Health and Social Care 'Moving On' Policy

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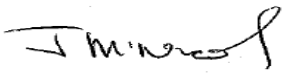
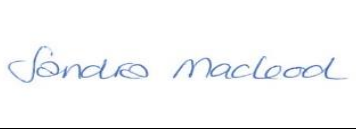
Reviewer:	Jenny McNicol, Exec Lead for Discharge	
Approver:	Sandra McLeod, Exec Lead for Unscheduled Care Portfolio	

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Executive Sign-Off

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Version History

Revision Date	Previous Revision Date	Summary of Changes (Descriptive summary of the changes made)	Changes Marked (Identify page numbers and section heading)
June 2021	March 2019	Lead Authors Document Reviewers Approvers Addition of legislation Change Reviewed by to TOR Membership Addition of rights Change of wording Change of Section Heading Document Written by Objectives clarified Clarity around inclusion criteria Refinement of exclusion criteria Heading Change Rewording Bullet 4 for consideration Heading Change Change of Wording Addition of "support planning" Change Social Work/Care Manager to Social Work Addition of MDT Change "will be" to "may" Change of wording Additional Comment Change of wording Change of wording Clarity around who arranges the meeting Change Heading Change "mental" to "welfare" Remove Comment due to changes in 5.5 Timeline changed from 2 weeks/14 days to 1 week/7 days Appendix 3 – Clarity around the complaint process not delaying discharge	Cover Page Cover Page Cover Page Page 2 Page 3 Page 3 Page 5, Section 1 Page 8 Section 1.1 Page 8 Section 1.2 Page 8 Section 1,1 Page 6, section 1.1 Page 8, section 1.2 Page 10, section 1.3 Page 11 Section 2 Page 11 Section 2 Page 11 Section 2 Page 11 Section 3 Page 11 Section 3.1, 3.2 Page 11 Section 3.3 Page 11, Section 3.33, 3.4, Page 12 Section 3.7, Page 13 Section 3.9 Section 3.4 Page 12, Section 3.7 Page 12, Bullet Point 3 Page 13, Section 3.9 Page 14, Section 3.14(a) & 3.15 Page 18 Section 4.16 Page 18 Section 4.11 Page 21 Section 5 Page 21 Section 5.1 Page 21 Section 6 Section 3 Pages 11-15, Section 4 Pages 15-18 Page 29, Appendix 3

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Document application: NHS Grampian, Aberdeen City Health and Social Care Partnership, Aberdeenshire Health and Social Care Partnership, Moray Health and Social Care Partnership

Purpose/description: Provide a clear policy for all NHSG and Partnership staff to support timely discharge from hospital to alternate care settings.

Policy statement: It is the responsibility of all staff to ensure that they are working to the most up to date and relevant policies, protocols, procedures, legislation and pathways.

Responsibilities for implementation:

Organisational: Operational Management Team and Chief Executive

Sector General Managers, Medical Leads and Nursing Leads

Departmental: Clinical Leads

Area: Line Manager

Responsibilities for review of this document: Cathy Young and Jenny McNicol

Document written by: (Only applicable if written by a group)

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Anne Munro	Flow Coordinator	NHS Grampian
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Ian Powell	Programme Manager	Aberdeenshire H&SCP
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Reviewed June 2021 by Discharge Expert Group	**As per group TOR**	**NHS Grampian and Aberdeen City, Aberdeenshire and Moray H&SCPs**

Contents :

MOVING ON POLICY

1. Introduction

Balancing the need for timely discharge from hospital with available community based (including residential) resources - whilst respecting patient, carer and family rights and autonomy - can be a significant issue. Preventing delays and 'moving on' from hospital care those patients who are **clinically fit for discharge** remains a challenge for health and social care organisations.

It must be stressed that the clear majority of hospital discharges occur appropriately, timeously, and safely without recourse to any formal procedure managing the process. It is expected that all staff will, in the first instance, engage with patients/clients, their families, proxies and carers in an informal, positive and collaborative manner to resolve any concerns regarding discharge planning and destination. Only once this informal engagement has been exhausted would formal "moving on meetings" (as set out in this procedure) be initiated.

All health and social care staff have a responsibility to ensure patients are discharged from hospital as soon as possible after the multidisciplinary team agree that hospital care is no longer needed. This responsibility also extends to ensuring that, on discharge, patients are safe to be transferred with appropriate after-care arrangements in place.

