Transfer of Care Policy

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1	02.11.23	Lloyd Forbes	Updates following review meeting and formatting
	19.10.23	Eilidh French	Updates following HFP finalising policy
	02.11.23	Eilidh French	Further updates following ICB feedback and Home First Partnership (HFP) review
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	01.12.23	Eilidh French	Minor updates to wording following feedback from United Lincolnshire Hospital (ULH) review
	14.12.23	Eilidh French	Introduction of the term Carer and Care Partner to the glossary and footnotes following feedback from United Lincolnshire Hospital (ULH) review
	20.12.23	Eilidh French	Slight Update to Letter Headings (appendix 4)
	21.12.23	Emma Coulson	Letters amended to state “hospital/care setting” to match headings

Contents

1. Introduction

1.1. This policy supports people's timely, effective and safe discharge from an NHS inpatient setting to a setting which meets their health and social care needs. It applies to all adult inpatients in Lincolnshire NHS provider settings (excluding Lincolnshire Partnership Foundation NHS Trust) and needs to be utilised during pre-operative assessment and during admission to ensure that those who are assessed as no longer meeting the criteria to reside can leave hospital in a safe and timely way.

1.2. This policy supports existing national policy on effective discharge. This policy should also be read in conjunction with the discharge policy and flow policy.

1.3. Mental Health inpatient services are not within scope for this guidance. Parallel guidance on managing demand and capacity across mental health acute and urgent care sector, learning disability and autism services has been developed and should be consulted with the lead provider.

1.4. Patient engagement and involvement are central to the process for managing hospital discharge. The term patient is used here to describe an individual who has been admitted to NHS inpatient settings. Oral or written communication with the patient applies equally or alternatively to communicating with the patient's representative, as appropriate and with consent.

1.5. The consequences of a patient who no longer meets the criteria to reside for remaining in a hospital bed might include:

a. Exposure to an unnecessary risk of hospital acquired infection.
b. Physical decline and loss of mobility / muscle use.
c. Sleep disturbance and symptoms of sleep deprivation.
d. Adverse impact of the mental and psychological health and wellbeing in an unfamiliar environment.
e. Frustration and distress to the patient and relatives due to uncertainty during any wait for a preferred choice to become available.
f. Increased patient dependence, as the hospital environment is not designed to meet the needs of people who do not meet the criteria to reside.
g. Severely ill patients being unable to access services due to beds being occupied by patients who do not meet the criteria to reside, including ambulances being unable to be released to attend to patients in the community.

1.6. Patients, Carers[1] and families can find it difficult to make decisions and/or make the practical arrangements for a range of reasons, such as:

[1] the term Care Partner is increasingly being used and is seen as synonymous with Carer; for the purpose of this document where we state Carer we also consider this to include Care Partners

a. A lack of knowledge about the options and how services and systems work.
b. Concerns about either the quality or the cost of care.
c. Feeling that they have insufficient information and support.
d. There is uncertainty or conflict about who will cover costs of care.
e. Concerns about moving into interim accommodation and then moving again at a later stage.
f. The options available do not meet the patient's preferences.
g. Concerns that their existing home is unsuitable, cold or needs work done to ensure a safe environment for discharge.
h. Worry about expectations of what family and carers can and will do to support them.
i. As such they will require proactive support from a variety of professionals from across health and social care to support them with their decision making

2. Purpose

2.1. The purpose of this policy is to ensure that a patient's discharge is managed sensitively and consistently throughout the discharge planning process, and people are provided with effective information and support to make an informed decision.

2.2. This policy sets out a framework to ensure that NHS beds across providers 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.

2.3. Where the patient lacks Mental Capacity to make decisions about discharge from hospital, then the application of the policy should be adapted as explained in Appendix 2, following the Mental Capacity Act 2005.

2.4. This policy will 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 better met. Ultimately it aims to improve outcomes for patients.

2.5. This policy includes all patients, aged 18 years and above, including those with very complex care needs, who may have been in hospital for an extended length of time, and people at the end of life.

2.6. This policy is to be used in conjunction with the Discharge Policy and is for use by all staff with responsibility for arranging the safe discharge of patients.

3. Scope

3.1. In scope:

a. All employees
b. Ward staff of all levels
c. Medics
d. Transfer of Care Hub
e. Community partner in-reach

3.2. Out of scope:

a. Mental Health services
b. All patients under the age of 18

4. Principles

4.1. Supporting people to make decisions

4.1.1. The principles of the 6Cs[2]; Care, Compassion, Competence, Communication, Courage and Commitment should be applied to this process.

4.1.2. The Discharge Policy underpins this process. Patients should not be expected to make decisions about their long-term future while in hospital and therefore a home first, strength-based approach will be used. Home care, reablement or community hospitals and transitional care will be utilised to support discharge.

4.1.3. Patients, and the people who support them, should be provided with high quality information, advice and support in a format that is accessible to them, as early as possible before or on admission and throughout their stay, to enable effective participation in the discharge process and in making an informed decision. They should be informed of their Expected Date of Discharge at an early stage in their hospital stay and kept updated as to any key issues which may impact upon this date.

4.1.4. All Lincolnshire health and social care staff will assume that a patient is returning home/usual place of residence, unless they are made aware, by community-based services, of circumstances that prevent this from occurring.

4.1.5. Where a patient lacks the capacity to understand the transfer of care policy, letters will be given to their Lasting Power of Attorney (LPA) in the same order they would be given to the patient. If there is no LPA in place, then the decision will be made following a best interests meeting (in accordance with Mental Capacity Act 2005 and Appendix 2 of this document)

4.1.6. Patients or their advocates should be involved in all decisions about their care, as per the NHS Constitution, and should be provided with high quality support and information in order to participate with discharge planning.

[2] introducing-the-6cs.pdf (england.nhs.uk),

4.1.7. Where the patient has been assessed as lacking Mental Capacity, information may be shared in their best interests in accordance with requirements set out in the Mental Capacity Act 2005 Code of Practice and Appendix 2 of this document. The responsibility to share essential information in the best interest of the patient is supported by Caldicot Guardian Principle 7 and under public task responsibilities in GDPR.

4.1.8. Where someone is providing care or considering providing care post-discharge, unpaid as a carer, they must be informed and invited to be involved in the discharge process and informed about their rights and sources of support. Any request to attend relevant meetings will endeavor to give 24 hours' notice, carers are expected to prioritise attendance however this will not contribute to delays in discharge by attending or postponing.

4.1.9. Carers must be offered, where appropriate, the information, training and support they will need to provide care following discharge. A Carer's assessment may be undertaken with informal carers to support discharge; however, this may occur after the patient leaves hospital. This is particularly important when there is a Young Carer under 18 years of age.

4.1.10. When a Carer has their own social worker, particularly with Young Carers or young adults, the social workers should be involved early in the discharge discussions in hospital.

4.1.11. ULHT Care Partners[3] Policy can be found here: Corporate Governance - Care Partners Policy.pdf - End User View (sharepoint.com) and provides guidance and advice on involving Care Partners in a patients care; particularly in considering early involvement in decision making. Use of the Care Partner Badge in clinical settings helps staff to easily identify a Care Partner and awareness of their role and need to be engaged with and involved.

4.1.12. If a patient is unwilling to accept the service(s) offered to facilitate their discharge, alternatives and any associated risks will be discussed, however this will not prevent or delay discharge.

