Final Version No 4 24th September 2003

SOUTH WEST PENINSULA STRATEGIC HEALTH AUTHORITY

JOINT POLICY
DELAYED TRANSFERS OF CARE AND REIMBURSEMENT

1. Purpose and scope

1.1 This Joint Policy is designed to assist health and social care organisations in the South West Peninsula Strategic Health Authority area to meet the requirements of the Community Care (Delayed Discharges) Act 2003.

1.2 The Joint Policy has been produced in conjunction with representatives of the Acute Trusts, Primary Care Trusts and Social Services Departments across the Strategic Health Authority area under the leadership of the Peninsula Delayed Discharge (Reimbursement) Project Board The project board is jointly chaired by the SHA Director of Strategic Partnerships and the Director of Social Services for Devon and was established by the Peninsula NHS Chief Executives Group with support from the Directors of Social Services in Devon and Cornwall.

1.3 In the South West Peninsula Strategic Health Authority area, health and social care services are provided by 18 health and 5 social care organisations with overlapping boundaries and cross border patient flows. In this context, the aim of the Joint Policy is to assist local health and social care systems to develop consistency across the region in terms of approach, process, data recording and definitions in relation to appropriate transfer of patients within and across health and social care systems.

1.4 It is not the intention in this Joint Policy to prescribe how local organisations will do things, but it offers a framework within which local health and social care communities should be developing best practice discharge from hospital procedures based on national guidance from the Department of Health in the hospital discharge workbook "*Discharge from hospital: pathway, process and practice".*

1.5 To further support and develop consistent best practice discharge from hospital processes, the "Discharge Milestones Working Group" (a development sub group of the Peninsula Delayed Discharge (Reimbursement) Project Board), has developed " A *Best Practice Discharge Milestones Toolkit*" for use by implementation teams in local health and social care systems.

1.6 In developing this policy a publication "*Joint protocols for delayed transfers of care and reimbursement"* produced by Birmingham and Black Country Strategic Health Authority has been adapted with permission of the authors.

2. Department of Health requirements and expectations

2.1 This section describes the legislative framework within which health and social care systems are expected to operate effective transfers of care.

2.2 The Community Care (Delayed Discharges) Act 2003 sets out:

2.2.1 A new statutory duty on NHS bodies to notify Social Services Departments that a patient receiving acute hospital care is likely to need social care services on discharge (Section 2 Notification), and to notify Social Services of the proposed discharge date (Section 5 Notification);

2.2.2 A requirement for the NHS body to assess whether a person needs fully funded NHS Continuing Care prior to discharge from acute care.

2.2.3 A requirement for the NHS body to identify the responsible local authority prior to notification.

2.2.4 A defined timescale for Social Services Departments to complete assessments and provide services, (a minimum of 3 days from a Section 2 Notification and 1 day from a Section 5 Notification)*;(see appendix one for summary of key recommendations)*

2.2.5 A requirement for local authorities to make a set payment (currently £100 per day) to the acute Trust for each day's delay if the patient's discharge is delayed solely because the Social Services assessment is not complete or where a person is eligible for social care services, there is a delay in arranging them.

2.3 The Department of Health states ***"the purpose of reimbursement is to encourage and reinforce good practice and ensure patients receive the right care in the right place at the right time".***[1] The Department has provided detailed and definitive guidance on good practice covering all aspects of hospital discharge in the revised and updated version of the Hospital Discharge Workbook "*Discharge from hospital: pathway, process and practice"* (Department of Health 2003).

2.4 The Department also emphasises that reimbursement should not be approached as a stand-alone policy but should be addressed within the policy framework of the National Service Framework for Older People and the introduction of the Single Assessment Process.

2.5 Specific funding has been allocated to local authorities for the implementation of reimbursement. The total allocation of funding to local authorities in the Peninsula for 2003/4 is £1,695,000 (Cornwall £ 554,000, Devon £723,000, Isles of Scilly £3,000, Plymouth £247,000 and Torbay £168,000) The purpose of the funding is to enable local health and social care systems to increase capacity by developing a greater range and volume of services which will reduce delays in transfers of care, and to meet the costs of reimbursement when delays do occur.

2.6 The provisions of the legislation with respect to notification will be implemented from October 2003, with full implementation, including payment for delays, from 5th January 2004. The Regulations to accompany the legislation were issued on 31st July 2003 and detailed guidance on the operation of reimbursement will be available from the Department of Health in September 2003.

The regulations, guidance, sample protocols and links to the legislation are available at www.doh.gov.uk/reimbursement. Appendix 2 contains a preparation checklist for local action in the context of this Joint Policy.

[1] DoH Website www.doh.gov.uk/reimbursement

3. Principles

3.1 The following principles for the implementation of reimbursement have been adopted in the Peninsula and form the basis of this Joint Policy:[1]

- Avoidance of reimbursement by providing services, for the right patient at the right place and at the right time;
- Delivering person and carer centred care and processes;
- Taking a whole system approach to tackling delayed transfers of care and avoiding unnecessary hospital/in-patient admissions across primary, community, secondary and social care.
- Involving all partners in planning for and investment in intermediate care, transitional care and related transport services;
- Using best practise discharge processes including the SAP (Single Assessment Process) at all levels in the system;
- Multidisciplinary and multi sectoral training

3.2 These principles have been used and expanded to form the operational guidance produced by the "Discharge Milestones Working Group" (a development sub group of the Peninsula Delayed Discharge (Reimbursement) Project Board), "A *Best Practice Discharge Milestones Toolkit*" for use by implementation teams in local health and social care systems.

4. Definitions

4.1 Local definitions and interpretations of the key concepts around hospital discharge and reimbursement have to be consistent with the national definitions set down by the Department of Health. This section summarises the national definitions relating to reimbursement that will need to be used by local health and social care systems from October 2003.

Reimbursement applies to delays in discharging adults who have been receiving acute care and who are eligible for community care services under the NHS and Community Care Act 1990.