This policy serves to localise and make operational within Grampian the Scottish Government guidance **CEL (Chief Executive Letter) 32 (2013) "Guidance on Choosing a Care Home on Discharge from Hospital"**. In particular it satisfies the specific statement in the guidance that:

"Clear local protocols, that are robustly and consistently implemented with the support of all staff including senior managers, clinicians, ward and social work staff are essential to improve discharge planning and improve outcomes for patients".

In addition, by formally localising and endorsing a robust moving on policy for discharge, this document also addresses for Grampian one of the key recommendations of the Expert Group on Delayed Discharges (2012), namely:

"The Choice Policy should be reinvigorated at a local level with senior ownership among health and social care executives and medical practitioners".

It should be noted, however, that this document **goes further** than the CEL 32 guidance (which addresses 'moving on' arrangements purely for individuals seeking care home placement). Within Grampian, there are multiple alternate discharge options for patients that are not classified as care home placements e.g. interim housing, intermediate care facilities, etc. As a result, this policy also sets out clear arrangements to manage 'moving on' and discharge to these alternative settings. The principles of CEL 32 are now being utilised to support the much larger suite of discharge options available following a hospital admission.

NOTE: Moray Health and Social Care Partnership has local operational procedures which sit under the NHS Grampian Moving On Policy. Those local procedures will continue to be used

pending their review to align them with these NHSG wide arrangements.

1.1 Objectives

- To establish a clear and consistent local process for staff, patients/clients, and their families and carers to arrange a timely discharge from hospital to the setting that best meet the patient's outcomes. This includes the need for a collaborative MDT approach and documentation of discussions and legal decisions made regarding discharge with patients, relatives and the MDT in the clinical notes.

- To understand and appropriately use legislation for shared decision making including Adults with Incapacity (Scotland) Act 2000, and Social Work Scotland Act 1968 (specifically S13ZA SW (S) Act 1968)

- To ensure that all Health and Social Care staff understand and embrace the ethos of Home First to take an enablement approach. And that they are aware of their responsibilities in ensuring a timely discharge to a setting which best meets their outcomes for patients/clients.

- To establish a clear process for escalation if there are delays in progressing discharge.

1.2 Patient / Client Groups to Which This Document Applies

This policy applies to:

- Patients/clients who have been assessed as requiring care at home prior to discharge, and care at home services are not immediately available. Consideration should be given as to the risk assessment of existing care package and support required to enable a safe discharge.

- Patients/clients who have been assessed as requiring rehousing prior to discharge after all opportunities for rehabilitation or reablement, (including through the use of Intermediate Care), have been fully investigated and discussed with the patient/client, family or proxy.

- Patients/clients who have been assessed as requiring long-term care in a care home after all opportunities for rehabilitation or reablement, (including through the use of Intermediate Care), have been fully investigated and discussed with the patient/client, family or proxy.

- Patient/client, family or proxies who have identified a care home of choice with no current vacancy therefore temporary alternative care home arrangements are required.

- Patient/client, family or proxies who have identified a housing setting/location of choice with no current availability.

- Patient/client, family or proxy who are unwilling to engage with the discharge planning process, by refusing to make suitable care home or housing choices.

- Patient, family or proxy who are unwilling to move from hospital until a vacancy

becomes available at their preferred care home or housing setting of choice.

- Patient, family or proxy who are unwilling to move to another care home, housing or care setting temporarily (an interim move), when their preferred resource is currently unavailable.

- Patients who are not eligible for NHS Hospital Based Complex Clinical Care and do not accept alternative arrangements.

1.3 Patient / Client Groups to Which This Document Does Not Apply

This policy does **NOT** apply to:

- Children under 16 years of age
- Patients who are clinically unwell and unsafe to transfer
- Patients/families are in agreement with the MDT that they do not have ongoing health and social care needs
- Patients not requiring housing/social care intervention
- Patients whose housing and social care resource is immediately available and there will be no delay in their discharge
- Patients awaiting specialist placement.
- Patients, family or proxy who are appealing whether they should be discharged from hospital care due to being clinically unwell or due to potentially meeting the criteria for NHS Hospital Based Complex Clinical Care.

1.4 The Role of Carers in Discharge Planning and Related Arrangements

A carer is someone who provides unpaid support to a family member or friend. They may care for an older person, someone who is disabled, have a long-term illness, mental health illness or is affected by alcohol or drug misuse (NHS Education for Scotland and Scottish Social Services Council 2014)

Under the 2016 Carers Act, there is a duty on NHS boards to inform and involve carers in the discharge planning of the person they care for, or intend to provide care for.

