay's Localised Process for Supporting Patient Choices to Reduce Long Hospital Stays (To be used alongside the overarching principles in the National Policy)**	**Version Number:** 2
	Status: Ratified
Scope: All staff involved in the discharge planning process	**Classification:** Organisational
Author / Title: Pauline Turner, Discharge Lead	**Responsibility:** Acute Medicine
Replaces: Version 1.1, Supporting Patient Choices to Reduce Long Hospital Stays, Corp/SOP/062	**Head of Department:** Leanne Cooper, Divisional General Manager
Validated By: Medicine Procedural Documents Group Medicine Governance and Assurance Group	**Date:** 07/06/2018 15/06/2018
Ratified By: Procedural Documents & Information Leaflet Group Chairs Action	**Date:** 01/08/2018
Review dates may alter if any significant changes are made	**Review Date:** 01/10/2021

Which Principles of the NHS Constitution Apply? **Please list from principles 1-7 which apply** 1-7 Principles	**Which Staff Pledges of the NHS Constitution Apply?** **Please list from staff pledges 1-7 which apply** 1-7 Staff Pledges

Does this document meet the requirements of the Equality Act 2010 in relation to Race, Religion and Belief, Age, Disability, Gender, Sexual Orientation, Gender Identity, Pregnancy & Maternity, Marriage and Civil Partnership, Carers, Human Rights and Social Economic Deprivation discrimination? **Yes**

Document for Public Display: Yes

Reference Check Completed by……. Joanne Phizacklea……Date:.... 18/07/2018…….

To be completed by Library and Knowledge Services Staff

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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. Across University Hospitals of Morecambe Bay (UHMB), Cumbria County Council (CCC) and Lancashire County Council (LCC), a joint Standard Operating Procedure (SOP) has been developed to enable a localised process to be delivered alongside the overarching principles of the national "Supporting Patient Choices' to Avoid Long Hospital Stays"[1] policy.
2. The localised SOP has been supported by our A&E delivery board to enable an informative and supportive approach to discharge planning for patients within our hospitals.
3. Taken from the national policy, the flow chart (appendix 1) outlining the 6 steps in discharge planning and patient choice, and the accompanying letters and leaflet (appendix 2-11) have been localised to support and inform the discharge process enabling additional information to help and support patients, relatives and staff.

2. PURPOSE

1. The purpose of this SOP is to ensure that choice is managed sensitively and consistently throughout the discharge planning process, and people are provided with effective information and support to make a choice.
2. This SOP sets out a framework to ensure that NHS inpatient beds will be used appropriately and efficiently for those people who require inpatient care, and that a clear process is in place for when patients remain in hospital longer than is clinically required.
3. When implemented consistently, this policy should reduce the number and length of delayed discharges and result in patients being successfully transferred to services or support arrangements where their needs for health and care support can be met. Ultimately it aims to improve outcomes for patients.

3. SCOPE

The target audience for this policy is all professionals in the health and social care sector across UHMB, CCC and LCC who will be involved in the hospital journey and discharge planning for patients in UHMB hospitals.

4. STANDARD OPERATING PROCEDURE

4.1 Supporting Patient Choices' to Avoid Long Hospital Stays; 6 Step Flow Chart

4.1.1 Step 1: Admission

1. Step one is about recognising the need to communicate with the patients and if appropriate their carers or relatives as early as possible when they arrive in hospital.
2. At ward level the admitting nurse, or if relevant the discharge coordinator, is to issue a welcome letter (Appendix 2) and a leaflet (Appendix 3) to all patients who are admitted to hospital. This is regardless of how simple or complex they may be to discharge.
3. The professional providing the welcome letter and leaflet to the patient, or if appropriate their carer or relative, will explain the content of both to ensure understanding and answer any questions or queries that may arise. The professional who has undertaken this duty must record this action within the patient's record and the date and time when this conversation was held and to whom it was held with and why it was held with that person (i.e. the patient's daughter because the patient lacked the understanding of the content of the information being provided). The record of this discussion must also include how the content of both the welcome letter and leaflet was received.
4. If at the point of admission it is not an appropriate time to provide the welcome letter or leaflet, for instance the patient may be acutely unwell and not an appropriate or sensitive time to have this discussion with either the patient or their carer/relative, this must be recorded in the patient's notes and must be shared with the multidisciplinary team (MDT) and an action set as to who to and when this information will be provided. It may also be appropriate to hand this task over when the patient is admitted during the night, therefore it is a duty of the day team, or because the admitting nurse or discharge coordinator is unable to complete the task this must be handed over to the next set of staff to be completed.
5. If the welcome letter and the leaflet have not been given in an assessment area and the patient is transferred to a downstream ward or community ward, this action must be handed over in the wards by using the Situation, Background, Assessment, Recommendation (SBAR) form.
6. The welcome letter and leaflet will not be left in the patients' bed area without explanation of the content of this information.
7. An expected discharge date must be set within 24-48 hours of admission and discussions commenced as early as possible with the patient about the plan for them and their expected discharge.
8. Even at this early stage it may be possible to identify those patients who may have more complex and longer term needs, in which case early engagement with the health and care professionals responsible for their further assessment and care will also happen at this stage, to ensure discharge is not delayed.
9. Throughout the hospital journey, the MDT will ensure that they are clear as a team who will undertake these actions and what their own individual actions will be.
10. To support the process of managing choice, all patients will have an audit trail attached to their notes (appendix 13) (this will be paper based until this is developed within Lorenzo). This will enable the process to be monitored ensuring that each step has been taken prior to the last step of the policy being enacted.

4.1.2 Step 2: Assessing need

1. The majority of patients will be assessed, receive treatment or be scheduled for treatment and discharged to expected timescales. For the patients with further assessment needs, the MDT will continue to engage with the patient and if appropriate carers and relatives to schedule further assessments.
2. With consent or in best interests refer the patient and any carers to required health and social care services when they are ready to have their needs assessed for discharge.
3. Refer to support services and/or advocacy as required.
4. Discuss all options for discharge and ensure assessments to clarify needs are completed.
5. The professional leading on discharge will explain the decision making process, including how to appeal any decisions, to the patient and advise that the hospital will expect discharge within a 7 day window.
6. Discharge planning is everyone's responsibility therefore as an MDT we will work together to ensure that we understand who is taking what action and what support individual professionals need.
7. The MDT will ensure that they are clear as a team who will undertake these actions and what their own individual actions will be and all will be recorded in the patients' notes.