4.1.1 Acute Care

The Department of Health has defined acute care for the purposes of reimbursement as [2]**"Intensive medical treatment provided by or under the supervision of a consultant which is for a limited time after which the patient no longer benefits from that treatment; and does not include any of the following":**

i) care relating to conditions to do with mental health or learning disabilities
ii) maternity care
iii) intermediate care.
iv) care provided for the purposes of recuperation or rehabilitation
v) palliative care

Initially reimbursement will not apply to patients receiving mental health, maternity or palliative care. In the context of reimbursement the above definition – described in the mandatory regulations - applies to patients not beds. Nevertheless, it will be

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[1] Peninsula NHS Chief Executives Meeting 16th June 2003
[2] DoH Reimbursement Protocol Checklist No 3:Acute Care and Reimbursement

necessary for each local health and social care system to define precisely which inpatient hospital beds are typically used for patients receiving acute care based on this definition. ***An interim Peninsula agreement has been reached so that during shadow arrangements the definition will apply to acute hospital beds with the exception of those designated as rehabilitation beds. However community hospital beds maybe specifically included following a review in January 2004 and in addition it is expected that whilst these beds may be not be included in reimbursement, parallel processes should be applied to community hospital beds. This is good practise and will assist in understanding the whole system and the unusual profile of delays with NHS to NHS transfers demonstrated in the Peninsula.***

Mental Health
Social services will not be liable for reimbursement for delays in transfers from mental health services until Parliament have debated such an extension of the provisions of the Act. However reimbursement *is* triggered if the delay is in the provision of local authority services for post-acute care, for example residential or nursing home care for people with dementia, who were receiving acute care for a physical condition rather than dementia. This would be the case whether the patient's mental health condition was known about before admission, or only became apparent during the hospital stay and applies to all adults over the age of 18.

Palliative Care
Patients receiving specialist palliative care, for example in hospices or palliative care units, are also currently excluded from the definition of acute care, because in many cases they will continue to be the NHS's responsibility whichever setting they move to under continuing NHS care. This does not mean that their discharge should not be planned according to good practice as outlined in *Discharge from hospital: pathway, process and practice*.

Self-Funders
The term 'self-funder' is often used to describe a range of different situations including situations where social services charge the client for the full cost of their care. For some people, the local authority will both undertake an assessment and arrange services, but the patient will be assessed as liable for charging for the full or partial cost of these services. Regardless of whether service users are required to pay a charge for the local authority service, if there is a delay in assessment for or provision of that service, then reimbursement is payable.

Some individuals receive an assessment from the local authority, but following the assessment, patients or their families take responsibility for making and funding their own arrangements for their care. In these circumstances, local authorities are liable for delays in assessment only.

Recent changes to the means test for those who need to enter a residential home, such that the value of any property is disregarded for 12 weeks, mean that local authorities are now responsible for a large proportion of patients who need to enter a care home when they leave hospital. Also, if the patient wishes social services to arrange care in their own home, then social services are responsible for this. They are liable for reimbursement if services are not available within approximately 3 days of the assessment notification being issued, or the day after the proposed date of discharge given in the discharge notification, whichever is the later.

Where individuals choose to have no involvement with social services and go on to fund their own domiciliary, nursing or residential home care, local authorities have no liability for reimbursement for delays.

There will be individuals who wish to organise their own social care. In these circumstances the hospital staff may invite social services to become involved in providing information to support the hospital's patient advice services in achieving timely discharge. If the local authority has been involved in providing advice only, delays in such cases should not count towards a reimbursement liability

Patients treated privately

The definition of 'prescribed care' used in the Regulations does not apply to patients who are paying for their own care, either directly or via a health insurance scheme. This means that patients who are receiving private acute medical treatment, whether or not this is provided at an NHS hospital, do not fall within the scope of the Act.

Asylum seekers and other foreign nationals

The basic principle to be applied here is that where councils are responsible for providing community care services for an individual, they are also liable to pay reimbursement for any delays in providing assessments or services to that individual when they have been admitted to hospital for acute care.[3]

People of no fixed abode

Where delays occur for people of no fixed abode, the crucial issue is to identify the local authority responsible for providing them with community care services. If they are admitted to hospital from a public place then the postcode of that place should be used to identify the council responsible. That social services authority is liable for reimbursement if the person is delayed in hospital due to a failure to assess them or provide services to enable them to leave hospital safely.[4]

4.1.2 Assessment

The Department of Health defines assessment as **"a process whereby the needs of an individual are identified and their impact on daily living and quality of life evaluated"[5].**

In the acute setting, assessment relates to the diagnostic and treatment process and the decision that the patient is safe to transfer[6]. The assessment for discharge is part of a community care assessment but not necessarily all of it[7]. It may not be possible, or desirable, to complete a full community care assessment, while a patient is in an acute bed. What is essential is that the multi-disciplinary team knows enough to be able to make the decision that a person is safe to discharge or transfer. The use of rehabilitative and intermediate care services or interim care arrangements, including care or rehabilitation in a patient's own home, will enable a comprehensive assessment of a person's health and social care needs to be undertaken at a more appropriate time and in a more appropriate setting.

[3] Guidance on councils' responsibilities in providing community care services to asylum seekers and other foreign nationals is available at www.doh.gov.uk/jointunit/asylums54clarification11mar03.pdf

[4] A search tool to identify the relevant local authority for any given postcode in England is available at www.doh.gov.uk/reimbursement/links.htm

[5] Discharge from Hospital: Pathway, Process and Practice (DOH 2003 p.xi)

[6] DoH: Health and Social Care Change Agent Team/Reimbursement Team: 2Medical Stability and Safe to Transfer"

[7] DoH Reimbursement Implementation Team: "Frequently asked questions on reimbursement Q15"

All screening and assessment arrangements for adults over 18 (excluding mental health patients for whom the Care Programme Approach is used for the specialist assessment component of the SAP) will need to be integrated within the locally agreed framework for the **Single Assessment Process** (SAP) which must be in place by April 2004[8].

The SAP provides guidance on how the depth and scale of the assessment is kept in proportion to the persons needs. Agencies should not duplicate each other's assessments, and professionals need to contribute to assessments in the most effective way

Not all adults admitted to hospital will need community care services after discharge. Only those who are likely to need such services should be referred to social services.

