Lincolnshire Community Health Services NHS Trust

Transfer of Care Policy

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Ratified by:	LCHS Trust Board
Date ratified:	12 April 2019
Name of originator/author:	Matron for Transitional Care and Flow
Name of responsible committee/individual:	Effective Practice Assurance Group
Date approved by responsible committee/individual:	11 March 2019
Date issued:	April 2019
Review date:	April 2021
Target audience:	All staff
Distributed via:	Website

Transfer of Care Policy

Version Control Sheet

Version	Section	Amendments	Author	Date
1		Policy Created Replaces P_CIG_19 Choice on Discharge Policy	Liana Arnold	February 2019
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Transfer of Care Policy

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Transfer of Care Policy

Policy Statement

Background	The policy outlines the process for managing transfers out of Transitional Care placements including community hospitals and community transitional care beds. It aims to address the variance in practice and ultimately reduce delayed transfers of care whilst ensuring a good level of patient flow throughout the service.
Statement	All patients should be receiving the right care, in the right place, at the right time. Lincolnshire Community Health Service believes in Home First and where appropriate, will support patients in returning home as soon as this is a safe and viable option.
Responsibilities	Implementation and compliance with this policy will be the responsibility of all employees and managers.
Training	Specific training is not necessary. All staff should make themselves familiar with this policy.
Dissemination	Internet / Team Brief Notification
Resource implication	The organisation needs to consider the implications of taking legal action if required.

Transfer of Care Policy

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1. Introduction

Lincolnshire Community Health Service (LCHS) and its partners are committed to the principle of Home First which recognises the importance of discharging patients to their normal place of residence where this can be done safely.

The overarching aim of LCHS is that patients will be cared for in a place of safety with care, compassion and competence from staff. The decision to discharge is based upon an assessment of the patient's health and social care needs.

A proposed discharge date (PDD) will be agreed on admission, or shortly after admission (within 24 hours), and documented by the admitting therapist, nurse or coordinator. The discharge date and destination will be regularly reviewed, updated and discussed with the patient. This key step is linked to arranging timely discharge from a Transitional Care bed.

It is essential that Transitional Care beds are used appropriately. We have a duty to ensure that patients are getting the right treatment in the right place at the right time. If patients occupy Transitional Care beds when this is not clinically necessary, it effectively denies other patients the care they require. The consequence of this can be increased lengths of stay and pressure in the acute hospitals and unnecessary acute admissions resulting in a poor patient experience.

In addition to the above it is not in the best interests of patients to remain in Transitional Care setting longer than is clinically required. The risks attached to prolonged stays can be loss of functional independence, decrease in social skills, increased risk of depression and various other associated complications.

In summary – Transitional Care beds should only be used for the delivery of transitional care and not the delivery of services which can be better provided by other organisations for example adult care, local councils or elsewhere in the health service.

The policy sets out the procedure for resolving a delay in a patient's discharge or transfer of care from the Transitional Care setting where an assessed need on discharge has been identified. This policy applies to all LCHS sites (community hospital beds and community Transitional Care beds) and should be read in conjunction with the Delayed Transfer of Care (DTOC) Standard Operating Procedure and the Admissions, Discharges and Transfers Policy.

2. Purpose

- To support safe and appropriate discharge once transitional care is no longer required
- To ensure that the patient (where able) is involved in the planning of their transfer out of the Transitional Care bed. Where they are unable to be involved, their chosen representative will be consulted. Where there is nobody to be consulted, LCHS in conjunction with other relevant organisations will act

in accordance with The Mental Capacity Act (2005) and make a decision in the best interests of the patient
- To ensure that the patient does not remain in a Transitional Care bed unless it is clinically indicated
- To ensure that Transitional Care beds are made available for patients who need them
- To reduce length of stay and delays in discharges
- To provide a framework for staff to support well organised, safe and timely discharge from the Transitional Care.

3. Scope

The policy sets out the procedure for resolving a delay in a patient's discharge or transfer of care from a Transitional Care setting where an assessed need on discharge has been identified. This policy applies to all LCHS sites (community hospital beds and community Transitional Care beds) and should be read in conjunction with the Delayed Transfer of Care (DTOC) Standard Operating Procedure and the Admissions, Discharges and Transfers Policy.