4.1.3 Step 3: Preparing for discharge

1. The Complex Case Manager from the discharge team will with or without the support of the ward nurse in charge provide appropriate letter B to patient, and if appropriate their carer or relative, with tailored information on options which are suitable to meet assessed needs. A conversation will have taken place with the patient, and/or if appropriate their carer or relative by the professional leading on discharge (health or social) regarding the content of this letter so that all parties are aware of the content.
2. The patient, and if appropriate their carer or relative, should be given support and advice to make arrangements for discharge within 7 days.
3. Care Home Selection (CHS) will support the patient/relative in sourcing an appropriate option for discharge.
4. Daily ward and board rounds will be undertaken to routinely track that arrangements are progressing to the discharge date.
5. By use of the ward and board rounds, the MDT will ensure that they are clear as a team who will undertake these actions and what their own individual actions will be and all will be recorded in the patients' notes.

4.1.3.1 Types of letter B's

There are 3 letter B's

1. Letter B1 (Appendix 4) is to be given to the patient, and/or if appropriate their carer or relative, once all assessments have been completed and the patient will be discharged into 24 hour care. All patients who are being discharged to a care home, will receive letter B1
2. Letter B2 (Appendix 5) is to be given to the patient, and/or if appropriate their carer or relative, once all assessments have been completed and they are self-funding their own package of care. All patients who are being discharged home with a privately funded package of care will receive letter B2.

3. Letter B3 (Appendix 6) is to be given to the patient, and/or if appropriate their carer or relative, once all assessments have been completed and they are returning home with a package of care funded by the Local Authority (LA). This is to support the LA to then move a patient into an interim placement if the care cannot be sourced. Letter B3 is a bespoke letter written aside from the national policy to support the LA to discharge patients from acute and community care.

   This letter is only given to patients once it is evident that it is going to be difficult to source the care package (this therefore would not necessarily need to be given immediately once all assessments have been completed). The professional (named social worker) leading on this case will give direction as to the appropriateness of giving this letter but as an MDT this option must be discussed with the social worker to understand whether the option is appropriate or not.

   Please note the social worker will need time to source the package of care to understand the lack of resource available, therefore if this letter is given, it will be given later than the other B letters will have been given.

4. For all letters the check and challenge of this process will be managed by the Complex Case Managers from the Integrated Discharge Team (IDT) (regardless of whether the discharge is funded through health, social care or the patient is self-funding). This will happen on a daily basis alongside the recording of the daily Delayed Transfer of Care (DToC) number by using the discharge database report. Any cases which require escalation will be actioned by the IDT to the Discharge lead for UHMB.

4.1.4 Step 4: Seven day window

1. Following the letter B's being given, the patient and/or if appropriate their carer or relative have 7 days to consider their available options and this is detailed within the relevant letter B which the patient will have received. It is necessary that the professional who is leading on the patients discharge seeks availability of interim placements within this 7 day period regardless of whether it is felt this will progress to letter C. This can be supported with a referral to CHS. This is to prevent coming to the end of the 7 day period following letter B and then having to spend time sourcing a placement or package of care because the patient has now progressed to letter C.

4.1.5 Step 5: Interim placement or package of care

1. If a decision and/or discharge have not been made within 7 consecutive days, the MDT is to liaise with the patient and arrange for an interim placement which meets assessed needs.
2. Through the MDT if it is felt that the case will progress to the patient to letter C then the professional leading on discharge will bring this to the attention of the trusts escalation lead (i.e. acute trusts discharge lead) so they can be forewarned of any support they may need to provide. The escalation leads may at this time need to have a discussion with a delegate from the A&E delivery board to finalise funding if this is not straightforward or is causing a barrier to discharge.
3. The Complex Case Manager from the discharge team will with or without the support of the ward nurse in charge is to provide letter C appropriate to the discharge plan and offer further support. This will be signed by the consultant within

UHMB. A conversation must have taken place with the patient, and/or if appropriate their carer or relative, regarding the content of this letter so when the letter is provided to them they are not surprised about its content.

4. Care Home Selection (CHS) will support the patient, and/or if appropriate their carer or relative, to be discharged to an interim placement or with an interim package of care.
5. If an interim placement/package of care is being challenged and it is felt the discharge planning will progress to letter D, clearly identify the issues that are blocking discharge that cannot be addressed at operational level then formal escalation is required to the trusts Discharge Lead.
6. Potential funding discussions will be held between the trusts escalation leads and a delegate from the local A&E delivery board to agree a funding plan. This will be done on an individual basis.

4.1.5.1 Types of letter C's

1. Letter C1 (Appendix 7) is to be given to the patient, and/or if appropriate their carer or relative, when a home of choice has been identified, however there are no vacancies in the particular home at this time or when they have not identified a suitable care home at all within the 7 day period. This letter points out that there are no further vacancies, however that the patient cannot remain in hospital and there is a vacancy at another placement which can meet the patient's assessed needs therefore discharge will take place there and on the stated date.
2. Letter C2 (Appendix 8) is to be given to the patient, and/or if appropriate their carer or relative, of a self-funding patient whose package of care has not yet been arranged. This letter points out that a care package has not yet been arranged therefore a temporary package of care or an interim placement has been sourced until the chosen care package is arranged or available.
3. Letter C3 (Appendix 9) is to be given to the patient, and/or if appropriate their carer or relative, where they have not advised of an interim placement or if they have but there isn't a vacancy at that time, for those patients who are being planned to return home with a package of care however there is difficulty in this being sourced.
4. For all letters the check and challenge of this process will be managed by the Complex Case Managers from the IDT (regardless of whether the discharge is funded through health, social care or the patient is self-funding). This will happen on a daily basis alongside the recording of the daily Delayed Transfer of Care (DToC) number by using the discharge database report. Any cases which require escalation will be actioned by the IDT to the Discharge lead for UHMB.

