

Avoiding Delayed Transfers of Care

INTRODUCTION

1. The purpose of this protocol is to avoid delays in discharge or transfer of care of mental health patients from St Ann's Hospital. The protocol has been formally agreed by:
 - Barnet, Enfield, Haringey MHT
 - *Haringey Social Services*
 - *Haringey Housing Services*
2. The protocol follows the protocols set up by local acute care partners with Social Services and is designed to shadow the charging arrangements in operation in this sector. This will enable partners to monitor what would be the cost implications for each agency in the event that the charging arrangements¹ were to be extended to mental health. It is emphasised that the principles of good communication and effective local management underpin this protocol and are essential for avoiding delays in discharges.
3. The legislation governing the charging arrangements covers adults receiving "acute care" who qualify for community care services under the National Health Service and Community Care Act 1990, and who are in an NHS hospital or an independent hospital funded by the NHS.
4. This protocol will apply to the acute beds, intensive care beds, and rehabilitation beds for adult and older people services at St Ann's Hospital. However delays in waiting for internal transfers (eg from an acute to a rehab bed) will be shown separately.

UNDERPINNING PRINCIPLES

5. Once a patient no longer requires hospital treatment, a patient should not continue to be in hospital waiting for arrangements to support the patient in the community to be put in place. Typically such arrangements can include allocation of care coordinator, housing, specialist placements etc. Unnecessary stays in hospital can make people more dependent, and increase the risk of care and social networks breaking down.
6. Planning a patient's discharge needs to start early, preferably shortly after admission.
7. Decision making about discharge should usually be with both the patient and their carer although this protocol recognises that this may not always be appropriate.

¹ As set out in The Community Care (Delayed Discharges etc.) Act 2003, The Delayed Discharges (England) Regulations 2003, and The Community Care (Delayed Discharges etc.) Act 2003: Guidance for Implementation.

8. Discharge plans should be drawn up by the multidisciplinary team, and should consider the full range of a patient's needs ie both health and social. Care plan should also consider the needs of dependents (ie Children and others) of the patient.
9. This protocol does not override existing rights of patients or carers with respect to the acceptability of options presented to patients for discharge. However patients do not have the right to stay in a hospital bed if they no longer need that type of care.
10. Delays in discharge will be monitored daily, and there will be ongoing audit of the SITREP returns to ensure that reasons for delays are analysed, and remedial action taken.
11. The *Joint Mental Health Commissioner* will be expected to use this information to ensure that the required services are commissioned by the PCT and Social Services to avoid delays in discharging because of the lack of availability of services.
12. Periodic reports will be made to the *Mental Health Partnership Board*.

DISCHARGE or TRANSFER OF CARE

13. The Department of Health states that a patient is ready for transfer from hospital when:
 - A clinical decision has been made that the patient is ready for transfer **AND**
 - A multidisciplinary team decision has been made that the patient is ready for transfer **AND**
 - The patient is safe to discharge/transfer.²
14. In most cases a patient detained in hospital under the Mental Health Act (MHA) will not be medically fit for discharge. However some patients on section 3 of the MHA will have a care plan in place and while waiting for the appropriate placement may be sent on s17 leave. In such cases these patients may be correctly classified as DToCs. Patients on leave "trying out" placements will not be classified as DToCs.
15. Taking the above into account the following is noted:
 - Risk cannot be reduced to zero but must be managed as best as possible. This may mean involvement of other agencies in the discharge planning process (for example Children and Families Team, Police, Probation).
 - Risk assessments and management plans must be completed at discharge.

² SITREPS 2003-04 Definitions and Guidance, (DOH Version 1 Sept 03))

16. The involvement of other agencies should be anticipated and it is not acceptable that this should lead to any delays in discharge.

ASSESSING NEED IN PREPARATION FOR DISCHARGE

17. Discharge planning to start on admission by the collection of information that will be required for effective discharge planning. This would include information on individuals' current living arrangements, their family and social networks (including carers), employment and financial issues. It should be noted that much of this information should already be obtained as best practice.

18. Every inpatient will be assigned a care coordinator within **5 working days** of admission by the community mental health team manager for the relevant sector. This target is to be monitored by the inpatient services and community teams and reviewed at the end of 2005.

19. The nominated care coordinator will attend a meeting on the ward with the named primary nurse not longer than 10 days after admission to start planning discharge of the patient. This target is to be monitored by the inpatient services and community teams and reviewed at the end of 2005.