Staff must:

- There is an absolute expectation that carers will be involved, consulted, and supported to participate from admission and throughout the discharge process and prior to the “moving on“ policy being implemented and at each stage thereafter.
- Inform the carer, as soon as it is reasonably practical, of the intention to discharge the cared for person and invite the carer to give views about the discharge of the cared for person.
- Take account of the views given by the carer in making decisions relating to the discharge.

This duty applies to all health boards, including the State Hospital, or when a person is receiving services in a hospital other than a NHS under arrangements made by the health board.

2. Practice Basis for Policy

There is clear evidence that an unnecessary prolonged stay in hospital can be detrimental to a person's physical and mental wellbeing (cf Conroy 2011 and Mudge 2010).

Results of unnecessary and prolonged admissions can include:

- The ethos of Home First and why this is being implemented needs to be added in here.
- Need to add in acknowledgement of the need for good discharge planning and communication that takes into account the clients holistic needs.

- A sense of disconnection from family, friends and usual social network leading to boredom, loneliness, hopelessness, confusion and depression. (Whilst being mindful of the risks of discharge to settings that simply duplicate the disconnection in a non-hospital setting).

- Increased susceptibility to hospital associated infection, general deconditioning, a higher risk of delirium, malnutrition, pressure sores and falls.

- Loss of confidence and ability to cope at home, resulting in a premature shift to permanent care, particularly for people with dementia.

- Distress to the patient, family carer or proxy as they are unable to plan ahead for the discharge date, and have to spend more time and money on regular, frequent visits to the hospital.

On this basis, the evidence is clear that timeous and appropriate discharge from hospital has a positive impact on an individual. It is this known benefit to the patient/client of a timeous discharge that underpins the need to promote quick and effective discharges.

3. The Moving on Process – Care Homes

3.1 Home to assess is the default, however on rare occasions where this is not deemed to be safe direct admission to a care home can be considered by a Care Manager through referral and assessment process.

3.2 Prior to a patient/clients "Ready for Discharge Date" appropriate work amongst the multidisciplinary team (MDT) should have taken place to ensure that all appropriate assessments, (including mental capacity assessments and consideration of complex based hospital care), have been undertaken.

3.3 As part of this work, if an individual will require a care home following discharge, **Social Work** staff will have lead responsibility for the assessment of needs, support planning, and provision of services on discharge from hospital.

3.4 **Social Work** will ensure that the patient/client, family or proxy has early access to a list of appropriate care homes to meet the patent/client's assessed needs. They, along with all members of the MDT, will also ensure that discussions have been held at an early point that reinforce that the patient/client **cannot** remain in an NHS

facility

3.5 All staff involved in caring for the patient/client (including **Clinician, Senior Charge Nurse, Ward Staff, and other professionals**) will endorse and publically support the view that waiting in hospital is not an option once clinically ready for discharge.

To assist staff to communicate with non-English speaking patients and their relatives and carers, the "Language Line" telephone interpretation service is available. By prior arrangement, "face to face" interpreters can also be provided. If the patient and their family members and carers have a communication Disability appropriate communication support such as British Sign Language (BSL) interpretation can be provided.

3.6 **Social Work** will also issue to the patient/client, family or proxy the leaflet "Moving from Hospital to a Care Home" which sets out in written format the expectations of the moving on policy, namely:

- The patient/client cannot remain in hospital to wait for their preferred choice of home to become available once they are clinically fit for discharge.