4.1.5.2 When letter C wouldn't be given

1. If an interim placement or package of care including placements out of area, are not available to discharge, the patient and/or if appropriate their carer/relative, the professional leading on discharge will need to communicate using the update letter (appendix 10). This will explain that the interim placement or package of care will continue to be sourced. Once sourced then letter C is to be given as per standard operating procedure (SOP). All actions will be record in the patients' records.

4.1.6 Step 6: Escalation

1. The trust Discharge Lead will review reasons, options given for challenge, in liaison with associated directors of commissioning in health and social care and the A&E delivery board delegate as appropriate.

2. The trusts Discharge Lead with the presence of the MDT will hold a formal meeting with the patient, and/or if appropriate their carer or relative, to agree resolutions. A risk assessment (Appendix 12) will be completed which will determine the risk of staying in hospital versus being discharged to a placement or with a package which is not of their first choice (factoring in the human rights).
    - Before a formal meeting will be held the trust's Discharge Lead will complete an audit of the process up to date. This is to ensure that all relevant and necessary steps have been taken prior to escalation which must demonstrate effective communication and that relevant support has been provided.

3. If all reasonable options have been given and there are no grounds for challenge, legal advice and measures are to be taken by the trust's escalation lead to ensure that legally the suggested discharge is appropriate.
4. The trust's Discharge Lead will provide the patient, and if appropriate their carer or relative, a copy of letter D (Appendix 11) and the risk assessment following the formal meeting or if the patient, and/or if appropriate their carer or relative, does not engage in a formal meeting (note this is where reasonable options have been rejected and there are no grounds to challenge) explaining the arrangements for discharge and the date discharge will take place.
5. The purpose of letter D is to:
    - Clearly summarise the case so far outlining preferred choice for discharge and options available.
    - The outcome of the risk assessment.
    - The details of the placement the patient will be transferred to.
    - The details around onward funding.
    - Confirm the discharge destination (or if home with a package of care, the details of this) and the date discharge will take place.
6. The purpose of the risk assessment is to:
    - Establish the person's past, present preferences and wishes, beliefs and values.
    - Summarise the risk of remaining in a hospital setting.
    - Summarise the risk of being discharged to an interim placement.
    - Outline what has or could have been done to mitigate negative effects of staying in hospital.
    - Outline what can be done to mitigate negative effects of transferring to an interim placement.

4.2 End of life care patients

1. It is identified that when implementing this SOP we need to ensure equity and fairness; however we also need to ensure we consider each individual case.
2. As noted within the national policy, professionals will consider discharging from both acute and community hospital beds for end of life care within this SOP. Staff will be required to understand the Preferred Place of Care (PPC) and also the clinical condition in terms of time to enable a decision as to whether the SOP applies to them. It may not be appropriate to progress with this SOP for patients who are imminently dying, if their Preferred Place of Care (PPC) is the hospital or community bed or if the only option for discharge is an out of area placement which is not sensitive to the patients' end of life care requirements (i.e. maintaining relationships). However we would need to ensure that this was reviewed if their

condition changed to ensure we were treating all individuals equally.

It may be appropriate to use this SOP to consider patients who have end of life care needs that are not imminently dying to prevent those patients remaining in an acute or community bed longer than required. A rationale for considering or not considering these patients will be fully recorded in the patient records.

4.3 Changes in the patients clinical condition

1. Throughout the discharge process for all patients there may become times when a patient's condition clinically changes.
2. If the patient's clinical condition changes whilst the patient is being managed through this SOP a full explanation of the next steps will be communicated to the patient, and if appropriate their carer and relative, and will be fully documented in the patient's records
3. There are 2 scenarios to consider here:
    - Changing the date the patient can be discharged from hospital due to a change in clinical need which has consequently adjusted their EDD. This is about explaining to the patient, and/or if appropriate their carer or relative, that the clinical condition of the patient has changed whilst they are in the progress of discharge planning, however discharge planning can continue alongside any treatment the patient maybe receiving. It will be considered at this time if the EDD needs changing to reflect the patient's clinical condition and to ensure all involved understand the new date being worked towards for discharge.
    - Stopping discharge planning. This is about explaining to the patient, and/or if appropriate their carer or relative that the patient's condition has clinically changed, therefore at this time discharge planning will be put on hold until a review takes place to deem discharge planning to be appropriately recommenced. A new EDD must be set at this point to ensure all involved understand the new date being worked towards for discharge.

5 ATTACHMENTS	
Number	**Title**
1	Morecambe Bay localised flow chart for the 6 steps in managing choice
2	Welcome Letter
3	Supporting Patient Choices to Avoid Long Hospital Stays Leaflet
4	Letter B1
5	Letter B2
6	Letter B3
7	Letter C1
8	Letter C2
9	Letter C3
10	Update Letter
11	Letter D
12	Risk Assessment
13	Audit Trail
14	Equality & 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	DH (2016). Quick guide: supporting patients' choices to avoid long hospital stays. Available from: http://www.nhs.uk/NHSEngland/keogh-review/Documents/quick-guides/Quick-Guide-supporting-patients-choices.pdf (accessed 18/07/2018)
2	
3	

8 DEFINITIONS / GLOSSARY OF TERMS	
Abbreviation or Term	**Definition**

9 CONSULTATION WITH STAFF AND PATIENTS Enter the names and job titles of staff and stakeholders that have contributed to the document		
Name	**Job Title**	**Date Consulted**
STP	Sustainable Transformation Pathway meeting	Monthly

10 DISTRIBUTION PLAN	
Dissemination lead:	Pauline Turner
Previous document already being used?	Yes
If yes, in what format and where?	Trust Procedural Document Library
Proposed action to retrieve out-of-date copies of the document:	
To be disseminated to:	
Document Library	
Proposed actions to communicate the document contents to staff:	Include in the UHMB Friday Corporate Communications Roundup – New documents uploaded to the Document Library