4. Responsibilities

- The Ward Manager or Lead Therapist has responsibility for ensuring that their staff follow the Transfer of Care Policy with support from the coordinators and any other appropriate organisation, such as adult care.
- Section 9 details a flow chart with the process to be followed once a patient with an assessed need is declared ready for discharge and identifies the individual roles of staff at each stage
- Where the process has been followed and documented but the patient still remains in/refuses to leave the Transitional Care premises, the case will be escalated to the Matron for Transitional Care and Flow to seek legal advice. Recovery of costs for occupancy of the Transitional Care bed, from the date on which the patient refused to leave, may also be considered.

5. Applications of the policy

- Every patient admitted into a Transitional Care bed at LCHS will be issued with the Welcome Letter and have this explained to them at the time of completion of admission paperwork.
- Subsequent Transfer of Care Letters will be issued as and when required (see Transfer of Care Policy Flow Chart for process and responsibility)
- The Transfer of Care Letter template will be personalised to the patient and include information related to their proposed discharge

- Transfer of Care Letters apply to patients who have an assessed need for support on discharge but their preferred option is not currently available regardless of funding
- In exceptional cases, a patient may be excluded from this policy at the Trust's discretion

6. Exclusions to the policy

- Patients who fall within the protected characteristic of Pregnancy & Maternity will not be subject to The Transfer of Care Policy.
- Patients who are declared "homeless" and who do not have care and support needs that require a service to meet these needs are not covered by this policy and will be directed to the local appropriate service. Any letters required to support LCHS in this circumstance should be bespoke and follow a similar process to that described within the Transfer of Care Policy Flow Chart.

7. Documentation

1. Welcome Letter
2. Transfer of Care Policy Flow Chart
3. Transfer of Care Letter 1
4. Transfer of Care Letter 2
5. Transfer of Care Letter 3
6. Transfer of Care Letter 1 (Self-Funder)
7. Transfer of Care Letter 2 (Self-Funder)
8. Transfer of Care Letter 3 (Self-Funder)

Welcome Letter

Lincolnshire Community Health Services
Beech House
Waterside South
Lincoln
LN2 7JH
www.lincolnshirecommunityhealthservices.nhs.uk

DATE

Dear XXX

PRIVATE & CONFIDENTIAL

Dear Sir or Madam,

Welcome to Lincolnshire Community Health Services NHS Trust. We wish to make your stay with us as pleasant as possible, and aim to return you to your normal place of residence as soon as you become well enough and no longer require transitional care.

We will start to plan for your discharge from transitional care as soon as possible after you are admitted, so that your stay is no longer than necessary. We want to involve you actively in this planning so that there are no surprises and we come up with a plan which is tailored to you.

What to expect:

- The nurse in charge (if you are in a Community Hospital bed) or your Occupational Therapist/Physiotherapist (if you are in a community Transitional Care bed) will be responsible for your day to day care
- The team looking after you will discuss with you the date they expect you will be able to leave the transitional care bed – this is called a predicted date of discharge – and will keep you informed should this date need to change
- We will assess the things you may need upon discharge as soon as possible after you are admitted; to help put them in place with minimal delay. If you need some extra support, the teams will meet with you to talk about what options are available and make a plan that will best meet your needs. We do expect you and your family and/or representatives to work with us to ensure you are able to be discharged on the date planned

The Transitional Care beds are designed to meet your needs whilst you are unable to safely return home. Some important things to consider:

- Staying in Transitional Care longer than necessary is not good for you – it can put you at greater risk of infections, and decrease your ability to function independently
- It is also not good for the NHS – other people who are unwell, or who are waiting to be discharged from hospital may need to be admitted to a Transitional Care bed. If we do not have space to do this, this puts us under pressure and the acute hospitals.