Carer's assessments

Carers are entitled to request an assessment of their needs in supporting the person they care for, including following hospital discharge of that person. This assessment should be undertaken in the same timescales as the cared for persons assessments. However, just as assessment for discharge need not be a full community care assessment, carer's assessment in these circumstances may only be part of the full assessment, which continues after the patient is discharged.

4.1.3 Continuing Care Assessments

Reimbursement requires assessments for long-term health needs against the local eligibility criteria for continuing care funding[9] to be undertaken by the NHS before a Section 2 Notification is given to a social services authority.[10] If preliminary assessment at this point indicates fully funded NHS continuing care, an assessment notification should not be issued, as social care services will not be needed.

If it is uncertain after initial screening whether or not the patient would be eligible, then an assessment notification should be issued so that full assessment can be undertaken. The notice should state that it is unclear at the stage of notification that the patient is eligible for continuing care. It is very important that this initial screening does not rule out the possibility of identifying NHS continuing care needs further on in the course of the patient's treatment. If at any point the patient is assessed as needing continuing health care, any notices issued should be withdrawn and the 'reimbursement clock' stopped. Similarly, if the patient asks for a review of the decision not to provide fully funded NHS continuing care, this should take place within 14 days, during which time they continue to be cared for by the NHS and no delay accrues to social services.

All continuing care assessment must be done in the context of the SAP and local health and social care systems will need to undertake a fundamental review of current systems for assessing eligibility and making funding decisions. Guidance on best practice will be available in September 2003 from the Peninsula Continuing

[8] DoH: National Service Framework for Older People (June 2001)
[9] SWPSHA: NHS responsibilities for meeting continuing healthcare needs and the NHS contribution to continuing health and social care June 2003
[10] DoH: Delayed Discharges (Continuing Care) Directions 2003: consultation draft July 2003

Care Steering Group[11] established by the Peninsula NHS Chief Executives with support from the Directors of Social Services.

4.1.4 Assessment timescales

The Department of Health advises that local systems should agree protocols for what is reasonable in terms of response times for the various elements of the assessment process, safe transfer and placement. These times should be agreed in the best interests of patients, not for professional or organisation convenience. For reimbursement purposes, Social Services have two days to complete an assessment; this offers a useful benchmark for other professions[12].

4.1.5 Multi disciplinary team

A multi disciplinary approach is essential to ensure safe and effective discharge practice.

The multi-disciplinary team for each patient should consist of the appropriate range of health and social care workers involved in his/her care. The Department of Health emphasises that the early involvement of nurses, therapists and social care workers can be crucial in determining outcomes for patients[13]. In some places it has been the practice for a clinician to make a decision that the patient is medically fit for discharge, followed by referral to Social Services. Here the multi disciplinary input to the decision making process is minimal. This will need to change and each local health and social care system will need to review current procedures. ***(Reference here to the toolkit)***

Where social care needs are identified, a Social Services representative should always be included in the multi-disciplinary team.

4.1.6 "Ready" for transfer

The Department of Health states that a patient is ready for transfer from an acute hospital bed when

a) A clinical decision has been made that patient is ready for transfer AND

b) A multi-disciplinary team decision has been made that patient is ready for transfer AND

c) The patient is safe to discharge/transfer.[14]

These three criteria are not separate or sequential stages; all three should be addressed at the same time whenever possible[15].

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[11] SWPSHA
[12] DoH: Health and Social Care Change Agent Team/Reimbursement Team: "Medical Stability and Safe to Transfer"
[13] DoH: Health and Social Care Change Agent Team/Reimbursement Team: "Medical Stability and Safe to Transfer
[14] DoH: SITREP Definitions and Guidance Draft July 2003
[15] DoH: Health and Social Care Change Agent Team/Reimbursement Team: "Medical Stability and Safe to Transfer

a) **Clinical decision that patient is ready for transfer**

The Department of Health notes that "clinical" here can include medical, nursing or therapy inputs, although in practice a senior doctor (Consultant) usually makes such decisions[16]. The Department of Health advises that ward based teams should ensure they are clear who can make the decision and the processes for ensuring that no delays occur because of the clinician's non-availability.

The term **"medical stability"** is in common use and regarded as a key element in the clinical decision. Many older people have fragile health and medical stability is not static; moreover, a patient may be very poorly yet still be medically stable and able to be moved. The risks of moving the patient to an intermediate care or interim setting have to be balanced against those of remaining in an acute bed[17].

b) Multi-disciplinary team decision that patient is ready for transfer

The multi-disciplinary team (see above) should be involved at the earliest opportunity. It is not acceptable to wait for the clinical decision before referring for assessments by other professionals[18].

c) The patient is safe to discharge/transfer

Where a person has both health and social care needs, they should only be discharged when a multi disciplinary team assessment concludes he/she is safe to transfer. This decision should take account of the relative safety of remaining in hospital or being elsewhere and the patient's and carer's views of these risks. It is important to include the carer as part of the team as they have expertise regarding the patient's home environment.

The multi-disciplinary team should ensure that they know enough to make the decision that the patient is safe to transfer. This should include a clear picture of the patient's circumstances prior to admission and an understanding of the services and support available to vulnerable older people in other settings and in the community. Completing this assessment should not cause unnecessary delays (see Assessment timescales above). A risk assessment should be undertaken by the multi disciplinary team, balancing the risks of moving the patient with that of remaining in an acute bed.

The responsibility and accountability of clinicians and members of the multi-disciplinary team within this process needs to be clarified locally, and set out in the local hospital discharge policy which will need to be developed in conjunction with key partners across the health and social care system and in line with DoH guidance.[19]

4.1.7 Delayed transfer of care

[16] DoH: Health and Social Care Change Agent Team/Reimbursement Team: "Medical Stability and Safe to Transfer
[17] DoH: Health and Social Care Change Agent Team/Reimbursement Team: "Medical Stability and Safe to Transfer
[18] DoH: Health and Social Care Change Agent Team/Reimbursement Team: "Medical Stability and Safe to Transfer
[19] DoH :Discharge from Hospital: Pathway, Process and Practice (2003)

The Department of Health states, **"A delayed transfer of care occurs when a patient is ready for transfer from an acute hospital bed, but is still occupying such a bed"[20].** Delays can be down to failure to complete an assessment or to arrange services, including other NHS care. **For the purposes of reimbursement, only delays that are the sole responsibility of Social Services are liable for reimbursement.**

If a patient is awaiting completion of a health assessment, or the arrangement of health services, Social Services will not be liable even if the Social Services element of an assessment is not complete or social care services are not in place. Social Services Departments are, however, responsible for all delays relating to social care services, even it they are not directly responsible for those services, for example housing services[21] or private residential and nursing care homes.