11 TRAINING

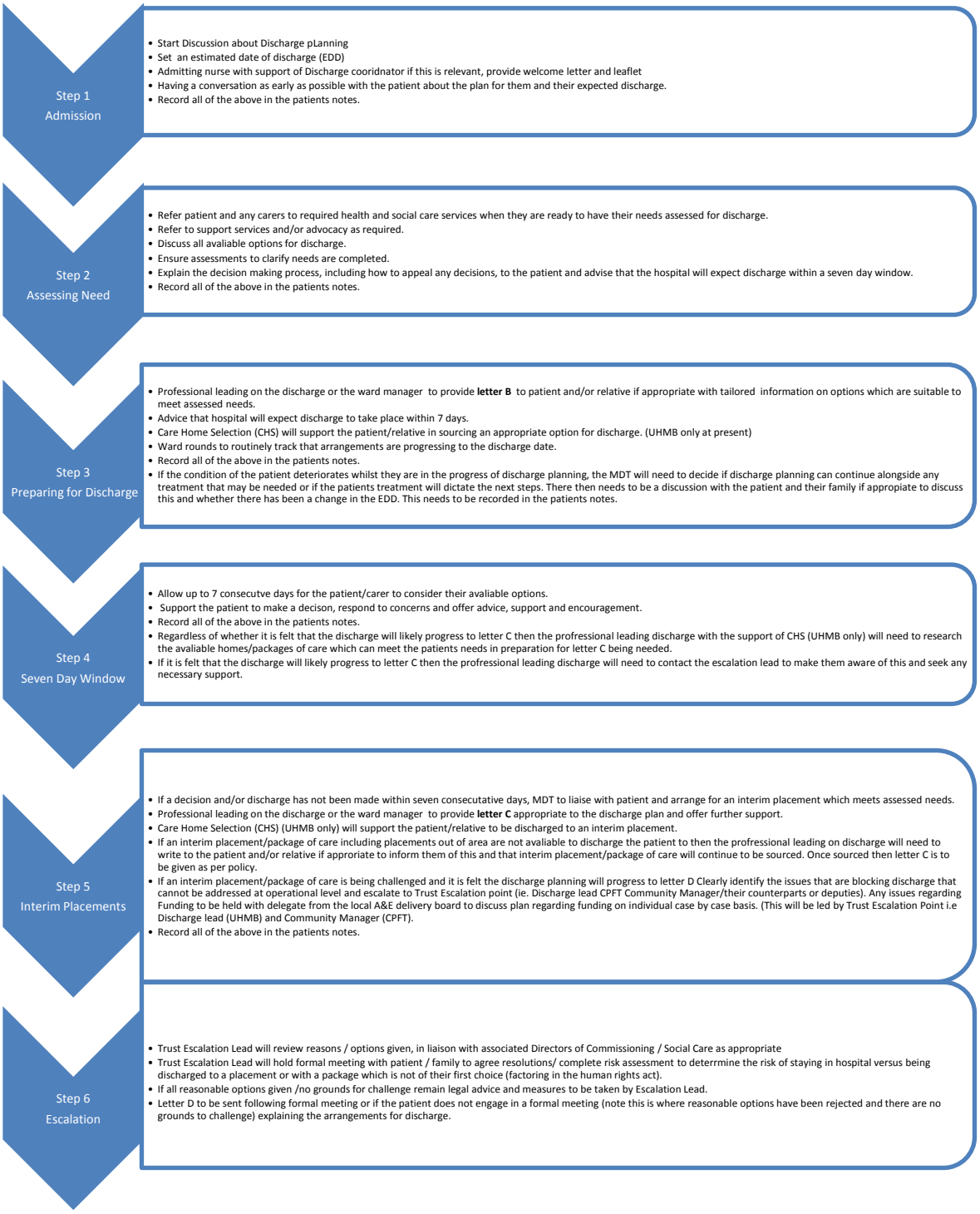
Is training required to be given due to the introduction of this policy? Yes

Action by	Action required	Implementation Date
Pauline Turner	Awareness sessions on the wards	Aug17 - ongoing

12 AMENDMENT HISTORY

Version No.	Date of Issue	Page/Selection Changed	Description of Change	Review Date
2		Full document	Removal of CPFT and updated re discharge process	1.10.20

Appendix 1: Localised Flow Chart for Complex Discharges under Home of Choice



Appendix 2: Welcome Letter

University Hospitals of Morecambe Bay NHS Foundation Trust

Insert Address

Trust Headquarters
Westmorland General Hospital
Burton Road
Kendal
Cumbria
LA9 7RG

Tel: 01539 732288

Web: www.uhmb.nhs.uk

Date

Dear

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

Your individualised care plan will include your discharge plan and expected date of discharge. This will be regularly discussed with you and any person you have nominated to be involved with your discharge planning.

It is very important that, as soon as possible following your admission, you inform us of any actual or potential problems relating to your discharge so that we can begin to make appropriate plans with you and assist you in any way we are able. There are many risks associated with delaying your discharge which a member of staff will be happy to discuss with you.

Please read the attached leaflet, which fully explains how your discharge or transfer from hospital may take place.

If you have any concerns or questions regarding your discharge plans or the content of this letter, please talk to any of the ward staff who will assist in any way they can.

A copy of the trusts Discharge policy, the National Supporting Patient Choices' to Avoid Long Hospital Stays policy and the trusts standard operating procedure in relation to delivering this policy can be provided upon request.

Yours sincerely

Aaron Cummins

Chief Executive Officer

Appendix 3: Supporting Patient Choices to Avoid Long Hospital Stays Leaflet

Travelling to our hospitals

For the best way to plan your journey visit our website: **http://www.uhmb.nhs.uk/** or contact Patient Advice and Liaison Service (PALS): **01539 795497** or for any CPFT patient advice please visit our website **https://www.cumbriapartnership.nhs.uk/** or contact Cumbria Partnership (CPFT) Patient Experience Team (PET) team 01228 608257.