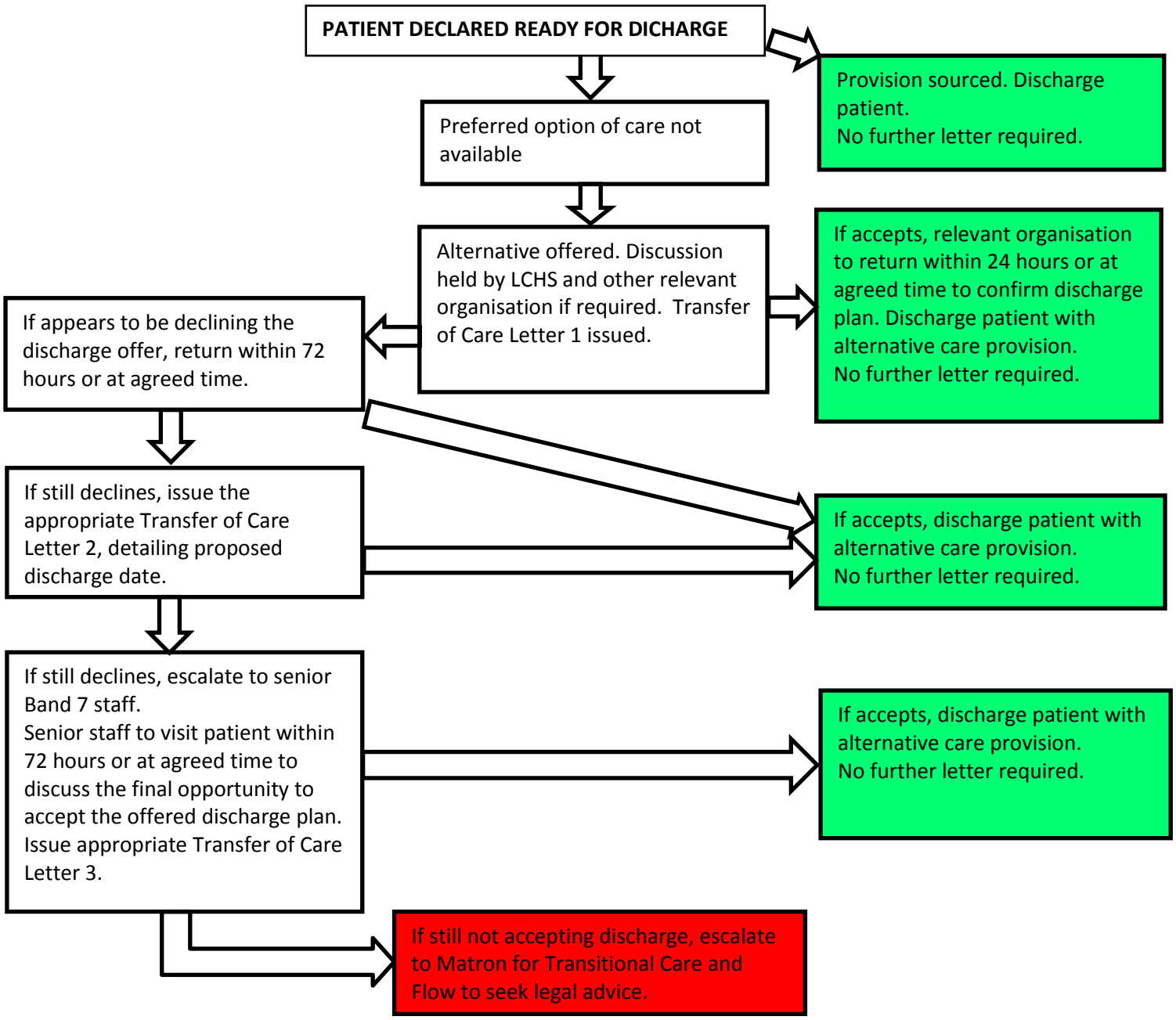
Whilst you are in Transitional Care, it would help if you could think about how you will get home. We expect that most patients should be able to provide their own transport. If this is not possible/appropriate, we will work with you to arrange an alternative. Before you are discharged from Transitional Care we will ensure that you have any medications and information you may need.

If at any time you are unsure about your care or your discharge plans please speak to the team who will be happy to help you.

With best wishes

Andrew Morgan
Chief Executive

Transfer of Care Policy Flow Chart



NB: Ensure all conversations are documented on Systm1 (including who was present) and copies of the Transfer of Care Letters are attached to the record.