Delayed transfers of care occur throughout the whole system and the Community Care (Delayed Discharges) Act 2003 allows for all delays to be included in reimbursement. However the regulations defining the act limit reimbursement at this stage to the above definition of acute care. However local health and social care systems will need to have a detailed understanding of the delays across its whole system in order to reduce delays in acute care. ***(reference to toolkit here)***

4.1.8 Identifying ordinary residence

One of the new NHS responsibilities covered in the Act is a duty to identify the patient's responsible local authority, so that assessments and service provision can be arranged promptly and charges, where necessary, are invoiced to the correct council. Notices should be issued to the local authority in which it appears to the NHS body that the patient is ordinarily resident at the time [for patients of no fixed abode, see section 37]. The NHS body is not required to undertake lengthy investigations to establish with certainty which authority this is, but it must make reasonable efforts to identify which authority is responsible, and then serve notice to that authority. A mapping tool to identify the relevant local authority for any given postcode in England is available on the STEIS information system and is also available together with detailed guidance on the reimbursement website[22].

5. Key elements of a local system

5.1 It is not the intention in this Joint Policy to prescribe how local organisations will do things, but, for each local health and social care economy, discharge arrangements will need to include agreed systems for each of the following elements:

- Identifying patients with a possible need for services on discharge linked into SAP
- Notification to Social Services of such patients (Section 2 Notification)
- Assessment by multi disciplinary team and decision on ready for transfer
- Notification to Social Services of proposed discharge date (Section 5 Notification)
- Identification of delays and liability for reimbursement

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[20] DoH; SITREP Guidance and Definitions July 2003
[21] For clarification see DoH Reimbursement Implementation Team: "Frequently asked questions on reimbursement Q23"
[22] www.doh.gov.uk/reimbursement/links.htm

5.2 Detailed guidance on best practice and the legislation in relation to the above can be found in the "A *Best Practice Discharge Milestones Toolkit*" produced by the "Discharge Milestones Working Group" - a development sub group of the Peninsula Delayed Discharge (Reimbursement) Project Board. ***(Reference to toolkit here)***

6. Involving patients and carers

6.1 Involving patients and carers is one of the key principles emphasised in Discharge from Hospital: Pathway, Process and Practice (Department of Health 2003). ***"The engagement and active participation of individuals and their carer(s) as equal partners is central to the delivery of care and in the planning of a successful discharge".*** The focus on interagency relationships and agreements in the reimbursement legislation should not cause patients' and carers' involvement to be overlooked. Involving patients and carers gives them confidence in the system and a sense of control, which are essential in achieving successful discharge.

6.2 The pre-admission and admission process is the critical time to explain to patients and their carers what to expect and how they are to be involved in key decisions.

6.3 The legislation requires the NHS to exchange information with local authorities where a patient is considered likely to need services on discharge. It is important that the patient's consent is obtained for this exchange of information, or, if this is not possible, the consent of a relative or carer.

6.3.1 When obtaining consent to pass on or seek information from another agency, the Data Protection Act 1998 is clear that explanation should be given to service users about:

- The purpose of approaching other individuals or organisations
- The reason for disclosure of information
- Details of the individuals or organisations being contacted
- What information will be sought and shared
- Why the information is important
- What it is hoped will be achieved.

6.3.2 Although not a statutory requirement, NHS and social care organisations are also committed to the Caldicott principles when considering whether confidential information should be shared. These are:

- Justify the purpose(s) for using personal information
- Only use personal information when absolutely necessary
- Use the minimum amount of personal information that is required
- Ensure access to personal information is on a strict need to know basis
- Ensure everyone with access to personal information is aware of their responsibilities
- Ensure everyone with access to personal information understands and complies with legislation that governs personal information.

6.3.3 Once the decision has been made that social care services are likely to be required on discharge, the patient's (or their representative's) consent must be obtained prior to a Section 2 Notification being sent to Social Services. The Department of Health considers the patient's verbal consent is sufficient

for this[23], but organisations may wish to ensure that patient's consent has been obtained by requiring written consent and by ensuring that where verbal consent is given this is formally recorded. ***(reference to specimen consent form in toolkit)***

6.4 Hospitals will need to ensure that they have in place a consistent process and timescale for giving standardised information leaflets or letters to patients and carers about their hospital stay and discharge arrangements. It may be useful to link these letters or leaflets to the issue of Section 2 and section 5 Notifications. This would make explicit to patients and their families the discharge process and the need to make speedy arrangements and choices to move out of hospital once medically fit to do so. ***(reference to samples in toolkit)***

6.5 Where residential or nursing home placement is under consideration, information needs to be provided on the patient's right to choose (the Direction on Choice) but should emphasise that the process of choosing should not delay a patient's discharge from an acute hospital bed. The information provided should outline services available to help with choice and what alternative arrangements could be offered if a person's choice of home were not immediately available (for instance, interim care or alternative placement). ***(reference to samples in toolkit)***

6.6 Finally, organisations will need to determine their local policy for situations in which the patient does not agree the discharge plan or has not resolved their future placement. Involving patients and carers throughout the decision making process, and ensuring they have clear information about the need to move from an acute bed when medically fit and the alternatives available should reduce the potential for disagreement and delay. ***(reference to toolkit for sample policy)***

7. Data collection and recording

7.1 The foundation for a successful partnership approach to reimbursement has to be confidence in the local information available on the numbers and causes of delays, including agreement on the proportion that are the responsibility of Social Services alone.