4.2. Timely discharge from acute care

4.2.1. Patients do not have the right to remain in hospital longer than required.

4.2.2. Planning for effective transfer of care, in collaboration with the patient and/or representatives and all Multi-Disciplinary Team (MDT) members, should be commenced at or before admission, or as soon as possible after an emergency admission. The principles of SAFER (Senior Review; All patients; Flow; Early

[3] the term Care Partner is increasingly being used and is seen as synonymous with Carer; for the purpose of this document where we state Care Partner, we also consider this to include Carer

discharge; and Review) patient flow bundle should be applied to support timely discharge.

4.3. Funding arrangements

4.3.1. This policy applies equally to people regardless of the funding arrangements and the nature of their ongoing care.

5. Overview of Process

Step 1: Providing standard information and support	• Discharge coordinator identified for each patient. • Discharge expectations discussed with patient, and they are made aware of policy – documented in patient notes. • Provided patient with Factsheet A. • Patient given EDD/PDD. • Any carers/ advocates provided with Factsheet C. • Patient Flow Bundle.
Step 2: Assessing need	• Early identification of complexities likely to delay discharge. • Sharing information on risks identified with community services. • Ensures all necessary referrals are made. • Provide Fact sheet C to carers if required.
Step 3: Preparing for Discharge	• Completed 24hrs prior to EDD/PDD • Explain process and timelines to patient. • Transfer of Care Letter B provided to support decisions. • Home First Principles – assume patient is going home. • SPA form completed and sent to Transfer of Care Hubs for triage. • Discharge plans discussed daily.
Step 4: Escalation Process	• Follow stages 1-3 of the Transfer of Care escalation Policy.

5.1. Step 1 - Providing standard information and support

5.1.1. The nurse undertaking the admission on the ward will, in discussion with the ward multidisciplinary team, identify discharge plans for all patients at the point of admission and they will explain the discharge planning process. At this point consideration will be given whether further support will be required upon discharge for hospital be that to home or alterative setting.

5.1.2. Early identification of a Carer or Care Partner is critical to not only ensure their knowledge and expertise is considered but also to enable partnership working to support discharge decisions.

5.1.3. Discharge expectations will be discussed with the patient and supported using the written Factsheet A (Appendix 4).

5.1.4. The discharge coordinator will ensure that the patient is aware of this policy and of the circumstances in which a short-term package of care or placement might be necessary before being assessed for more permanent solutions. All communication will clearly set out the process that the hospital will follow in order to work towards the patient's timely discharge when their need for inpatient treatment ends.

5.1.5. All patients will be given a Predicted Discharge Date (PDD) as soon as possible after admission by a consultant or senior clinician. Regular review and discussion about the EDD / PDD as part of 'board rounds' will ensure all parties understand when support will be required to facilitate discharge.

5.2. Step 2 - Assessing need

5.2.1. Patient discharge requirements will be considered upon admission.

5.3. Step 3 - Preparing for discharge

5.3.1. If the patient is identified as having care needs to support discharge, they will be referred to appropriate transfer of care hub team.

5.3.2. Information will be provided to the patient about the care options available to them either at home or in a placement. After discharge, a Care Act or CHC Checklist may be completed if required.

5.3.3. If not eligible to progress to a CHC assessment a level of contribution to the long-term care/placement may be required and is dependent on the completion of a financial assessment. The allocated social worker will be able to provide additional information about this process once you are discharged from hospital.

5.3.4. The patient should be directed to the local advocacy service for advice and information regarding advocacy, if required.

5.3.5. The initial care will be provided through NHS funding and will be up to a period of 4 weeks.

5.3.6. Self-funders should be provided with the same level of information, advice and

support as people whose care is being funded by the NHS or the local authority.

5.3.7. The discharge coordinator will discuss discharge plans with the patient regularly. The discharge coordinator will consider patient's wishes regarding discharge plans, if concerns are brought to their attention.

5.3.8. Every effort should be made to ensure that patients are involved in all stages of decisions that affect them, and that their agreement to such decisions is obtained. Patients should be informed of the right they have to complain and provided with details of how to do so, including recourse to formal complaints procedures and statutory agencies.

5.3.9. By giving appropriate information on packages of care or placements, clarifying concerns, and giving the welcome letter to the patient there should be no delay in their discharge (Appendix 4).

5.3.10. Patients do not have the right to remain in hospital longer than required however, they do have the right to "respect for a private life" and not to be treated in an inhuman or degrading way. Therefore, it is crucial for the hospital to ensure that the planned transfer is appropriate and in line with human rights legislation.

5.3.11. The discharge coordinator will advise the patient that the hospital will expect discharge to be achieved within the agreed timescale.

5.4. Step 4 – Packages and placements

5.4.1. A package of care or placement will be offered to a patient to facilitate discharge. A short-term option may be required where the appropriate care package, placement, or adaptation as identified by the transfer of care hub and the multi-disciplinary team is not yet available. Patients do not have the right to reside in hospital to wait for their preferred option to become available.

5.4.2. Where a patient declines the planned discharge destination, they will be provided with Transfer of Care Letter B1 OR B2 (Appendix 4). The patient or their advocates will have 24 hours to identify an alternative discharge destination.

5.4.3. After a further 24 hours have elapsed, and no alternative has been identified the patient will be given Letter C (Appendix 4). and be discharged to the planned discharge destination.