Transfer of Care Letter 1

Lincolnshire Community Health Services
Beech House
Waterside South
Lincoln
LN2 7JH
www.lincolnshirecommunityhealthservices.nhs.uk

DATE

Dear XXX

PRIVATE & CONFIDENTIAL

As discussed, the nursing/therapy team has confirmed that you no longer require transitional care.

Following assessments and discussions with you (add in family/representatives/power of attorney if they have any supporting), we have agreed that the following service(s) (insert service) has/have been identified to meet your needs on discharge.

Unfortunately at this time (insert appropriate statement from below into this paragraph as a continuous statement).

- we have been unable to source the required package of care. As discussed we have identified a vacancy in an alternative setting which can meet your needs. Please be re-assured that the Adult Care team will continue to monitor availability for your package of care. As soon as this becomes available you will be supported to return home.
- your home of choice is not available. However we have identified an alternative home which can meet your needs.
- the re-ablement service is unable to provide your care. As discussed the following alternative, (Adult Care package of care/transitional care bed/placement in a care home), is available and we have advised you that there may be a charge for this service.
- the transitional care bed that you would prefer is not available/appropriate. As discussed we have identified an alternative which can meet your needs.

As we explained in the Welcome Letter, staying in Transitional Care once you no longer require inpatient care is not in your best interest.

We will return to confirm the details of your discharge within 72 hours.

If you have any questions please contact the team on XXXXXX.

Yours sincerely

Andrew Morgan
Chief Executive

Transfer of Care Letter 2

Lincolnshire Community Health Services
Beech House
Waterside South
Lincoln
LN2 7JH
www.lincolnshirecommunityhealthservices.nhs.uk

DATE

Dear XXX

PRIVATE & CONFIDENTIAL

Following our previous discussions and letter, as advised you no longer require transitional care and are therefore unable to remain in a transitional care bed.

You have declined the discharge plan provided to you as detailed in our previous letter.

Whilst we recognise that this is an important decision and do not wish to cause you or your family undue anxiety or distress, we do need to be able to offer treatment to others requiring transitional care at the earliest opportunity. Consequently, we would like to assist you to complete your move out of a transitional care bed as smoothly as possible.

Therefore we will be discharging you to (insert location) on (date).

After this date you will no longer have the right to remain on these premises and if you decline this discharge we will seek advice from our legal team.

I would like to take this opportunity to thank you for your understanding and co-operation.

Yours sincerely

Andrew Morgan
Chief Executive

Transfer of Care Letter 3

Lincolnshire Community Health Services
Beech House
Waterside South
Lincoln
LN2 7JH
www.lincolnshirecommunityhealthservices.nhs.uk

DATE

Dear XXX

PRIVATE & CONFIDENTIAL

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

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 transitional care premises.

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 transitional care stay beyond (insert letter 2 date).

Yours sincerely

Andrew Morgan
Chief Executive

Transfer of Care Letter 1 (Self-Funder)

Lincolnshire Community Health Services
Beech House
Waterside South
Lincoln
LN2 7JH
www.lincolnshirecommunityhealthservices.nhs.uk

DATE

Dear XXX

PRIVATE & CONFIDENTIAL

As discussed, the team has confirmed that you no longer require transitional care.

Following assessments and discussions with you (add in family/representatives if they have any supporting), we have agreed that the following service(s) (insert service) has/have been identified to meet your needs on discharge.

Unfortunately at this time (insert appropriate statement from below into this paragraph as a continuous statement)

- you have been unable to source the package of care you need to enable discharge. As a result of this we are requesting that you consider a short term placement in an alternative setting whist you are waiting for your preferred package of care to become available. We are happy to assist you with this if required.
- your home of choice is not available. However an alternative home has been identified which can meet your needs and therefore we are requesting that you move to this home while waiting for your home of choice to become available.

As we explained in the Welcome Letter, staying in a transitional care once you no longer require it is not in your best interest.

We will return to confirm the details of your discharge within 72 hours.

If you have any questions please contact the team on XXXXXX.

Yours sincerely

Andrew Morgan
Chief Executive

Transfer of Care Letter 2 (Self-Funder)

Lincolnshire Community Health Services
Beech House
Waterside South
Lincoln
LN2 7JH
www.lincolnshirecommunityhealthservices.nhs.uk

DATE

Dear XXX

PRIVATE & CONFIDENTIAL

Following our previous discussions and letter, as advised you no longer require transitional care and are therefore unable to remain in a transitional care bed.