Useful Contact Details

NHS Direct (24 hour health advice): **111**

Your Information:

If you would like to know how we use, share, disclose and secure your information and your rights of access to the information we hold about you, visit the Trust's website: **http://www.uhmb.nhs.uk/** or contact Patient Advice and Liaison Service (PALS) **01539 795497**

Feedback

We appreciate and encourage feedback. If you need advice or are concerned about any aspect of care or treatment, please speak to a member of staff or contact PALS: **01539 795497**
Cumbria Partnership (CPFT) Patient Experience Team (PET) team 01228 608257.

SMOKEFREE

Smoking is not permitted on any of the hospital sites. Giving up smoking is the best thing you can do for your health.

Contact your local NHS stop smoking service:
NHS North Lancashire: **01524 845145**
NHS Cumbria: **01900 324222**

A great place to be cared for; a great place to work

Approved by: ??
Date of Publication: 22/04/2016
Reference Number: UHMB-FT39
Author: NHS England
Review Date: 01/04/2019

Health & care information you can trust

Cumbria Partnership NHS
NHS Foundation Trust

University Hospitals of Morecambe Bay NHS
NHS Foundation Trust

NHS England

Supporting patients' choices

This leaflet provides a summary of what this means for patients.

PATIENT LEAFLET

Introduction

Following a hospital admission, most people are able to return home. Sometimes this can be with relevant equipment, therapy support or a package of care. However, some people are unable to return home and may need the added support which is only available in a care home.

Once people no longer need hospital care, it is best to get home or to another community setting as quickly as possible because:

- Nobody wants to stay in hospital any longer than is necessary.
- Being at home or in a community setting (such as a care home) is the best place to continue recovery once an illness requiring hospital care is over.
- Once people are aged 80 years and over, 10 days spent in a hospital bed equates to 10 years of muscle wasting.
- Severely ill patients may be unable to access services, if hospital beds are occupied with patients who no longer need them.
- We will involve you in all decisions about your care, treatment and discharge and give you all the information and support you need to make the best decisions.

What can you expect as a patient?

1. A named person to coordinate your hospital stay

You should be provided with a named member of staff who will support you throughout your time at hospital and make sure that things happen when they are supposed to.

2. Right to high quality information and support

Wherever you need to go following hospital, the NHS and local authority will do all that they can to help you. They should give you all the information you need to make the best decision.

- You should be involved in all decisions about your care and treatment.
- You should be informed of where you can access detailed support, advice and advocacy about making a decision, should you wish this support.
- You should be provided with high quality information to make a decision about your ongoing care, including:
  - an understanding of your care needs.
  - the process and outcome of the assessment of needs.
  - offers of care and options available.
  - costs of any care.

3. Timescales for decisions

- You should know when your treatment is due to end and when you would be considered well enough to leave hospital (this is called an expected date of discharge) - you should know this within 24 hours of you being admitted.
- Once you have received information about the choices that are available to you, we will request that you make a decision within 7 days. You may wish to arrange for yourself or a family member to meet with the care providers during this time. NHS and local authorities are responsible for supporting as many people as possible to achieve this. We will do our best to help make this possible for you and you will be able to speak with ward staff.

4. Interim placements

Once you are well enough to leave hospital but you are unable to return home, you will be offered an alternative option temporarily in the following situations:

- Your preferred choice is not currently available.
- You have not yet made a decision.
- You are waiting for further assessments to be carried out.

In these circumstances, it is not possible for people to wait in hospital.

5. Day of discharge

- We aim to discharge you as early as possible.
- Hospital transport will only be provided if assessed as appropriate, this may be by ambulance or hospital car.
- We will provide you with medication if appropriate.
- You will be offered a copy of your discharge summary and a copy will be sent to your GP.
- We will hand over the details of your on-going care to relevant partner services.
- Please do not hesitate to ask questions about your discharge anytime during your hospital stay.

Appendix 4: Letter B1

University Hospitals of Morecambe Bay
NHS Foundation Trust

Insert Address

Trust Headquarters
Westmorland General Hospital
Burton Road
Kendal
Cumbria
LA9 7RG
Tel: 01539732288
Web: www.uhmb.nhs.uk

[B1 care home **please delete**]
Date

Dear,

We are pleased to hear that you/your relative [Delete as appropriate] is/are now well enough to be discharged from hospital.

All of the necessary assessments have been completed and you/your relative's [state name] care and wellbeing needs have been fully discussed with you. I understand that this has identified that you/your relative no longer requires an inpatient hospital bed and that your/their needs could now be appropriately met in a Care Home.

I understand that from assessment, you have been advised on an appropriate level of care home that can meet your/your relative's needs. You will also have been provided with information with regards to cost and financial implications. With the assistance of CHS, our hospital Care Home Selection Team, you will be supported in finding an appropriate care home.

If within 7 days of receipt of this letter, a suitable care home has not been identified we will ask you/you're relative to accept a suitable, temporary alternative whilst you wait for your preference.

The demand for hospital beds is extremely high and in order to meet this demand it is important that all patients are discharged in a safe, effective and timely manner once they are well enough.

Please will you confirm your preference for accommodation by contacting [insert lead discharge professional] on [insert contact details], as soon as possible so that we can arrange your/your relatives discharge safely and promptly.

If you have any queries or wish to discuss further or would like a copy of this letter to be provided to a family member or carer, please contact [insert lead discharge professional] on [insert contact details].

If you have any concerns or questions regarding your discharge plans or the content of this letter, please talk to any of the ward staff who will assist in any way they can.

A copy of the trusts Discharge policy, the National Supporting Patient Choices' to Avoid Long Hospital Stays policy and the trusts standard operating procedure in relation to delivering this policy can be provided upon request.

Thank you for your co-operation.

Yours Sincerely

Clinician (patients' named doctor), CC Patient's file

Appendix 5: Letter B2

University Hospitals of Morecambe Bay
NHS Foundation Trust

Insert Address

Trust Headquarters
Westmorland General Hospital
Burton Road
Kendal
Cumbria
LA9 7RG

Tel: 01539 732288
Web: www.uhmb.nhs.uk
Date

Dear
We are pleased to hear that you/your relative [Delete as appropriate] is/are now well enough to be discharged from hospital.