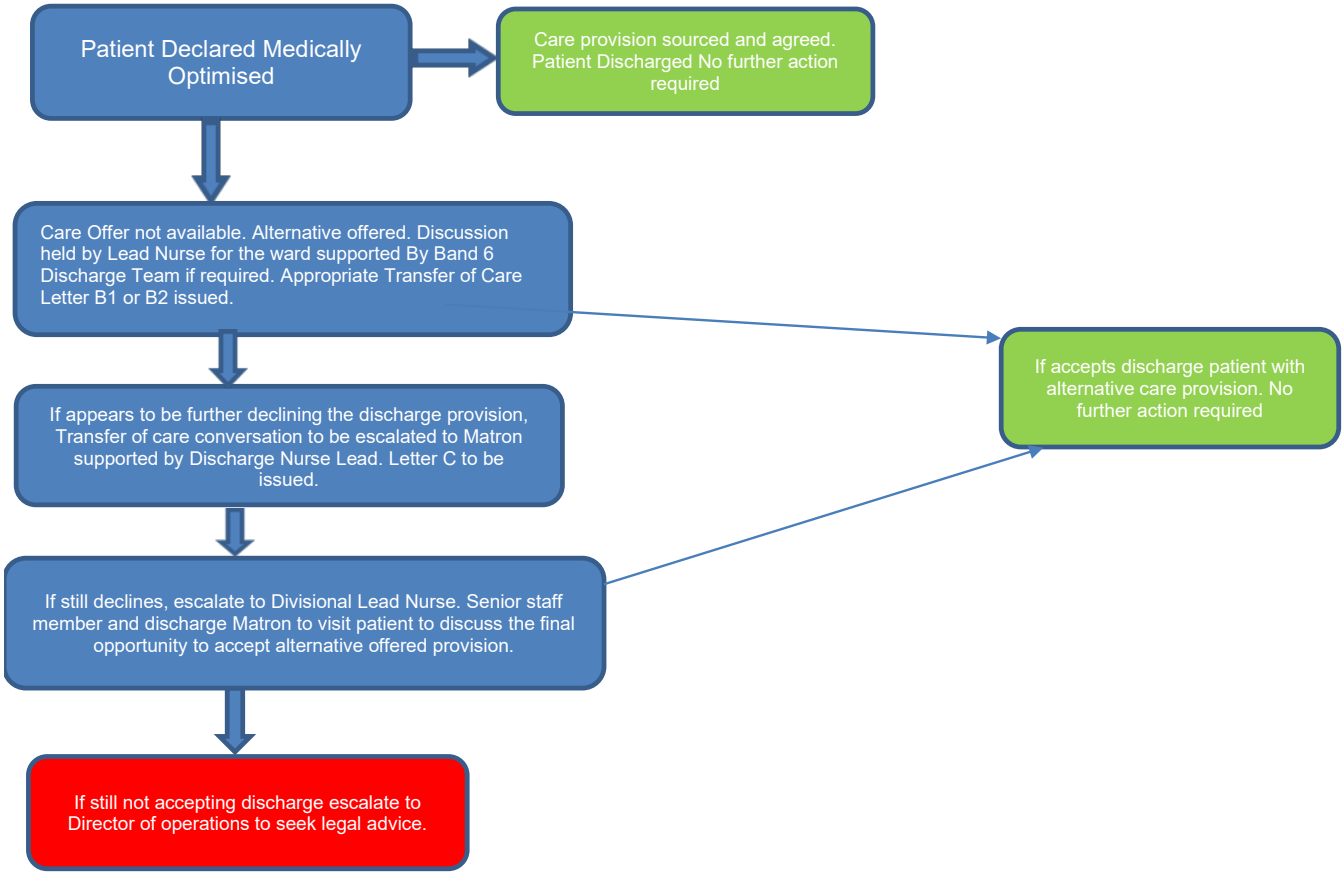
5.5. Facilitated discharge

5.5.1. Each hospital has a Facilitated Discharge Policy that will be enacted when the discharge plan is disputed or declined by the patient or their advocate.

5.6. Escalation process

5.6.1. If no agreement has been reached regarding discharge arrangements after steps 1-5, and transfer arrangements are challenged by the patient. The patient will be given Choice Letter B1 (Appendix 4). The provider will then follow the designated escalation process.

ESCALATION FLOW CHART: TRANSFER OF CARE CONVERSATION



Following all discussions, feedback to the nurse in charge, document the discussion and place a copy of the appropriate Choice Letter in the patient's notes.

Staff member who conducts the Choice Letter discussion (Choice letter B1 & B2) - Systemwide professionals and organisations supporting discharge:

- ULHT nurse in charge of the ward supported by Matron and Adult Social Care/LCHS if required.
- If escalation is required, the conversation will be conducted by the Divisional Lead Nurse.

Staff member who conducts the Choice Letter discussion (Letter C) – Systemwide professionals and organisations supporting discharge:

- ULHT nurse in charge of the ward supported by Matron and Adult Social care/LCHS if required.
- If escalation is required, the conversation will be conducted by the Divisional Lead Nurse.

6. Mental capacity

6.1. All patients should be assumed to have mental capacity to make a decision about their ongoing care, including discharge.

6.2. Mental Capacity assessment is not required if the person is returning to their usual place of residence and there is no dispute in that expectation.

6.3. A Mental Capacity assessment should be undertaken at any point during the patient hospital stay, if their ability to make informed decisions, in relation to the

discussions and decisions about discharge, is in doubt. It is recommended that this occurs at the time that the doubt is raised and is conducted by the member of the MDT who knows the patient best.

6.4. Appendix 2 sets out in detail how the application of this policy should be adapted for cases where the patient may lack Mental Capacity to make the relevant decisions at the appropriate time.

7. Consultation and approval process

7.1. This policy was developed locally by a collaboration of partners with input from people working across the system.

7.2. Approval will be sought from all partners responsible for the policy as listed on page 7.

8. Review, revision

8.1. This policy will be reviewed every 3 years, or as appropriate, to ensure that it remains current with national policy.

8.2. Should any national policy or legislation change occur within this period that impacts the wording of the policy changes will be made at that time to ensure that it remains current with policy and legislation.

9. Monitoring compliance and effectiveness

9.1. Supported by education and training, ward staff are expected to implement this policy as described. Compliance with this policy, will be managed by the ward manager.

9.2. This will be monitored through the discharge team and the audit team, on an annual basis or more frequently, if appropriate.

9.3. Local monitoring will include an audit of the Transfer of Care Policy Implementation checklist (detailed below)

9.3.1. Staff training in place relevant to the policy and ensure undertaken.
9.3.2. Policy effectiveness.
9.3.3. Review of when choice information is provided.
9.3.4. Patient and/or representative feedback and complaints.
9.3.5. Number of Delayed Transfers of Care.
9.3.6. Length of Delayed Transfers of Care.
9.3.7. Equality monitoring.
9.3.8. Patient/carer feedback

10. Equality and diversity statement

Promoting equality and addressing health inequalities are at the heart of our values. Throughout the development of the policies and processes cited in this document, we have:

- Given due regard to the need to eliminate discrimination, harassment and victimisation, to advance equality of opportunity, and to foster good relations between people who share a relevant protected characteristic (as cited under the equality act 2010) and those who do not share it.
- Given regard to the need to reduce inequalities between patients in access to, and outcomes from healthcare services and to ensure services are provided in an integrated way where this might reduce health inequalities.
- Entrenched the value of a strength-based approach to delivering health and care. Valuing patients as partners in this process who each bring their individual strengths to their discharge from hospital.

11. Interaction with other policies

11.1. This policy should be read in conjunction with the Discharge Policy, the Transfer of Care Hub documents and Intermediate Care and Continuing Health Care policy (Appendix 3) and Care Partners Policy.

12. Appendices

12.1. Appendix 1: Glossary

Advocacy: a service to help people be involved in decisions, explore choices and options, defend their rights & responsibilities, and speak out about issues that matter to them.

Carer or Care Partner: the term Care Partner is increasingly being used and is seen as synonymous with Carer; for the purpose of this document where we state Carer we also consider this to include Care Partners. This refers to anyone who cares, unpaid, for a friend or family member who due to illness, disability, mental health problem or an addiction cannot cope without their support'

CHC: NHS Continuing Healthcare is defined as a package of ongoing care for an individual aged 18 or over which is arranged and funded solely by the NHS where the individual has been found to have a 'primary health need'.

Criteria to reside: A set of medical criteria where the need can only be addressed within an acute and community hospital setting. Anyone not meeting the criteria to reside can have their nursing and care needs met in a less intensive environment.

Deprivation of liberty: when an individual without mental capacity to consent is under continuous supervision and control and is not free to leave, and this is imputable to the state. See Appendix 2.

Independent Mental Capacity Advocate (IMCA): 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.

Independent Advocate: someone not employed by either health or adult social care who can ensure that the patients voice is heard in decision making, this is not mandated in law, however it is considered best practice when a person may find it difficult to express their own thoughts in formal meetings, for whatever reason

Interim care: A provisional placement that is suitable and able to meet the patient's assessed needs whilst they wait for their preferred option.

Lasting Power of Attorney (LPA): The holder of a lasting power of attorney (LPA) has been legally appointed by a patient. This person is referred to as the **attorney** and will help make or make decisions on behalf of the patient, if it is deemed they lack the capacity to make those decisions themselves. An LPA can be for health and welfare and/or finance. You would use an LPA to make sure that your wishes are followed and to give you control over what happens to you if you cannot make your own decisions.

MDT: Multidisciplinary team of health and social care professionals involved in the care and assessment of patients.

Patient: The individual receiving treatment in hospital.

PDD: Planned or Predicted date of discharge.

Reablement: Reablement services are meant to help people adapt to a recent illness or disability by learning or relearning the skills necessary for independent daily living at home. Reablement should be provided free of charge by the local

authority for up to six weeks.

Self-funder: A person who financially meets the full cost of their social care needs (apart from reablement care and the 12 week property disregard), because their financial capital exceeds the threshold for adult services funding, their level of need is not deemed to be high enough for local authority funding, or because they or a representative choose to pay for their care.