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7.2 To achieve this it is vital that discharge procedures within each health and social community include the outputs that meet the requirements of the Act and will enable patients whose discharge is delayed to be readily identified. The reason for the delay is required to ascertain whether Social Services is liable for reimbursement, and the length of delay is required to calculate the charge for reimbursement.

7.3 The information collected for the current Sitrep reports is a weekly snapshot, and will need to be modified to meet the requirements of reimbursement in line with the draft guidance currently out for consultation. The Department of Health recommends that a single system is developed, incorporating information from the new notifications, to provide accurate daily information in such a way that it can be aggregated each week to provide the Sitrep report.

7.4 The use of sub-categories under each of the Sitrep delay categories will promote consistency of interpretation across the area, will enable responsibility for the delay to be accurately ascribed, and will assist health and social care organisations

[23] DoH; Reimbursement Implementation Team: Frequently Asked Questions Q28

understand the causes of delay in their local area and where most attention needs to be targeted.

7.5 In each health and social care organisation there will need to be clearly defined responsibility for data collection, entry and verification. Organisations may wish to assign this role to specialist joint posts.

7.6 Organisations will require a robust mechanism for agreeing data between agencies, which is capable of verification at audit. Current arrangements for verifying Sitrep information locally will need to be strengthened. All key decisions should be noted on patient's records, and any spreadsheet or database used should be capable of recording the history of a patient's discharge status and arrangements.

7.7 It is recommended that local organisations should be planning on integrating reimbursement requirements within any Single Assessment Process IT implementation project***. In the interim a local agreement has been reached so that the existing SAP processes for Devon and Cornwall are amended to incorporate the information requirements of the Act and that the relevant project teams undertake this work, this will include the production of a standard pro-forma for section 2 and section 5 notifications.***

7.8 A sub group of the Peninsula Delayed Discharge (Reimbursement) Project Board is currently being convened to develop a consistent policy in relation to the above points. The outcome of this work will be recorded in a Joint Reimbursement Data Policy to be finalised by end of September 2003

8. Joint monitoring and analysis

8.1 At present there are variable arrangements across the Strategic Health Authority area for local health and social care organisations to monitor delays jointly and take corrective action together where required.

8.2 A whole systems approach suggests the need for each health and social care system to establish a joint forum between partner agencies where Sitrep and other information on delayed transfers is reported and analysed, and joint decisions made on action to reduce delays, including the use and reinvestment of reimbursement charges. The potential transfer of funds through reimbursement should be used to strengthen rather than undermine existing partnerships.

8.3 A joint forum including representatives from the local Acute Trust, PCT and Social Services Authority would use the detailed information collected through the discharge recording process to enable senior managers to understand how the discharge process is operating locally and where and why delays, not only those with liability for reimbursement. Links with existing local capacity planning systems and joint investment planning processes need to be ensured.

8.4 Financial monitoring systems will need to be established in each trust to ensure appropriate tracking of any fines as they become liable under reimbursement.

8.5 Between October and December 2003 the Health Authority will be monitoring arrangements to ensure that effective local systems are in place.

9. Disputes

9.1 The Strategic health Authority is required to establish a Disputes Panel, to assist in the resolution of disputes between NHS and Social Services authorities about the need for community care services on discharge or about liability for reimbursement.

9.2 The Panel may be used either for disputes about individual patient delays or issues of broader disagreement between partner organisations in relation to the management of the reimbursement provisions. The Panel will include an independent chair, an NHS representative from an organisation not involved in the dispute and a local authority representative, also from an organisation not involved in the dispute.

9.3 The Department of Health regards recourse to the formal disputes mechanism as a measure of failure in collaboration. It emphasises that the incidence of disputes relating to reimbursement will be kept to a minimum where joint discharge planning arrangements are well developed and there is good partnership working. The purpose of this Joint Policy is to assist this process and reduce the scope for disagreement. Local health and social care organisations have a joint responsibility for solving problems and addressing disagreements purposefully and constructively before they develop into disputes.

9.4 When disputes occur, it is in the interests of the patient and all agencies concerned for these to be resolved speedily and effectively, without recourse to the formal disputes mechanism if at all possible. In all cases, disputes about responsibility and reimbursement should not prevent the patient receiving the right care in the right place at the right time.

9.5 The Regulations require each Strategic Health Authority to establish and maintain lists of persons from which panels can be appointed to assist in the resolution of disputes between two or more public authorities (defined as NHS bodies or social services authorities). The function of each panel is to consider and make recommendations on the resolution of disputes which arise either from the determination of the need for community care services on discharge, or about liability for delayed discharge payments (Part 1 of the Act) where these cannot be resolved by informal means.

9.6 The panel may be used either for disputes about individual patient delays, or issues of broader disagreement between partner organisations in relation to the management of the reimbursement provisions. Although advisory, it is expected that panel recommendations be accepted in most cases. Furthermore, the Regulations prevent the social services authority or NHS body from bringing legal proceedings without first having attempted resolution via a panel.

9.7 In line with the Department of Health requirements the Health Authority will establish a clear, staged process, with clearly identified roles, responsibilities and timescales, which should encourage resolution at the earliest opportunity. The focus on this process will be that operational staff should be empowered to resolve issues at the frontline wherever possible, within agreed policies and procedures. If they are unable to reach agreement, operational staff should have timely and ready access to senior managers who would be expected to negotiate a resolution of the issue with their counterparts. A decision to invoke the formal disputes procedure should only be made after all the informal steps have been exhausted. The formal disputes procedure will be produced by end of September 2003.

10. Cross-boundary issues

10.1 Within the South West Peninsula Strategic Health Authority area patients flow between and across sectors and organisational boundaries. There are also significant patient flows to and from systems outside of the region. The Department of Health recommends health and social care organisations prepare for reimbursement[24] by:

10.1.1 Understanding and sharing the detail of patient flows, both patients using "out of area" hospitals, and "out of area" patients using local hospitals.

10.1.2 Understanding any significant pattern of cross boundary placements in residential and nursing homes. Where local authorities are involved in placing residents in care homes outside their area, they need to ensure that they receive timely information of the admission of these residents to hospital.