You have declined the discharge plan provided to you as detailed in our previous letter.

Whilst we recognise that this is an important decision and do not wish to cause you or your family undue anxiety or distress, we do need to be able to offer treatment to others requiring acute consultant led care at the earliest opportunity. Consequently, we would like to assist you to complete your move out of transitional care as smoothly as possible.

Therefore we will be discharging you on (date) and we expect you to make arrangements for your required care on discharge.

After this date, you will no longer have the right to remain on these premises and if you decline this discharge we will seek advice from our legal team.

I would like to take this opportunity to thank you for your understanding and co-operation.

Yours sincerely

Andrew Morgan
Chief Executive

Transfer of Care Letter 3 (Self-Funder)

Lincolnshire Community Health Services
Beech House
Waterside South
Lincoln
LN2 7JH
www.lincolnshirecommunityhealthservices.nhs.uk

DATE

Dear XXX

PRIVATE & CONFIDENTIAL

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

You have refused to undertake the necessary arrangements to facilitate your discharge from this bed. Due to this we have instructed our legal team to begin proceedings to remove you from the transitional care premises.

However, if you would like to prevent this, a suitable discharge plan remains available and as discussed this will be at full cost to you. If you require any assistance to arrange this we will be happy to support 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 transitional care stay beyond (insert letter 2 date).

Yours sincerely

Andrew Morgan
Chief Executive

8. Appendix 1 - Monitoring Template

Minimum requirement to be monitored	**Process for monitoring eg audit**	**Responsible individuals / group committee**	**Frequency of monitoring /audit**	**Responsible individuals/ group/committee (multidisciplinary) for review of results**	**Responsible individuals / group / committee for development of action plan**	**Responsible individuals / group/ committee for monitoring of action plan**
Number of patients who have required use of the policy	Audit of letters	Community Hospitals, Transitional Care and Flow Quality Assurance Group	As required	Community Hospitals, Transitional Care and Flow Quality Assurance Group	Community Hospitals, Transitional Care and Flow Quality Assurance Group	Community Hospitals, Transitional Care and Flow Quality Assurance Group

9. Appendix 2 - Equality Analysis

Equality Analysis

Name of Policy: Transfer of Care Policy

Equality Analysis Carried out by: Liana Arnold

Date: 04.02.19

Equality & Human rights Lead: Rachael Higgins

Director\General Manager: Susan Ombler

***In this template the term policy\service is used as shorthand for what needs to be analysed. Policy\Service needs to be understood broadly to embrace the full range of policies, practices, activities and decisions: essentially everything we do, whether it is formally written down or whether it is informal custom and practice. This includes existing policies and any new policies under development.**

Section 1 – to be completed for all policies

A.	Briefly give an outline of the key objectives of the policy; what it's intended outcome is and who the intended beneficiaries are expected to be	The key objectives of this policy are to support staff in managing transfers out of transitional care placements. The intended outcomes are reduced numbers of delayed transfers of care and also fewer complaints due to patients receiving a welcome letter on admission which clearly states the expectations of transitional care.
B.	Does the policy have an impact on patients, carers or staff, or the wider community that we have links with? **Please give details**	The policy could have an impact on both patients and carers as they would be held to account if they refused to leave a transitional care bed.
C.	Is there is any evidence that the policy\service relates to an area with known inequalities? **Please give details**	No.

D.	Will/Does the implementation of the policy\service result in different impacts for protected characteristics?	No.		
		Yes	**No**	
	Disability		**X**	
	Sexual Orientation		**X**	
	Sex		**X**	
	Gender Reassignment		**X**	
	Race		**X**	
	Marriage/Civil Partnership		**X**	
	Maternity/Pregnancy		**X**	
	Age		**X**	
	Religion or Belief		**X**	
	Carers		**X**	
	If you have answered 'Yes' to any of the questions then you are required to carry out a full Equality Analysis which should be approved by the Equality and Human Rights Lead – please go to section 2			
The above named policy has been considered and does not require a full equality analysis				
Equality Analysis Carried out by:	Liana Arnold			
Date:	04.02.19			