Transitional care: Short-term care provided free of charge by the NHS for people who no longer need to be in hospital but may need extra support to help them recover. It lasts for a maximum of six weeks and can be in the patient's home or in a residential setting.

12.2. Appendix 2: Hospital discharge and mental capacity issues

All staff must follow the five guiding principles of the Mental Capacity Act 2005 ("MCA"). This means:

- Presume that adults from 16 are mentally capable of making their own decisions.
- Do not determine the person lacks capacity until all practicable steps to support them have been taken without success.
- Do not consider someone to lack mental capacity because they make a decision, we consider to be unwise.
- When the patient is assessed to lack mental capacity, we must act in their best interests.
- Before taking any action or decision on their behalf we must consider if it can be achieved in a less restrictive way.

Mental Capacity is specific to the decision that must be made, at the relevant time, and so it is possible that a patient who has been assessed as having mental capacity to consent to or refuse the treatment they have had as an inpatient may lack mental capacity to make decisions around discharge and care planning (and vice versa). Where there is a reason to doubt mental capacity for a particular decision, it must be specifically assessed, in accordance with the Mental Capacity Act (MCA), the MCA Code of Practice and relevant case law and documented appropriately.

All practicable steps must be taken to support the patient to make the decision before concluding that they are unable to make it themselves. This might involve taking a number of steps such as a providing information in a different format or breaking information down into smaller chunks.

If a person is assessed to lack mental capacity this means that staff have tested whether they can:

- Understand the information relevant to the decision.
- Retain the information long enough to make a decision.
- Use and weigh the information as part of the decision-making process.
- Communicate the decision they want to make.

In the context of a discharge plan, the information relevant to the decision will include an understanding of their care needs on discharge, offers of care and options available, with the person being given a concrete plan to engage with.

A patient with mental capacity can make unwise decisions, however, they cannot insist on staying in hospital after they no longer meet the criteria to reside.

Where a patient, despite all reasonable efforts to support them, lacks mental capacity for discharge decisions, the decision must be made in their best interests (see MCA s4).

It is important to identify who the decision maker is, as it could be a number of different people. The decision maker may be an attorney (if a health and welfare Lasting Power of Attorney has been granted, and is valid, applicable, and registered) or a Deputy (if a health and welfare Deputy has been appointed by the Court). If neither of these are appointed, then it will be the health or care professional who needs to make the decision in question.

The wishes and feelings of the patient are paramount, however, this does not mean they will always get what they want, any more than a patient with mental capacity would.

"Best interests" is interpreted widely and goes beyond medical risk and benefit to include social, psychological, and emotional factors. Before making a best interests decision, it should be tested by asking whether the patient's best interests can be achieved in a way which is less restrictive of their rights and freedoms.

A patient who lacks Mental Capacity and is unbefriended is entitled to an Independent Mental Capacity Advocate (IMCA) to support the long-term decisions about care provision. Therefore, IMCAs are required when the discharge plan is for long term care provision. Decisions about long term care provision are best made outside of an acute hospital.

If the proposed care package or placement on discharge puts a patient without capacity to consent to it at risk of being deprived of liberty (Article 5, European Convention of Human Rights), currently as interpreted by the Supreme Court in Cheshire West [2014] UKSC 19 to mean "under continuous supervision and control and not free to leave" then additional safeguards are required to ensure that the deprivation is lawful.

During discharge planning, health and care providers should continue to meet their responsibilities regarding Deprivation of Liberty Safeguards, where appropriate. This is especially the case for, but not limited to, people with learning disabilities, dementia, acquired brain injury or people currently lacking capacity to make decisions about their mental health treatment. This includes carrying out a capacity assessment before a decision about discharge is made if there is reason to believe a person may lack the mental capacity to consent to their discharge arrangements which amount to a deprivation of liberty. No one should be discharged to somewhere assessed to be unsafe.

Any decision by the decision maker must be taken specifically for each person and not for groups of people. The Deprivation of Liberty Safeguards - Code of Practice outlines further information in relation to Mental Capacity.

It may be appropriate for an Independent Advocate to support an individual during the discharge planning process, and in some cases, this may be a legal requirement (e.g., if the Deprivation of Liberty Safeguards are being applied). Advocates are independent from the NHS and Local Authority and are trained to help people understand their rights and options, express their views and wishes, and help make sure their voice is heard.

Advocates play a vital role for people including but not limited to those with learning disabilities, dementia, acquired brain injury or people currently lacking capacity to make decisions about their mental health treatment. Referrals to Independent Advocacy services should be made as soon as discharge planning begins and ideally upon admission.

Where the proposed deprivation of liberty is in a hospital or a registered care home, a referral must be made for a standard authorisation under the Deprivation of Liberty Safeguards (DoLS). However, DoLS do not extend to other placements, such as supported living or domiciliary care and so any proposed deprivation of liberty there can only be authorised by the Court of Protection. [In either case, case law has found that it is preferable for any proposed deprivation of liberty to be authorised in advance by a prior referral to DoLS or Court application – see for example Re AJ (DoLS) [2015] EWCOP 5, or Re AG [2015] EWCOP 78]

It may be appropriate to seek legal advice on cases where deprivation of liberty after discharge appears to be an issue.

12.3. Appendix 3: Intermediate care and NHS continuing healthcare

National framework for NHS continuing healthcare and NHS funded care

www.gov.uk/government/publications/national-framework-for-nhs-continuing-healthcare-and-nhs-funded-nursing-care

Intermediate care is a programme of care provided for a limited period of time to assist a person to maintain or regain the ability to live independently. Intermediate care is aimed at individuals who would otherwise face unnecessarily prolonged hospital stays or inappropriate admission to acute or longer-term in-patient care or long-term residential care. It should form part of a pathway of support. For example, intermediate care may be appropriately used where an individual has received other residential rehabilitation support following a hospital admission and, although having improved, continues to need support for a period prior to returning to their own home. It should also be used where an individual is at risk of entering a care home and requires their needs to be assessed in a non-acute setting with rehabilitation support provided where needed. This is irrespective of current or potential future funding streams.

Individuals should not be transferred directly to a long-term residential care setting from an acute hospital ward unless it is clearly appropriate under the circumstances. These circumstances might include:

- where the individual has an existing placement that can continue to meet their needs.
- where the individual has already completed a period of specialist rehabilitation, such as in a stroke unit or other appropriate setting.
- where the individual has had previous failed attempts at being supported at home (with or without intermediate care support).
- those for whom the professional judgement is that a period in residential intermediate care followed by another move is likely to be unduly distressing.

12.4. Appendix 4: Supporting template factsheet and letters

Fact sheet A:

Planning your discharge from hospital / care setting:

This letter explains the need to plan your discharge now.

Why start to plan now?

Our top priority is to help you get better and support you to leave hospital when you no longer require acute consultant led care. You may need ongoing support which could be within your own home or an alternative setting for your ongoing recovery, reablement and rehabilitation.

If you are a care home resident, you will return to your care home unless the Care Home can no longer meet your needs. If you require more complex care and support this could be in another bed in a community setting.

What might I expect?

Early conversations – Upon admission we will discuss and plan how you will leave when you no longer need consultant-led care. We will involve your carers, family and/or friends in conversations if you would like them to be included.

'Predicted date of discharge' – Soon after you arrive in hospital you will be given a predicted date of discharge, which will be reviewed during your stay.

What we expect from you?

Full participation in treatment, therapy and discharge planning

Early discussions with family, friends and carers about what support you will need and can arrange prior to discharge.

Start planning how you will leave hospital including transport should you be returning home.