All of the necessary assessments have been completed and you/your relative's [state name] care and wellbeing needs have been fully discussed with you. I understand that this has identified that you/your relative no longer requires an inpatient hospital bed and that your/their needs could now be appropriately met in their own home with the support of a care package.

I understand that from assessment you have been advised on an appropriate package of care that can meet you/your relative's needs. You will also have been provided with information with regards to cost and financial implications. With the assistance of Social Services if you so wish, you will be supported in finding a suitable care provider to meet your/your relative's needs.
If you do not wish to have any support from social service, our Care Home Selection team would be more than happy to support you with this. They can be contacted via the ward staff if you let them not you would like to pursue this option.

If within 7 days of receipt of this letter, a suitable care package has not been identified we will ask you/you're relative to accept a suitable, temporary alternative whilst you wait for your chosen care package to commence. This maybe an alternative package of care or a care placement.

The demand for hospital beds is extremely high and in order to meet this demand it is important that all patients are discharged in a safe, effective and timely manner once they are well enough.

Please will you confirm your preference for care by contacting [insert lead discharge professional] on [insert contact details], as soon as possible so that we can arrange your/your relatives discharge safely and promptly.

If you have any queries or wish to discuss further or would like a copy of this letter to be provided to a family member or carer, please contact [insert lead discharge professional] on [insert contact details].

A copy of the trusts Discharge policy, the National Supporting Patient Choices' to Avoid Long Hospital Stays policy and the trusts standard operating procedure in relation to delivering this policy can be provided upon request.

Thank you for your co-operation.
Yours Sincerely

Clinician (patient's doctor) CC: Patient's file.

Appendix 6: Letter B3

University Hospitals of Morecambe Bay
NHS Foundation Trust
Trust Headquarters
Westmorland General Hospital
Burton Road
Kendal
Cumbria
LA9 7RG

Tel: 01539 732288
Web: www.uhmb.nhs.uk

Date

Dear

We are pleased to hear that you/your relative [Delete as appropriate] is/are now well enough to be discharged from hospital.

All of the necessary assessments have been completed and you/your relative's [state name] care and wellbeing needs have been fully discussed with you. I understand that this has identified that you/your relative no longer requires an inpatient hospital bed and that your/their needs could now be appropriately met in their own home with the support of a care package.

Unfortunately finding a suitable care provider in your/ your relative's area is proving difficult, and may take some time to arrange. Due to this unforeseen circumstance, we will ask you/you're relative to accept a suitable, temporary alternative whilst you wait for your care package to commence.

It is well recognised that an unnecessary prolonged hospital stay can be detrimental to an individual's health and wellbeing. In addition to this the demand for hospital beds is extremely high and in order to meet this demand it is important that all patients are discharged in a safe, effective and timely manner once they are well enough.

Therefore within the next 7 days CHS, our Care Home Selection Team will assist you to identify a suitable interim care placement and will continue to support you/your relative's return as soon as possible with the appropriate care package.

If within 7 days of receipt of this letter, a suitable interim care placement has not been identified we will ask you/you're relative to accept a suitable, temporary alternative whilst you wait for your chosen care package to commence.

Please will you confirm your preference for accommodation by contacting [insert lead discharge professional] on [insert contact details], as soon as possible so that we can arrange your/your relatives discharge safely and promptly.

If you have any queries or wish to discuss further or would like a copy of this letter to be provided to a family member or carer, please contact [insert lead discharge professional] on [insert contact details].

A copy of the trusts Discharge policy, the National Supporting Patient Choices' to Avoid Long Hospital Stays policy and the trusts standard operating procedure in relation to delivering this policy can be provided upon request.

Thank you for your co-operation.

Yours Sincerely

Clinician (patients' named doctor)
CC: Patient's file.

Appendix 7: Letter C1

University Hospitals of Morecambe Bay NHS Foundation Trust

Insert address

Trust Headquarters
Westmorland General Hospital
Burton Road
Kendal
Cumbria
LA9 7RG
Tel: 01539 732288
Web: www.uhmb.nhs.uk
Date

Dear

Further to our letter dated **(date of letter B1)**

I understand that you/your relative's (insert name) preferred care home following discharge is [insert name of chosen care facility], however they are unable to accommodate you/your relative at this time.

Or **(Please delete the sentence that isn't applicable to the situation)**

I understand that you have not yet advised us of your/your relative's preferred care home following discharge.

Unfortunately you/your relative will not be able to stay in hospital whilst you/they wait for a vacancy at your preferred care home. We are now offering to transfer you to temporary accommodation in the following location which has been assessed as suitable to meet your short-terms needs.

Discharge destination:	
Address:	
Tel number:	
Date of discharge:	

Please be assured that CHS, our hospital Care Home Selection Team will continue to support you to transfer to your preferred choice.

It is very important that those who have been assessed as well enough for discharge move to a more suitable placement promptly as unnecessary prolonged hospital stays are detrimental to you/your relative's wellbeing. I am sure you will also understand that we need to ensure that hospital beds are available for patients who need them for urgent treatment. It is therefore important that those who have been assessed as well enough to be leaving hospital do so in a safe, effective and timely manner.

If you have any queries or wish to discuss this further, please contact [insert lead discharge professional] on [insert contact details].

If you would like a copy of this letter to be given to a relative or carer please let the staff on the ward know and we will arrange this for you.

A copy of the trusts Discharge policy, the National Supporting Patient Choices' to Avoid Long Hospital Stays policy and the trusts standard operating procedure in relation to delivering this policy can be provided upon request.

Thank you for your cooperation.

Yours sincerely
Clinician (Patients' doctor)

CC: Patient's file.

Appendix 8: Letter C2

University Hospitals of Morecambe Bay
NHS Foundation Trust
Trust Headquarters
Westmorland General Hospital
Burton Road
Kendal
Cumbria
LA9 7RG
Tel: 01539 732288
Web: www.uhmb.nhs.uk
Date

Dear

Further to our letter dated……

I understand that you have not yet advised us of and interim placement following discharge whilst you await your package of care to start at home.