10.1.3 Acute trusts establishing mechanisms for identifying the correct local authority for patient notifications and reimbursement. A directory by post code is available on the Department of Health website, but acute trusts will need to be clear, particularly where patients are admitted from residential or nursing homes or a relative's address, that they have identified the responsible local authority.

10.1.4 Social Services Departments reviewing reciprocal arrangements with neighbouring authorities to ensure rapid access to assessment and services for their residents.

10.1.5 Establishing clear contingency arrangements to deal with arrangements for patients where the responsible local authority is not known or disputed.

11. Financial arrangements for re-imbursement

11.1 Social Services Departments are obliged to pay reimbursement charges to the relevant NHS Acute Trust when they are responsible for delayed transfers of care.

11.2 The Government has transferred £50 million in the first year and £100 million in each of the following two years from the NHS to local authorities to meet the costs of reimbursement and assist in developing a whole systems approach to increasing the range and volume of services to reduce delayed transfers of care[25]. Local organisations will need to quantify the likely cost of reimbursement in order to manage risk and inform investment decisions.

11.3 **Regardless of local agreement, it will not be possible for Social Services Departments to avoid paying reimbursement charges to the Acute Trust where liable.** In order to ensure that reimbursement resources are available for reinvestment in the local health and social care systems to reduce delays, Acute Trusts, PCT's and Social Services Departments will need to agree on how the funding generated locally by reimbursement will be used.

[24] DOH: Reimbursement Protocol Checklist: Cross-Boundary Arrangements
[25] DOH: Reimbursement Implementation team: using Reimbursement Funds to Increase Capacity and Reduce Delayed Transfers of Care.

11.4 Pooling funds using the Health Act 1999 flexibilities is one option for managing the financial flows resulting from reimbursement. Partners may combine the Delayed Discharges Grant, the Access and Systems Capacity Grant, any funds from reimbursement and perhaps an agreed sum from individual partner budgets to set up a budget focussed on improving community care services with the aim of reducing delayed transfers. This option enables partners to combine their funds in one single 'pot', following a legal partnership agreement setting out the objectives of the fund, who is authorised to spend it, agreed contributions from partners etc. Once in the pooled fund, money can be spent on any jointly agreed objective, without the restrictions of individual budget headings. This means that partners, who must include the hospital, could agree to reinvest any funds from reimbursement charges in older people's services.[26]

11.5 Each health community and its relevant local authorities will need to decide whether to manage the financial aspects of reimbursement via a pooled budget process. In making this decision consideration will need to be given to ensure that the financial systems agreed upon ensure pro-active investment takes place to avoid unnecessary hospital admissions, supports swift and appropriate discharge and avoids fines.

11.6 The reimbursement grant should be invested in a whole system approach to managing delays within the context of joint service and capacity planning. The investment of the grant should therefore result in clear evidence of:

- Reduction in emergency admissions
- Decrease in length of stay in acute and community hospitals
- The number of bed days saved in acute and community hospitals
- A reduction in the number of cancellations in elective admissions
- Improvements in the speed of assessment and care planning timescales
- Reduction in the number of people delayed in hospital due to either health or social care reasons
- Improvements in the patient and carer experience of the discharge process

11.7 Each health and social care community will need to prioritise investment within the following key areas:

Immediate priorities:

- Systems, processes and services in place to divert patients from A&E and MAU from admission to hospital.

- Systems, processes and services in place to screen individuals who may require social care services, and then assess for those services, prior to admission wherever possible. This may require investment in system/business support and practitioner time.

- Tracking patients through the hospital system, ensuring appropriate transfers and minimising lengths of stay. This may require investment in both system/ business support and tracker nurse time.

- Enabling people to leave hospital as soon as their acute care is finished, either by going home with support or by transferring to an intermediate care

[26] For more detail on financial flows from reimbursement, see www.doh.gov.uk/reimbursement/systems.htm
For more guidance on pooled funds, see www.doh.gov.uk/jointunit/s31guidance.htm

or interim care facility. This will interface with other investments for example; prevention services, intermediate and interim care services and community hospitals.

- Training and education time to include staff cover and linked with SAP and continuing care requirements.

- Extension of working hours to achieve assessment / care planning timescales.

- Ability to report and monitor requirements and track outcomes. This may require investment in systems and / or staff

- Publicity / patient / public information

11.8 Additionally, local communities will need to address priorities for investment to sustain / improve capacity. This could include:

- Care home beds and capacity co-ordinator.
- Integrated nighttime service with health and domiciliary care
- Purchase of equipment
- Domiciliary care capacity including a link role of capacity co-ordinator

12. Reviewing the Joint Policy

12.1 The introduction of reimbursement is intended to reduce delayed discharges and strengthen joint working through financial incentives. This protocol is intended to assist health and social care organisations in the South West Peninsula Strategic Health Authority area achieve those aims. It is proposed that, through the work of the Peninsula Delayed Discharge (Reimbursement) Project Board evaluation of how the Joint Policy has been implemented and any adjustments required should take place between October and December 2003, ready for full implementation of reimbursement in January 2004.

12.2 The SHA will monitor shadow arrangements for reimbursement through written reports from each health community presented to the Project Board at its monthly meetings. In exceptional circumstance, where local health and social care organisations decide to operate outside of the Joint Policy or are unable to reach local agreements the SHA will instigate alternative monitoring arrangements.

12.3 It would also be helpful to evaluate the effect on patient outcomes on a longer term basis, using information such as emergency readmission rates, numbers going into residential or nursing care permanently, and information from patient and carer surveys. Organisations may wish to do this routinely on a local basis. There will also be value in partner organisations agreeing to review the implementation and operation of the Joint Policy across the strategic health authority area after the first year of operation, to see whether the aims have been achieved.