Questions to ask during your hospital stay:

1. What is the main reason I am in hospital for?
2. What is going to happen to me today and tomorrow?
3. What extra help might I need when I leave hospital?
4. When will I be able to leave hospital?

Transfer of care letter B1

You no longer need a hospital / care setting bed:

Returning home

Why am I leaving hospital / care setting?

The medical team providing your care, have agreed that you no longer need to be in hospital and you can return home to continue your recovery.

Why can't I stay in hospital / care setting?

When you no longer need to be in hospital, it is better to continue your recovery out of hospital. It is irrelevant whether you are self-funding or receiving public funding be that from health or the local authority. Staying in hospital for longer than necessary may reduce your independence, result in you losing muscle strength or expose you to infection. Leaving hospital when you are ready is not only best for you but will free-up a bed for someone who is very unwell.

What might I expect?

The team caring for you will discuss transport and other arrangements with you (and your carers, family and/or friends if you wish).

If you need more care and support now than when you came into hospital assessments of your needs, as well as decisions about the provision of any long-term care and support, will be made during this time. After this time, you may be required to contribute towards the cost of your care and support, if you need it.

Yours sincerely

Transfer of care letter B2

You no longer need to be in hospital / care setting: moving or returning to another place of care

Why am I leaving hospital / care setting?

The medical team providing your care have agreed that you no longer need to be in hospital, and you are ready to move to another place to continue your recovery.

Why can't I stay in hospital / care setting?

When you no longer need hospital care, it is better to continue your recovery out of hospital. It is irrelevant whether you are self-funding or receiving public funding be that from health or the local authority. Staying in hospital for longer than necessary may reduce your independence, result in you losing muscle strength or expose you to infection. Leaving hospital when you are ready is not only best for you but will free-up a bed for someone who is very unwell.

Our top priority is to ensure you are in the right place at the right time for the best recovery possible. The best place for you right now is a bed in the community which can best meet your needs at this time. If you are a care home resident this will be your care home unless the care home can no longer meet your needs.

What might I expect?

Assessments of your needs, as well as decisions about the provision of any long-term care and support, will be made during this time. After this time, you may be required to contribute towards the cost of your care and support, if you need it.

Yours sincerely

Transfer of care letter C

You no longer need to be in hospital / care setting: moving or returning to another place of care

Why do I need to leave hospital or other care setting?

Following our previous discussions and letters, we would like to re-iterate that you do not require acute consultant led care and are therefore legally not entitled to stay in an acute hospital bed.

What might I expect?

You have refused to comply with the discharge plan arranged for you on (insert date). We have instructed our legal team to begin proceedings to remove you from the acute hospital premises. It is irrelevant whether you are self-funding or receiving public funding be that from health or the local authority.

However, if you would like to prevent this, a suitable discharge plan remains available, and we will be happy to arrange this for you.

If we do not hear from you, we will assume that you are unwilling to accept the advice offered and our legal team will be in touch. This may mean you are charged for your hospital stay beyond (insert letter 2 date).

Yours Sincerely

Factsheet B

Planning for family or friends after they leave hospital / care setting?

This leaflet lists useful advice for family and friends of people needing ongoing care or support with day-to-day life.

What kind of support could you give someone

Support may be in the home or remotely (e.g. by phone), such as:

- Emotional support like helping someone manage anxiety or mental health;
- Housework like cooking, cleaning or other chores;
- Personal support like help moving around, washing, eating or getting dressed;
- Assistance with getting essential items like medicine or food; or
- Help to manage money, paid care or other services

If you are not able to care, and/or need help, then you have a right to a carer's assessment to have your needs considered too.

Check what your council or local authority can offer. Find their websites using the online postcode tool at www.gov.uk/find-local-council.

What to consider if you are looking after someone

1. Get help from others with caring and everyday tasks:

- Lincolnshire Support for Carers: Support for carers – Lincolnshire County Council If you are caring for someone and are feeling under strain or finding it difficult to cope, contact the Lincolnshire Carers Service to talk to someone. You can complete the request for support form, or if you feel that you or the person you are caring for are at risk or you are unable to continue your caring role, please do not complete the form and instead call 01522 782224 (Monday to Friday, 8.00am to 6.00pm, except public holidays) or 01522 782333 (outside office hours) or email CarersService@lincolnshire.gov.uk

- If you are a carer and you feel at risk of being harmed by the person you care for, or you are concerned that an adult who is being cared for is at risk of abuse or neglect, call the following numbers or tell your GP:

- Customer Service Centre - 01522 782155 (Monday to Friday, 8.00am to 6.00pm, except public holidays) or 01522 782333 (outside office hours)
- Go to the Carers UK and Carers Trust websites for information about support available. Carers UK also have an online forum where you can speak to other carers, and a free helpline, open Monday to Friday, 9am to 6pm on 0808 808 7777. Carers UK website: www.carersuk.org/

- If you are employed, talk to your employer about managing work whilst caring. You may be able to arrange flexible working and many employers offer other support to make things easier.

- If you are at school, college or university, let them know you are caring for someone so they can help you manage your studies. Carers Trust has lots of helpful advice for young people looking after family members or friends. Carers Trust website: www.carers.org/

- Get specialist advice about caring from condition-related organisations like Alzheimer's Society, MIND and others. Also, Age UK: www.ageuk.org.uk/information-advice/care/arranging-care/homecare/

- Try not to do everything yourself! Speak to friends and family about what others can do to help. Can they share any tasks?

2. Look after your health as well as the person you support:

It is important to look after your own health and wellbeing. Eat a balanced diet, get enough sleep and try to make time each day for physical activity. Even taking a few breaths can relieve stress and help you manage each day. Check out the NHS 'Every Mind Matters' website for more tips: www.nhs.uk/oneyou/every-mind-matters/. If your own health or the health of the person you support gets worse, with coronavirus or another illness, talk to your GP or call NHS 111

3. Think ahead to make care manageable if things change:

Write down what care the person needs and what others should do if you cannot continue providing care for any reason. It is important that others can easily find your plan and quickly understand what needs to be done if you aren't there. Carers UK have advice on their website on how to make your plan.

4. Read the Government guidance for unpaid carers:

For more detailed advice on caring for friends or family during coronavirus search for 'unpaid care coronavirus gov.uk' online.

5. Seek extra support from NHS Volunteer Responders:

Carers as well as those they care for can get a range of help including with shopping and other support by calling 0808 196 3646.

12.5. Appendix 5: Equality Impact Assessment Form (EIA)

Equality Impact Assessment Form
Project Details

Project name	Transfer of Care
EIA author	Lloyd Forbes
Team	Home First Partnership
Date completed	02.11.23
Version	1

What is the aim of the project/proposal?

2. Purpose

2.1. The purpose of this policy is to ensure that a patient's discharge is managed sensitively and consistently throughout the discharge planning process, and people are provided with effective information and support to make an informed decision.

2.2. This policy sets out a framework to ensure that NHS beds across providers 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.

2.3. Where the patient lacks Mental Capacity to make decisions about discharge from hospital, then the application of the policy should be adapted as explained in Appendix 2, following the Mental Capacity Act 2005.

2.4. This policy will 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 better met. Ultimately it aims to improve outcomes for patients.

2.5. This policy includes all patients, aged 18 years and above, including those with very complex care needs, who may have been in hospital for many months or years, and people at the end of life.

2.6. This policy is to be used in conjunction with the Discharge Policy and is for use by all staff with responsibility for arranging the safe discharge of patients.