Or (delete the one which is not appropriate to the patients' situation)

I understand that you/your relative's (insert name) preferred care home following discharge is [insert name of chosen care facility], however that they are not able to accommodate you/your relative at this time.

Unfortunately you/your relative will not be able to stay in hospital whilst you/they wait for a vacancy at your preferred care home. We are now offering to transfer you to temporary accommodation in the following location which has been assessed as suitable to meet your short-terms needs.

Discharge destination:	
Address:	
Tel number:	
Date of discharge:	

Please be assured that CHS, our hospital Care Home Selection Team will continue to support you to transfer to your preferred choice.

It is very important that those who have been assessed as well enough for discharge move to a more suitable placement promptly as unnecessary prolonged hospital stays are detrimental to you/your relative's wellbeing. I am sure you will also understand that we need to ensure that hospital beds are available for patients who need them for urgent treatment. It is therefore important that those who have been assessed as well enough to be leaving hospital do so in a safe, effective and timely manner.

If you have any queries or wish to discuss this further, please contact [insert lead discharge professional] on [insert contact details].

If you would like a copy of this letter to be given to a relative or carer please let the staff on the ward know and we will arrange this for you.

A copy of the trusts Discharge policy, the National Supporting Patient Choices' to Avoid Long Hospital Stays policy and the trusts standard operating procedure in relation to delivering this policy can be provided upon request.

Thank you for your cooperation.

Yours sincerely

Clinician (Patients' doctor)

CC: Patient's file.

Appendix 9: Letter C3

University Hospitals of Morecambe Bay
NHS Foundation Trust

Insert address

Trust Headquarters
Westmorland General Hospital
Burton Road
Kendal
Cumbria
LA9 7RG
Tel: 01539 732288
Web: www.uhmb.nhs.uk

Date

Dear

Further to our letter dated…….

I understand that you have not yet advised us of and interim placement following discharge whilst you await your package of care to start at home.

Or (delete the one which is not appropriate to the patients' situation)

I understand that you/your relative's (insert name) preferred care home following discharge is [insert name of chosen care facility], however that they are not able to accommodate you/your relative at this time.

Unfortunately you/your relative will not be able to stay in hospital whilst you/they wait for a vacancy at your preferred care home. We are now offering to transfer you to temporary accommodation in the following location which has been assessed as suitable to meet your short-terms needs.

Discharge destination:	
Address:	
Tel number:	
Date of discharge:	

Please be assured that CHS, our hospital Care Home Selection Team will continue to support you to transfer to your preferred choice.

It is very important that those who have been assessed as well enough for discharge move to a more suitable placement promptly as unnecessary prolonged hospital stays are detrimental to you/your relative's wellbeing. I am sure you will also understand that we need to ensure that hospital beds are available for patients who need them for urgent treatment. It is therefore important that those who have been assessed as well enough to be leaving hospital do so in a safe, effective and timely manner.

If you have any queries or wish to discuss this further, please contact [insert lead discharge professional] on [insert contact details].

If you would like a copy of this letter to be given to a relative or carer please let the staff on the ward know and we will arrange this for you.

A copy of the trusts Discharge policy, the National Supporting Patient Choices' to Avoid Long Hospital Stays policy and the trusts standard operating procedure in relation to delivering this policy can be provided upon request.

Thank you for your cooperation.

Yours sincerely

Clinician (Patients' doctor)

CC: Patient's file.

Appendix 10: Update Letter

University Hospitals of Morecambe Bay NHS Foundation Trust

Insert address

Trust Headquarters
Westmorland General Hospital
Burton Road
Kendal
Cumbria
LA9 7RG
Tel: 01539 732288
Web: www.uhmb.nhs.uk

Date

Dear

Further to our letter dated **(date of letter B1)**

I understand that you/your relative's (insert name) preferred care home following discharge is [insert name of chosen care facility], however they are unable to accommodate you/your relative at this time.

Or **(Please delete the sentence that isn't applicable to the situation)**

I understand that you have not yet advised us of your/your relative's preferred care home following discharge.

In line with the national policy 'Supporting Patient Choices to Avoid Long Hospital Stays' the hospital at this point would offer a suitable temporary alternative. However we to have been unable to source a suitable alternative which will meet your/your relatives needs upon discharge.

It is very important that those who have been assessed as well enough to leave hospital are discharged promptly as unnecessary prolonged hospital stays are detrimental to you/your relative's wellbeing.

Therefore the hospital with support of Care Home Selection (CHS) will continue to actively source an interim placement/Package of care (please delete) and will communicate this to you as soon as this becomes available.

If you have any queries or wish to discuss this further, please contact [insert lead discharge professional] on [insert contact details].

If you would like a copy of this letter to be given to a relative or carer please let the staff on the ward know and we will arrange this for you.

A copy of the trusts Discharge policy, the National Supporting Patient Choices' to Avoid Long Hospital Stays policy and the trusts standard operating procedure in relation to delivering this policy can be provided upon request.

Thank you for your cooperation.

Yours sincerely
Clinician (Patients' doctor)
CC: Patient's file.

Appendix 11: Letter D

University Hospitals of Morecambe Bay
NHS Foundation Trust
Trust Headquarters
Westmorland General Hospital
Burton Road
Kendal
Cumbria
LA9 7RG

Tel: 01539 732288
Web: www.uhmb.nhs.uk

Letter D
Final Notification after formal meeting has taken place Consult with Discharge lead/community manager for follow up with Trust Legal Team before letter is sent out ** this letter needs to be personalised to each individual case.**

Date

Dear

We write further to the letter of (letter C (type) insert date) and following the formal meeting which was held on (insert date) in relation to the discharge arrangements for you/your relative. The hospital has offered you all the necessary support and advice to enable you to have a safe and appropriate discharge but you have decided not to accept the arrangements which have been offered.