13. Recommendations

The Community Care (Delayed Discharge) Project Board recommends that Peninsula NHS Chief Executives and Directors of Social Services agree to:

13.1 adopt this policy in principle;

13.2 discuss the policy within their individual organisations to ensure the policy is understood and adopted by each organisation, with particular emphasis on the:

- 13.2.1 principles in section 3 (3.1),
- 13.2.2 agreement to consider the inclusion of some community hospital beds in January 2004 (Section 4: 4.1.1),
- 13.2.3 agreement to link reimbursement into SAP in section 7 (7.7),
- 13.2.4 advice in relation to pooled budgets in section 11(11.5 – 11.8),
- 13.2.5 monitoring arrangements discussed in section 12;

13.3 ensure a swift decision within each of the health communities on the financial arrangements for reimbursement including the establishment or not of pooled budgets for investment to avoid fines;

13.4 nominate a senior manager in each organisation to have responsibility for implementing the policy within the local health and social care system.

Community Care (Delayed Discharges) Act
Appendix One
Reimbursement – Key Issues

Scope of reimbursement

The Department of Health states, "A delayed transfer of care occurs when a patient is ready for transfer from an acute hospital bed, but is still occupying such a bed"[27]. Delays can be down to failure to complete an assessment or to arrange services, including other NHS care. For reimbursement purposes only delays which are the sole responsibility of Social Services are liable for reimbursement.

Reimbursement applies to::
adults who have been receiving acute care – (excludes maternity, mental health, palliative, intermediate, recuperation or rehabilitation care)
where

- a multi disciplinary team decision has been made that the person is safe to transfer from acute care

and

- the person qualifies for, and wants, community care services and delays in arranging those services are the sole reason for the delay

and

- the person is not eligible for NHS continuing care

and

- assessment and discharge notifications have been issued by the NHS and not withdrawn

Prior to reimbursement notifications

The NHS must:

- screen whether the person is eligible for fully funded NHS continuing care – if so reimbursement does not apply;
- screen whether the person may need community care services-not everyone will need community care services after discharge;
- decide the most appropriate time to begin the assessment - the formal assessment notification should be made when an accurate assessment can be made of the care the person may need when they leave hospital;
- identify the local authority in which the person is ordinarily resident

Assessment Notification (Section 2)

Requires NHS to notify social services of a patient's likely need for community care services after discharge. Patient/carer must be informed.
An Assessment Notification (section 2):

- May be issued by NHS up to 8 days before the day of admission
- Must be issued by NHS to local authority in which the person is ordinarily resident;
- Must give the local authority a minimum 2 days to assess person/carer and arrange services;

[27] DoH; SITREP Guidance and Definitions July 2003

- 2 day period starts on day notice was issued if before 2 pm or following day if after 2pm. (excludes Sundays and Bank hols);
- Sundays and Bank holidays do not currently count as part of the minimum interval;
- A notice counts from the time it is received at the intended recipient's address.

The NHS should send notices well in advance of these times where possible

Withdrawing assessment notices

NHS must withdraw notices where:

- The person has made own arrangements;
- The person is an ordinary resident in another local authority;
- The person will not be admitted to hospital at the expected time;
- Package arranged by social services is not adequate for safe discharge – further care planning needed;
- The person requires NHS continuing care;
- Person dies;
- Person discharge her/himself;
- Social services and person / family must be advised as soon as possible that the notice has been withdrawn;
- Where a withdrawal can be combined with a new notice, it should be..

Discharge notifications (Section 5)

Requires NHS to notify social services of proposed date of patient's discharge.
Patient/carer must be informed

- NHS must give minimum of one day notice before the proposed discharge date given in the notice;
- Notices issued after 2pm Fridays and 5pm on other days are to be treated as having been issued on the following day.

The NHS may issue discharge notification with longer period of advance warning

Withdrawing discharge notices

NHS must withdraw notices where

- Person in not safe for discharge on the proposed date given in the notification (Applies to patients who are already delayed but whose health deteriorates.);
- Social services and person / family must be advised as soon as possible that the notice has been withdrawn;
- Where a withdrawal can be combined with a new notice, it should be..

Charging

- The charge will apply from 11 am on the day after the proposed discharge date identified by the NHS in the discharge notification or 3 days after social services have been given an assessment notification of a patient's likely need for community care assessment – ***whichever is later.***
- Both assessment and discharge notification must be in force for charging to start.

Appendix 2
SOUTH WEST PENINSULA STRATEGIC HEALTH AUTHORITY

JOINT POLICY
DELAYED TRANSFERS OF CARE AND REIMBURSEMENT

Reimbursement Preparation Checklist

The Joint Policy has been produced in conjunction with representatives of the Acute Trusts, Primary Care Trusts and Social Services Departments across the Strategic Health Authority area under the leadership of the Peninsula Delayed Discharge (Reimbursement) Project Board

This checklist aims to assist local health and social care communities to identify priorities for local action. More detailed protocols and checklists can be found in "A *Best Practice Discharge Milestones Toolkit*" designed by the "Discharge Milestones Working Group" (a development sub group of the Peninsula Delayed Discharge (Reimbursement) Project Board),

Section 3: Principles

1. Are local staff aware of and signed up to the principles of reimbursement described in the Joint Policy?

Section 4.: Definitions

2. Have you ensured that relevant health and social care staff are aware of, and understand the definitions contained within the Joint Policy?

3. Have you agreed locally which inpatient beds are used for acute care, for the purposes of reimbursement, within the agreement described in the Joint Policy?
   During shadow arrangements the definition will apply to acute hospital beds with the exception of those designated as rehabilitation beds.

4. Have you agreed parallel monitoring process for community hospital beds delayed transfers in line with the Joint Policy agreement?
   Community hospital beds maybe specifically included following a review in January 2004 and in addition it is expected that whilst these beds may be not be included in reimbursement, parallel processes should be applied to community hospital beds. This is good practise and will assist in understanding the whole system and the unusual profile of delays with NHS-to-NHS transfers demonstrated in the Peninsula.

Section 4: Assessment Systems

5. Has action taken place to ensure information required for reimbursement is integrated with the local SAP?

6. Have target groups for reimbursement been identified locally?

7. Has it been determined and agreed how screening will take place?

8. Has it been determined who will carry out screening?

9. Has a screening tool been agreed and is this integrated with SAP?

10. Is there a system for ensuring continuing health care assessments take place within the context of SAP and the SWPSHA Eligibility Criteria for Continuing NHS Healthcare?