Who will be affected by this work? e.g. staff, patients, service users, partner organisations etc.
3. Scope **3.1.** In scope: a. All employees b. Ward staff of all levels c. Medics d. Transfer of Care Hub e. Community partner in-reach **3.2.** Out of scope: a. Mental Health services b. All patients under the age of 18

Stage 1: Scoping point Is a full Equality Impact Assessment (EIA) required for this project? You should consider whether a full EIA is required, referring to the relevant guidance for information and guidance on making this decision. It is important this decision is made with an open mind and correctly, advice should be sought from the EIHR team if you are unsure.					
Yes	☑	Proceed to the full EIA form	**No**	☐	Explain why full EIA is not required
If no, explain below why further EIA is not required. *E.g. 'This report is for information only' or 'The decision has not been made by the ICB' or 'The decision will not have any impact on patients or staff'. Very few decisions affect all groups equally and this is not a rationale for not completing an EIA.*					

1. Evidence used

To demonstrate that the decision made has been informed you should include examples of the information used to determine the impact and complete the EIA.

Examples are likely to include:

- *Population Data - e.g. demographic profile (Census),*
- *Service Activity Data e.g. profile of patients using a service*
- *Consultation and Involvement findings - e.g. any engagement with service users, local community, specific groups.*
- *Research - e.g. good practice guidelines, service evaluations, literature reviews, reports*
- *Participant knowledge - e.g. experiences of working with different or population groups, experiences of service users in other service areas / localities*

Patient discharge data and workforce audits.

This policy is intended to support the NHS Constitution, in particular Principles, 1, 4 and 5. This policy also embodies the NHS Values of working together for patients and the policy's main intended outcomes are:

- To support safe and appropriate discharge once acute consultant led care is no longer required and the patient is medically optimised.
- To ensure that the patient (where able) is involved in the planning of their transfer of care outside the acute and community sector. Where they are unable to be involved, their representative will be consulted. Where there nobody to be consulted, Lincolnshire health partners in conjunction with the Local Authority will act in accordance with The Mental Capacity Act (2005) and decide in the best interests of the patient.
- To ensure that essential acute beds are made available for patients who require them.
- To reduce length of stay and delays in discharge.
- To provide a framework for staff to support well organised, safe and timely discharge from the acute hospital.
- To support staff to work as a team to have a choice conversation and provide clarity on the escalation process.

2. Impact of decision

In the following boxes detail the findings and impact identified (positive or negative) within the research detailed above; this should include any identified health inequalities which exist in relation to this work.

As part of these considerations you should consider how Lincolnshire organisations will be meeting the requirements of the Public Sector Equality Duty
•Removing or minimising disadvantages suffered by people due to their protected characteristics.
•Taking steps to meet the needs of people from protected groups where these are different from the needs of other people.
•Encouraging people from protected groups to participate in public life or in other activities where their participation is disproportionately low.

Patients and Service Users

All patients will be issued with FactSheet A (Appendix 4) on admission and this highlights the responsibilities of all parties.

The policy applies to all patients aged 18 years and over.

As part of the assessment process all patients will have their discharge options outlined clearly and be informed of the potential consequences of not vacating an acute bed once they no longer require acute consultant led care and they are medically optimised.
The transfer of care policy, and particularly the factsheets and letters supplied (Appendix 4) support a consistent process across the system. The outcome of not complying with these guidelines may lead to the instructing of legal proceedings to remove the individual from the hospital. This is described in detail in section 5 and supported with a visual flowchart of the escalation process (5.6).

Following Multi-Disciplinary Team (MDT) discussions with patient/family a transfer of care letter as appropriate depending on the situation (appendix 4) will be issued if/when they are not vacating an acute hospital bed once advised to do so.

Evidence suggests the benefits of being discharged from hospital once acute consultant led care is completed are: fewer hospital-acquired infections; patients have a greater chance of recovery, including maintaining and improving their independence and daily functioning.

Staff

All United Lincolnshire Hospital Trust (ULHT), Lincolnshire Community Health Services (LCHS), Lincolnshire ICB, Adult Care (AC) staff involved in patient care and discharge are to be aware of the policy

Discharge Co-ordinators, The Transfer of Care hub and Nurse in Charge of ward to be responsible for discussions alongside LCHS or AC staff as appropriate and issue Choice Letter 1 & 2. Appropriate matron, discharge lead or deputy discharge lead to issue Letter C. Support to be offered to all staff when conducting choice conversations by senior leads and the wider MDT.

Wider Community

The policy aims to improve the discharge and flow in and out of Acute and Community Hospitals and this will result in achieving shorter waiting times in Emergency Department (ED) better access to the appropriate ward and treatment first time, fewer cancellations of elective surgeries, bolstering care in the community, increasing bed capacity and developing across sector relationships thus improving care transition.

2.1 Age *Describe age-related impact and evidence. This can include safeguarding, consent and welfare issues.*
The policy is applied to patients aged 18 years or over. Although the organisation aims to treat patients fairly and equally irrespective of age, it is recognised that with increasing age the likelihood of multiple long term conditions increases. The organisation in partnership with health and Adult Care partners has systems, processes and specialist services in place to ensure individual assessments and care packages are planned for and delivered in a seamless method.
2.2 Disability *Describe disability-related impact and evidence. This can include attitudinal, physical, communication and social barriers as well as mental health/learning disabilities, cognitive impairments.*
<u>Patients</u> It is envisaged that patients identifying with the protected characteristic Disability will be neutrally affected as the Trust has mitigating support services in place. For patients with learning disabilities the organisation has a disability liaison nurse available on site. Issues appertaining to physical disabilities will be accounted for through discharge planning in assessments with health and adult care partners. Patients with sensory impairments will be supported through professional sensory impairment services provided by the organisation. For patients living with mental health, the Trust has direct support from Lincolnshire Primary Foundation Trust (LPFT) Mental Health Crisis and Liaison services on site. <u>Staff</u> Staff living with a disability that may require the policy document in a different format will be provided with this upon request.
2.3 Gender reassignment (including transgender) *Describe any impact and evidence in relation to transgender people. This can include issues such as privacy of data and harassment.*
A neutral impact is envisaged in relation to the protected characteristic Gender Reassignment.
2.4 Marriage and civil partnership *Describe any impact and evidence in relation to marriage and civil partnership. This can include working arrangements, part time working and caring responsibilities.*
A neutral impact is envisaged in relation to the protected characteristic Marriage & Civil Partnership.

2.5 Pregnancy and maternity *Describe any impact and evidence in relation to Pregnancy and Maternity. This can include working arrangements, part time working and caring responsibilities.?*
It is recognised that some patients covered by the protected characteristic of pregnancy and maternity could find themselves in receipt of hospital care, and the application of the transfer of care policy. The system will support safe and sensitive care as appropriate to the circumstances.
2.6 Race *Describe race-related impact and evidence. This can include information on different ethnic groups, Roma gypsies, Irish travellers, nationalities, cultures and language barriers.*
As the policy applies to patients from all racial and ethnic backgrounds, we expect this to have a neutral impact. However, it is recognised that for some patients from different racial and ethnic backgrounds, language support may be required, and this is provided by the organisation through a comprehensive interpretation and translation service.
2.7 Religion or belief *Describe any impact and evidence in relation to religion, belief or no belief on service delivery or patient experience. This can include dietary needs, consent and end of life issues.*
A neutral impact is envisaged in relation to the protected characteristic Religion or Belief. However, the organisation provides a full chaplaincy and spiritual service who are subject matter experts should this be required.
2.8 Sex *Describe any impact and evidence in relation to men and women. This could include access to services and employment.*
A neutral impact is envisaged in relation to the protected characteristic Sex.
2.9 Sexual orientation *Describe any impact and evidence in relation to heterosexual people as well as lesbian, gay and bisexual people. This could include access to services and employment, attitudinal and social barriers.*
A neutral impact is envisaged in relation to the protected characteristic Sexual Orientation.
2.10 Carers *Describe any impact and evidence in relation to part-time working, shift-patterns, general caring responsibilities. (Not a legal requirement but a ICB priority and best practice)*
Although the policy applies to patients, as an organisation we are mindful of the needs relating to carers. This is articulated in our Carers Policy which provides our framework for ensuring people with carer responsibilities are responded to accordingly.