20. The following will be considered and noted in the inpatient and community records with the appropriate action taken:

- Risk assessment and management
- Any issues regarding dependents living with the patient (especially children)
- Carers Needs assessment
- Safeguarding current housing arrangements
- Use of the Crisis and Home Treatment Team

DISCHARGE ASSESSMENT OF NEED NOTICE (“DAN notice”)

During the course of the patients stay in hospital the progress of the patient will be reviewed in ward rounds and team meetings on the ward. The care coordinator will assess the needs of the patient for discharge. The care coordinator, working with ward staff, will complete the needs assessment and send a copy of the **Discharge Assessment Of Need Notice** to the relevant agency (usually Social Services, Housing or Health) as formal notification of “likely need for community care services” together with the expected date of readiness for discharge. A copy of the form will be placed on the inpatient file and a copy sent to the Discharge Coordinator.

MANAGEMENT OF RISK

21. As well as assessing needs for services, the care coordinator and primary nurse at this point should consider risk and anticipate any requirement to

involve any other agencies in the discharge planning (for example Children & Families, Police, Probation) and this should be noted on the **Discharge Assessment Of Need Notice**. It is the responsibility of the primary nurse to ensure that these agencies are invited to the discharge CPA.

22. The Discharge Coordinator will hold a database of all patients and beds covered by this protocol and will monitor and progress chase the discharge of patients once a **Discharge Assessment Of Need Notice** has been issued.

COMMUNITY CARE SERVICES AND FOR NHS CONTINUING CARE

23. Request for funding for community care and for NHS continuing care placements must be made to the relevant Panel.
24. The care coordinator is expected to have put the care package in place by the date of the discharge CPA. This will include putting any request for community care funding to the Panel and to have obtained agreement before the date of the CPA meeting.
25. Where cancellation of the Panel leads to failure to discharge on the nominated day this will be recorded as a delayed transfer of care and will be covered by the Escalation procedures.

HOMELESS/OUT OF BOROUGH PATIENTS

26. Where people are of no fixed abode, and are admitted to hospital from a public place, then there can be an unresolved conflict between the definition of ordinary residence as defined by the NHS and by Social Services. The NHS treats the primary responsibility as resting with the Borough where the hospital is located, and Social Services works on the postcode of the public place which might be outside the borough of the hospital. In this case the care coordinator should make reasonable attempts to identify the local authority responsible for providing the Community Care Services and contact them when carrying out an assessment of need.
27. For patients who are clearly resident in other boroughs, the relevant Mental Health Services must be contacted in order to carry out an assessment of need and to ensure that services are provided in a way that does not delay discharge. The responsibility for coordinating this will rest with the care coordinator but any difficulties should be notified to the Discharge Coordinator as soon as possible for escalation.

WITHDRAWAL OF DISCHARGE ASSESSMENT OF NEED NOTICE

28. It should be noted that a **Discharge Assessment Of Need Notice** can be withdrawn if
 - Deterioration in the patient's mental health requires reassessment of need or requires patient to remain in hospital

- There is a change in the patient's ordinary residence after the **Discharge Assessment Of Need Notice** has been issued, so that a different Social Services Department becomes responsible.

NOTIFICATION OF DISCHARGE FORM

29. Where an **Discharge Assessment Of Need Notice** (called a Form 2 in the Acute Care Sector) has been issued and the need for community care services agreed, under the statutory arrangements applying in the Acute Care Sector, it is a statutory requirement for the NHS service to notify Social Services of the date it is proposed to discharge a patient.
30. This protocol adapts these arrangements. As soon as a date has been set for the discharge of a patient then all agencies noted on the **Discharge Assessment Of Need Notice** must be notified of this date using the **Notification Of Discharge Form**. This form will be completed at the Discharge CPA meeting and must be signed by the Ward Manager (for deputising ward nurse) and/or Consultant and by the care coordinator (or CMHT member covering the Care Coordinator).
31. The time and date of the decision must be noted and a copy must be sent to the relevant agencies within 24 hours. A copy must be sent to the Discharge Coordinator.
32. The **Notification Of Discharge Form** must be issued at least 1 day (one working day in acute protocol) before the proposed discharge date given in the notice. This target is to be monitored by the inpatient services and community teams and reviewed at the end of 2005.

ESCALATION PROCESS

33. Where the discharge date is not met the Discharge Coordinator must document the reasons for the delay in discharge on the Escalation Form and will fax/email a copy of the form within **24 hours** to the relevant agencies for their comments.
34. The delay in transfer of care will be recorded on the SITREP forms for the Strategic Health Authority and the internal reporting management summary.
35. The Discharge Team to work with the agencies to try to resolve difficulties and expedite discharge reporting to the fortnightly bed management group.
36. The completed escalation forms with the comments of the other agencies will be sent to the Director of Mental Health Services, Assistant Director of Adult Services (Social Services) and Assistant Director of Housing for resolution.

37.A summary report of all delays in discharges and reasons to be sent periodically *to the Mental Health Partnership Board*.