Section 4: Assessment by multi-disciplinary team and decision on ready for transfer

11. Is it clear who makes the decision that a patient is clinically ready for transfer from an acute bed?

12. Is there a shared understanding of who is involved in a multi-disciplinary team?

13. Are there systems to ensure the involvement of the multi-disciplinary team in discharge planning?

14. Does this include Social Services?

15. Is there a named person responsible for making the arrangements for discharge?

16. Is there a clearly recorded discharge plan?

17. Are intermediate care services routinely offered?

18. Are there alternative placements/facilities for patients who no longer need to be in an acute bed, but are not yet ready to return home or to the placement of choice, or whose assessment is not complete?

Section 5. Local Systems: Section 2 Notifications

19. Have NHS organisations determined who will be responsible for issuing Notifications?

20. Have Social Services Departments determined who will be responsible for receiving and acting on Notifications?

21. Does this include Notifications from out of area hospitals?

22. Has a template for Notification form been designed?

23. Have local agreements been made about the 8-day notification rule for planned admissions?

24. Has the system for exchange of information been determined (for instance, fax or email)?

25. Is the necessary equipment in place?

26. Is notification of the expected discharge date included in the Notification process?

Section 5. Local Systems: Section 5 Notifications

27. Is it clear who is responsible for issuing Section 5 Notifications?

28. Is there a proforma or electronic template for the exchange of information?

29. Is there a proforma or template for Social Services to confirm services are in place or the reason why not?

30. Is it clear who will determine if a patient becomes unfit and how this will be recorded?

31. Is there an agreed system for informing Social Services a Notification has been withdrawn?

32. Does the recording system have the capacity to retain information on patients who move into and out of the Notification process more than once?

Section 5 Local Systems: Identifying delays and liability for reimbursement

33. Is there a clear system for recording the actual date and time of discharge?

34. Is there agreement on who is be responsible for this?

35. Is there a joint forum for agreeing delays and liability for reimbursement?

36. Is there a joint forum for monitoring delays?

37. Are all organisations in the local health and social care economy involved in this?

<u>Section 6: Involving patients and carers</u>

38. Is there a clear and consistent process for involving patients and relatives in assessment and discharge planning?

39. Is there a system for obtaining patient’s consent to referral/Notification, and is this consistent with the consent process for SAP?

40. Do the systems in place for Notification comply with the Data Protection Act and Caldicott agreement as specified in the Joint Policy?

41. Has standard information in leaflet or letter been produced for patients and carers?

42. Are there clear processes for who will give out this information and at what point?

43. Does it make clear what support will be available and how to access it?

44. Is there specific information available for patients for whom residential or nursing care is being considered?

45. Is there a local policy on what to do if a patient does not agree the discharge plan or will not leave hospital?

Section 7. Data collection and recording

46. Have local organisations agreed the recording system they will use for Notifications and delays?

47. Does the system collect information on delays across the whole health and social care economy?

48. Have local organisations agreed to the sub-categories they will use to identify delays and responsibility for delays and is this consistent with the Joint Policy?

49. Have local organisations agreed together who will be responsible for collecting, inputting and verifying this information?

50. Will this require new resources/ specialist posts?

51. Is there appropriate equipment and software available?

52. Does the system used retain the history of events and changes?

53. Is there a clear audit trail for all decisions?

Section 8. Joint monitoring and analysis of delays

54. Is there a joint forum representing all the partner agencies which can monitor and analyse discharges and delays?

55. Does this forum receive Sitrep and more detailed information, with commentary, on a regular basis?

56. Is it a decision-making group?

57. Can it make decisions on the use of reimbursement and investment?

58. If not, where will these decisions be made?

59. How does the work of the forum link into local capacity planning and commissioning?

60. What mechanisms have been put in place locally to evaluate the impact of discharge arrangements and reimbursement?

Section 9. Disputes

61. Are all staff aware of the principles and practice of the Joint Policy they are implementing and their own responsibilities within this?

62. Does each organisation have in place named people with responsibility for resolving disputes with partner organisations?

63. Are all staff aware of how the Strategic Health Authority will convene a Disputes Panel if needed?

Section 10. Cross-boundary issues

64. Is there local understanding and sharing the detail of patient flows, both patients using "out of area" hospitals, and "out of area" patients using local hospitals?

65. Is there local knowledge of any significant pattern of cross-boundary placements in residential and nursing homes?

66. Are there systems in place to ensure that where local authorities are involved in placing residents in care homes outside their area, they have systems in place to ensure that they receive timely information of the admission of these residents to hospital?

67. Have acute trusts established mechanisms for identifying the correct local authority for patient notifications and reimbursement? (*A directory by post code is available on the Department of Health website, but acute trusts will need to be clear particularly where patients are admitted from residential or nursing homes or a relative's address, that they have identified the responsible local authority.)*

68. Are Social Services Departments reviewing reciprocal arrangements with neighbouring authorities to ensure rapid access to assessment and services for their residents?

69. Are local communities establishing clear contingency arrangements to deal with arrangements for patients where the responsible local authority is not known or disputed?

Section 11: Financial arrangements for reimbursement

70. Is there an overview of all resources available in your local whole system - across primary, community, acute and social care – for older people's services and consequently for avoiding unnecessary hospital admissions and facilitating swift discharge?

71. Are local organisations consulting each other in the course of budget-setting and service planning (capacity plans and local delivery plans)?

72. Has the local health and social care community considered the use of pooled budgets for older people's services e.g. residential & nursing home care, home care and intermediate care?

73. Has the local health and social care community considered the use of pooled budgets for reimbursement purposes?

74. Have you estimated and prioritised what investment would be required to minimise the number of delays for which Social Services are responsible across the whole system?

75. On the basis of current levels, have you calculated scenarios for the likely cost of reimbursement to Social Services for those delays for which it is responsible across the whole system?

76. Have you identified services/initiatives begun with short-term funding for which mainstream budget provision should be made?

77. Have you agreed clear outcomes for investment as suggested in the Joint Policy?

Section 12: Reviewing the Joint Policy

78. Has your organisation nominated a senior manager to joint the Peninsula Project board and submit monthly progress reports as described in the Joint Policy?