There is also a leaflet provided to carers and families signposting them to appropriate support in the community within the policy (Factsheet B).

2.11 Other disadvantaged groups

Describe any impact and evidence in relation to groups experiencing disadvantage and barriers to access and outcomes. This can include socio-economic status, resident status (migrants, asylum seekers), homeless people, looked after children, single parent households, victims of domestic abuse, victims of drug/alcohol abuse. This list is not finite. This supports the ICB in meeting its legal duties to identify and reduce health inequalities.

Social Isolation

The Organisation is mindful that in the rural county of Lincolnshire a significant number of people live in remote areas. In partnership with health and Adult Care colleagues, systems are in place to ensure appropriate care is planned for and delivered; therefore, a neutral impact is envisaged.

Deprivation

The organisation is mindful that in the rural county of
Lincolnshire a significant number of people live in remote areas. In partnership with health and Adult Care colleagues, systems are in place to ensure appropriate care is planned for and delivered; therefore, a neutral impact is envisaged.

Homelessness

Where housing forms part of a wider care package, this will be assessed and supported through health and Adult Care systems. Where housing is the only support need upon discharge, the policy does not apply. The organisation will support the patient to access services from their local council. Therefore, a neutral impact in envisaged.

Substance Misuse (Alcohol and Drugs)

The organisation, along with our health and social care partners, offers support to patients with substance misuse issues. Therefore, a neutral impact in envisaged.

Migrant Population

The organisation, along with our health and social care partners are mindful of some of the challenges for this group. Systems and processes are in place to support this group and a neutral impact in envisaged in relation to this policy.

Military

The organisation is aware that some veterans may require support in relation to Mental Health or Veteran services. Patients are asked whether they would like to declare their veteran status on admission. Should it become apparent that a patient requires Mental Health support, the appropriate crisis and/or liaison service would be sourced. Therefore, a neutral impact is envisaged.

3. Human rights *The principles are Fairness, Respect, Equality, Dignity and Autonomy.*				
Will the proposal impact on human rights?	Yes	☐	No	☑
Are any actions required to ensure patients' or staff human rights are protected?	Yes	☐	No	☑
If so what actions are needed? *Please explain below.*				

4. Health Inequalities. The Health and Social Care Act 2012 established the first specific legal duties on organisations to have regard to the need to reduce inequalities between patients in access to, and outcomes from, healthcare services and in securing that services are provided in an integrated way. These duties had legal effect from April 1st 2013. The duties require that organisations properly and seriously take into account inequalities when making decisions or exercising functions, and has evidence of compliance with the duties, whilst also assessing how well commissioned providers have discharged their legal duties on health inequalities.
1. What evidence have you considered to determine what health inequalities exist in relation to your work? This can include local and national research, surveys, reports, research interviews, focus groups, pilot activity evaluations or other Equality Analyses. If there are gaps in evidence, state what you will do to mitigate them. (this may be different or similar to that which has informed the EIA)
A number of interviews were carried out by Health Watch on behalf of Lincolnshire County Council (LCC), who are one of the system partners involved in the development of this policy. This localised research with a group of 31 patients, gathered information and views relevant to their experience of discharge. This gave the Home First Partnership Group a patient view of discharge to be considered in the context of re-writing the transfer of care policy, completing necessary documentation alongside this. As part of this, health inequalities and any potential impact have been reviewed via this document as part of the process. The introduction of this policy, supports a consistent discharge process to ensure that all patients are treated equitably. The Home First Partnership group also reviewed information from system partners IT databases and systems, to facilitate analysis related to discharge planning.
2. What is the potential impact of your work on health inequalities? Can you demonstrate through evidenced based consideration how the health outcomes, experience and access to health care services differ across the population group and in different geographical locations that your work applies to?

The transfer of care policy will be applied, with the appropriate support to enable the next stage of care to be accessed, with participation and support from system partners as appropriate.

The review process will provide further assurance that the policy and the approach taken by teams across the system does not impact specific groups of people.

3. How can you make sure that your work has the best chance of reducing health inequalities?

The transfer of care policy incorporates the following to ensure teams across the system are taking steps to achieve timely and supportive discharge, and ensure good flow within the system.

- Personalised discharge planning
- Strength based conversations
- Shared learning
- Complaints/Compliments
- Incident forms
- Regular review of information held in our systems related to transfers of care
- Escalation processes appropriate to the transfer of care

5. Engagement/consultation

What engagement is planned or has already been done to support this policy ?

It is expected that organisations will have carried out a level of engagement with those affected whether formal or informal. This should be focussed to the groups most affected.

Engagement activity	With whom? *e.g. protected characteristic/group/community*	Date
Healthwatch surveys	Lincolnshire residents	03/04/2023
Patient experience forums	LCC/ULHT/LCHS	Ongoing
Ratification process	LCC/LCHS/ULHT/ICB/LPFT	TBC

Please summarise below the key finding / feedback from your engagement activity and how this will shape the policy/service decisions e.g. patient told us, so we will… (If a supporting document is available, please provide it or a link to the document)

The themes from the interviews carried out identified the following:-

- Patients told us that all individuals in the integrated team were kind and caring
- Patients felt that they had been treated with dignity and respect
- Patients told us that too many staff were involved in discharge planning – and further investigation into our data revealed earlier identification of patients requiring a supported discharge and earlier planning of this discharge would support this.

The transfer of care policy sets out a process for the next stage of care, ensuring a consistent approach for all patients.

5. Engagement/consultation What engagement is planned or has already been done to support this policy ? It is expected that organisations will have carried out a level of engagement with those affected whether formal or informal. This should be focussed to the groups most affected.		
Engagement activity	With whom? *e.g. protected characteristic/group/community*	Date

6. Mitigations and changes *If you have identified mitigations or changes, summarise them below. E.g. restricting prescribing over the counter medication. It was identified that some patient groups require high volumes of regular prescribing of paracetamol, this needs to remain under medical supervision for patient safety, therefore an exception is provided for this group which has resolved the issue.*
This will incorporate the escalation chart and audit process which the nurse in charge will be supported to deliver for as per policy. This policy is to be enacted systemwide across health and social care services.

7. Is further work required to complete this EIA? *Please state below what work is required and to what section e.g. additional consultation or engagement is required to fully understand the impact on a particular protected group (e.g. disability)*			
Work needed	Section	When	Date completed

8. Development of the Equality Impact Analysis *If the EIA has been updated from a previous version please summarise the changes made and the rationale for the change, e.g. Additional information may have been received – examples can include consultation feedback, service Activity data*		
Version	Change and Rationale	Version Date
e.g. Version 0.1	*The impact on wheelchair users identified additional blue badge spaces are required on site to improve access for this group.*	*26 September 2017*

9. Final Sign off Completed EIA forms must be signed off by the completing manager. They will be reviewed as part of the decision making process. Service lines should maintain an up to date log of all EIAs.		
Version approved:	1	
	Name	Date

9. Final Sign off Completed EIA forms must be signed off by the completing manager. They will be reviewed as part of the decision making process. Service lines should maintain an up to date log of all EIAs.		
Signature of responsible officer	Nikki Pownall	03.11.23
Which committee will be considering the findings and sign off the EA?	Partnership Board (ICB) Exec Director (LCC) ELT (ULHT & LCHS)	03 Nov 2023 22 Nov 2023 24 Nov 2023
Minute number *(to be inserted following presentation to committee)*		

Planning your discharge from hospital/care setting

This letter explains the need to plan your discharge now.