Summary of meeting

Outcome of Risk Assessment- (Provide copy of risk assessment with Letter)

We will now arrange an appropriate transfer to the location below which has been assessed as suitable to meet you/your relative's needs on discharge from hospital.
Explain funding arrangements

Please be assured that with the support of CHS, our Care Home Selection team, you will continue to be supported to transfer to your preferred choice or return home with a care package which can meet your needs.

We hope you will appreciate the importance of the trusts Discharge policy and the national Supporting patient Choices' to Avoid Long Hospital Stays policy being enforced to ensure the most effective use of NHS resources. A copy of both policies are enclosed and clearly states that where patients have been assessed as no longer requiring NHS continuing inpatient care they do not have the right to occupy an NHS bed indefinitely.

If you have any queries relating to the content of this letter, please do not hesitate to contact [discharge lead detail].

For the avoidance of doubt, we confirm that the hospital bed you/your relative are currently occupying will no longer be available to you as of [INSERT TIME] ON [INSERT DATE]. Your discharge arrangement will be:

Discharge address:

A copy of the trusts Discharge policy, the National Supporting Patient Choices' to Avoid Long Hospital Stays policy and the trusts standard operating procedure in relation to delivering this policy can be provided upon request.

Yours sincerely

Clinician (patients' doctor)
Cc patients notes

Appendix 12: Risk Assessment

MDT Risk Assessment

For use in arranging Interim placements or packages of care to support discharge, including impact on carer and family. This document is to be retained in the Patient Notes

Name: Address: DOB:	Site: Ward: NHS Number: RTX Number:
Home of choice details	**Interim placement details**
What are the person's past, present preferences and wishes, beliefs and values?	

Identified Risk –

Summarise the risk of remaining in hospital setting.

Examples:
Hospital acquired infections
Falls
Reduced sleep
Pressure ulcers
Significant muscle weakness
Increased mortality
Reduced quality of life
Risk from other surrounding patients on the ward
Impact on hospital flow
Increased cost
(please delate when completing assessment)

Summarise the risk of being discharge to an interim placement.

Examples:
Social isolation (spouses separated- unable to visit)
Reduced quality of life
Unsettled- being transferred from one placement to another (multiple moves)
Emotional well-being- patient and/or families don't want to go.
Increased cost
(please delate when completing assessment)

Persons affected and why are they affected Patient, family member, other (please specify) -

Existing control measures -

What has/can been done to mitigate negative effects of staying in hospital?

What can be done to mitigate negative effects of transferring to an interim placement?

List of people involved in the meeting

Print name	Designation	Signature	Date
1.			
2.			
3.			

Appendix 13: Audit Trail

Supporting Patient Choices to Avoid Long Hospital Stays Audit Trail.		
Individuals name ……. **RTX number ……..……** **Hospital ……..**		
Action 1	**Patient information leaflet and welcome letter one provided with Expected Date of Discharge**	
	Date/time:	**Print and signed**
Action 2	**Letter B sent:**	
	Date/time:	**Print and signed**
Action 3	**Update letter sent (if appropriate)**	
	Date/time:	**Print and signed**
Action 4	**Escalation lead aware that patient is progressing to letter C**	
	Date/time:	**Print and signed**
Action 5	**Letter C sent:**	
	Date/time:	**Print and signed**
Action 6	**Formal referral to escalation lead to progress to letter D**	
	Date/time:	**Print and signed**
Action 7	**Formal meeting held with patient/family (if appropriate)**	
	Date/time:	**Print and signed**
Action 8	**Risk Assessment regarding interim placement completed.**	
	Date	**Print and signed**
Action 9	**Letter D sent:**	
	Date	**Print and signed**
Action 10	**Date and outcome of funding conference- who with who agreed, plan**	

Appendix 14: Equality & Diversity Impact Assessment Tool

University Hospitals of Morecambe Bay NHS Foundation Trust

Equality Impact Assessment Form

Department/Function	Discharge			
Lead Assessor	Pauline Turner			
What is being assessed?	Support Patient Choices to Avoid Long Hospital Stays			
Date of assessment	18/09/2017			
What groups have you consulted with? Include details of involvement in the Equality Impact Assessment process.	Equality of Access to Health Group	☐	Staff Side Colleagues	☐
	Service Users	☐	Staff Inclusion Network/s	☐
	Personal Fair Diverse Champions	☐	Other (Inc. external orgs)	☐
	Please give details:			

1) What is the impact on the following equality groups?

Positive:	**Negative:**	**Neutral:**
➢ Advance Equality of opportunity ➢ Foster good relations between different groups ➢ Address explicit needs of Equality target groups	➢ Unlawful discrimination, harassment and victimisation ➢ Failure to address explicit needs of Equality target groups	➢ It is quite acceptable for the assessment to come out as Neutral Impact. ➢ Be sure you can justify this decision with clear reasons and evidence if you are challenged

Equality Groups	**Impact** (Positive / Negative / Neutral)	**Comments** ➢ Provide brief description of the positive / negative impact identified benefits to the equality group. ➢ Is any impact identified intended or legal?
Race (All ethnic groups)	Neutral	
Disability (Including physical and mental impairments)	Neutral	
Sex	Neutral	
Gender reassignment	Neutral	
Religion or Belief	Neutral	
Sexual orientation	Neutral	
Age	Neutral	
Marriage and Civil Partnership	Neutral	
Pregnancy and maternity	Neutral	
Other (e.g. caring, human rights)	Neutral	

2) In what ways does any impact identified contribute to or hinder promoting equality and diversity across the organisation?	

---

3) If your assessment identifies a negative impact on Equality Groups you must develop an action plan **to avoid discrimination and ensure opportunities for promoting equality diversity and inclusion are maximised.** ➢ This should include where it has been identified that further work will be undertaken to further explore the impact on equality groups ➢ This should be reviewed annually.
Action Plan Summary

Action	**Lead**	**Timescale**

This form will be automatically submitted for review for Policies and Procedures once approved by Policy Group. For all other assessments, please return an electronic copy to EIA.forms@mbht.nhs.uk once completed.