Why start to plan now?

Our top priority is to help you get better and support you to leave hospital when you no longer require acute consultant led care. You may need ongoing support which could be within your own home or an alternative setting for your ongoing recovery, reablement and rehabilitation.

If you are a care home resident, you will return to your care home unless the Care Home can no longer meet your needs. If you require more complex care and support this could be in another bed in a community setting.

What might I expect?

Early conversations – Upon admission we will discuss and plan how you will leave when you no longer need consultant-led care. We will involve your carers, family and/or friends in conversations if you would like them to be included.

'Predicted date of discharge' – Soon after you arrive in hospital you will be given a predicted date of discharge, which will be reviewed during your stay.

What we expect from you?

<u>Full participation in treatment, therapy and discharge planning</u>

Early discussions with family, friends and carers about what support you will need and can arrange prior to discharge.

Start planning how you will leave hospital including transport should you be returning home.

Questions to ask during your hospital stay:

1. What is the main reason I am in hospital for?
2. What is going to happen to me today and tomorrow?
3. What extra help might I need when I leave hospital?
4. When will I be able to leave hospital?

Planning for family or friends after they leave hospital/care setting?

This leaflet lists useful advice for family and friends of people needing ongoing care or support with day-to-day life.

What kind of support could you give someone

Support may be in the home or remotely (e.g. by phone), such as:

- Emotional support like helping someone manage anxiety or mental health;
- Housework like cooking, cleaning or other chores;
- Personal support like help moving around, washing, eating or getting dressed;
- Assistance with getting essential items like medicine or food; or
- Help to manage money, paid care or other services

If you are not able to care, and/or need help, then you have a right to a carers assessment to have your needs considered too.

Check what your council or local authority can offer. Find their websites using the online postcode tool at www.gov.uk/find-local-council.

What to consider if you are looking after someone

1. Get help from others with caring and everyday tasks:

- Lincolnshire Support for Carers: Support for carers – Lincolnshire County Council If you are caring for someone and are feeling under strain or finding it difficult to cope, contact the Lincolnshire Carers Service to talk to someone. You can complete the request for support form, or if you feel that you or the person you are caring for are at risk or you are unable to continue your caring role, please do not complete the form and instead call 01522 782224 (Monday to Friday, 8.00am to 6.00pm, except public holidays) or 01522 782333 (outside office hours) or email CarersService@lincolnshire.gov.uk

- If you are a carer and you feel at risk of being harmed by the person you care for, or you are concerned that an adult who is being cared for is at risk of abuse or neglect, call the following numbers or tell your GP:

- Customer Service Centre - 01522 782155 (Monday to Friday, 8.00am to 6.00pm, except public holidays) or 01522 782333 (outside office hours)
- Go to the Carers UK and Carers Trust websites for information about support available. Carers UK also have an online forum where you can speak to other carers, and a free helpline, open Monday to Friday, 9am to 6pm on 0808 808 7777. Carers UK website: www.carersuk.org/

- If you are employed, talk to your employer about managing work whilst caring. You may be able to arrange flexible working and many employers offer other support to make things easier.

- If you are at school, college or university, let them know you are caring for someone so they can help you manage your studies. Carers Trust has lots of helpful advice for young people looking after family members or friends. Carers Trust website: www.carers.org/

- Get specialist advice about caring from condition-related organisations like Alzheimer's Society, MIND and others. Also, Age UK: www.ageuk.org.uk/information-advice/care/arranging-care/homecare/

- Try not to do everything yourself! Speak to friends and family about what others can do to help. Can they share any tasks?

2. Look after your health as well as the person you support:

It is important to look after your own health and wellbeing. Eat a balanced diet, get enough sleep and try to make time each day for physical activity. Even taking a few breaths can relieve stress and help you manage each day. Check out the NHS 'Every Mind Matters' website for more tips: www.nhs.uk/oneyou/every-mind-matters/. If your own health or the health of the person you support gets worse, with coronavirus or another illness, talk to your GP or call NHS 111

3. Think ahead to make care manageable if things change:

Write down what care the person needs and what others should do if you cannot continue providing care for any reason. It is important that others can easily find your plan and quickly understand what needs to be done if you aren't there. Carers UK have advice on their website on how to make your plan.

4. Read the Government guidance for unpaid carers:

For more detailed advice on caring for friends or family during coronavirus search for 'unpaid care coronavirus gov.uk' online.

5. Seek extra support from NHS Volunteer Responders:

Carers as well as those they care for can get a range of help including with shopping and other support by calling 0808 196 3646.

You no longer need a hospital/care setting bed

Returning home

Why am I leaving hospital/care setting?

The medical team providing your care have agreed that you no longer need to be in hospital and you can return home to continue your recovery.

Why can't I stay in hospital/care setting?

When you no longer need to be in hospital, it is better to continue your recovery out of hospital. It is irrelevant whether you are self-funding or receiving public funding be that from health or the local authority. Staying in hospital for longer than necessary may reduce your independence, result in you losing muscle strength or expose you to infection. Leaving hospital when you are ready is not only best for you but will free-up a bed for someone who is very unwell.

What might I expect?

The team caring for you will discuss transport and other arrangements with you (and your carers, family and/or friends if you wish).

If you need more care and support now than when you came into hospital assessments of your needs, as well as decisions about the provision of any long-term care and support, will be made during this time. After this time, you may be required to contribute towards the cost of your care and support, if you need it.

Yours sincerely

You no longer need to be in hospital/care setting: moving or returning to another place of care

Why am I leaving hospital / care setting?

The medical team providing your care have agreed that you no longer need to be in hospital, and you are ready to move to another place to continue your recovery.

Why can't I stay in hospital / care setting?

When you no longer need hospital care, it is better to continue your recovery out of hospital. It is irrelevant whether you are self-funding or receiving public funding be that from health or the local authority. Staying in hospital for longer than necessary may reduce your independence, result in you losing muscle strength or expose you to infection. Leaving hospital when you are ready is not only best for you but will free-up a bed for someone who is very unwell.

Our top priority is to ensure you are in the right place at the right time for the best recovery possible. The best place for you right now is a bed in the community which can best meet your needs at this time. If you are a care home resident this will be your care home unless the care home can no longer meet your needs.

What might I expect?

Assessments of your needs, as well as decisions about the provision of any long-term care and support, will be made during this time. After this time, you may be required to contribute towards the cost of your care and support, if you need it.

Yours sincerely

You no longer need to be in hospital/care setting: moving or returning to another place of care

Why do I need to leave hospital or other care setting?

Following our previous discussions and letters, we would like to re-iterate that you do not require acute consultant led care and are therefore legally not entitled to stay in an acute hospital bed.

What might I expect?

You have refused to comply with the discharge plan arranged for you on (insert date). We have instructed our legal team to begin proceedings to remove you from the acute hospital premises. It is irrelevant whether you are self-funding or receiving public funding be that from health or the local authority.

However, if you would like to prevent this, a suitable discharge plan remains available, and we will be happy to arrange this for you.

If we do not hear from you, we will assume that you are unwilling to accept the advice offered and our legal team will be in touch. This may mean you are charged for your hospital stay beyond (insert letter 2 date).

Yours sincerely