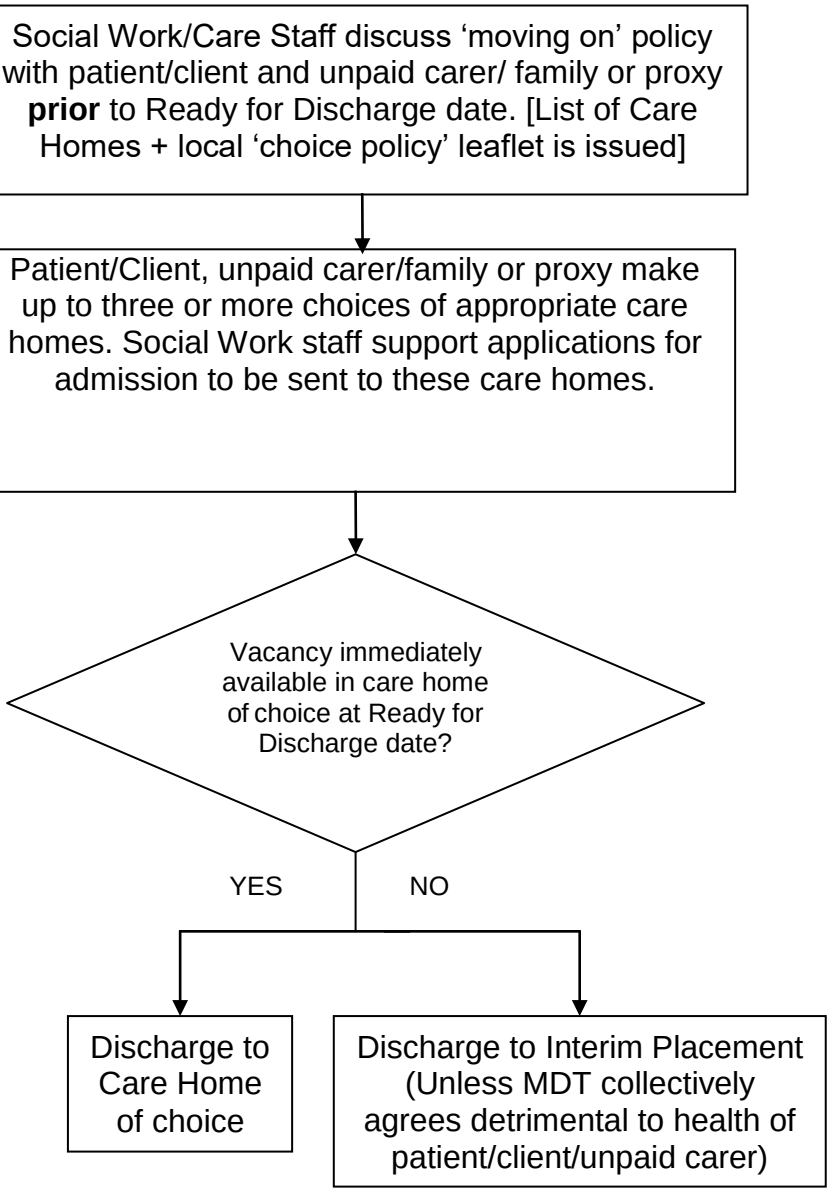
- Up to three choices of care home should be made
  [It would be expected that choices would be made within two week as a maximum].

- If none of the preferred homes have a vacancy available then the patient may move to an interim placement to wait for a vacancy in their preferred home. Consider moving patient to an interim place.

- If decisions on choice of care homes have not been taken by the time the patient/client is ready for discharge, then the patient/client may have to move to an interim care home place to wait whilst choices are made.

- Prior to the Moving on Meeting the individuals physical and emotional health, and any impact there may be on it to the individual and their families, will be taken into account to the interim placement as well as the legalities of the move.

3.7 The following flowchart sets out how the process of choosing a care home **should** work all other things being equal:



3.8 Issues may arise with this process via the patient/client, family or proxy either:

- disputing the decision to discharge, or
- refusing to make a choice of preferred home, or
- refusing to make a choice of interim home, or being unwilling to accept/pay for a move to the interim home, any other dispute affecting timely discharge. Some families and patients can take longer than the allotted two weeks to choose a Care Home – this can delay the discharge. In such circumstances, if informal discussions do not resolve matters, **Social Work** will take responsibility for informing the **Senior Charge Nurse** on the patient/client's ward of the need for a **moving on meeting** to be convened.

3.9 The **Senior Charge Nurse** will contact the **Clinician in Charge (or equivalent)** who will ensure arrangements are put in place for the **moving on meeting**. A template letter for inviting the patient/client, family or proxy to such a meeting is included in Appendix 2 [The moving on meeting will be convened within **one week** of the matter being escalated by social work staff.]

3.10 At the **moving on meeting** all those involved with the care of the patient/client will discuss the reasons why discharge is not progressing and attempt to find a way forward that is acceptable to all parties.

3.11 However, the primary purpose of a **moving on meeting** is to make clear that refusal to make a choice, or participate in the process of choosing a care home **does not mean** the patient/client can remain indefinitely in hospital. The **moving on meeting** will be clear that if no progress is made, the patient/client **will** be discharged to a care home place with a vacancy - to be cared for in an appropriate setting until a permanent care home placement of choice is available. The **moving on meeting** should be minuted, and a letter sent to all parties which documents the outcome of the meeting (a template letter is contained in Appendix 3).

3.12 If no progress is made following the **moving on meeting** the next steps will depend on whether lack of progress relates to:

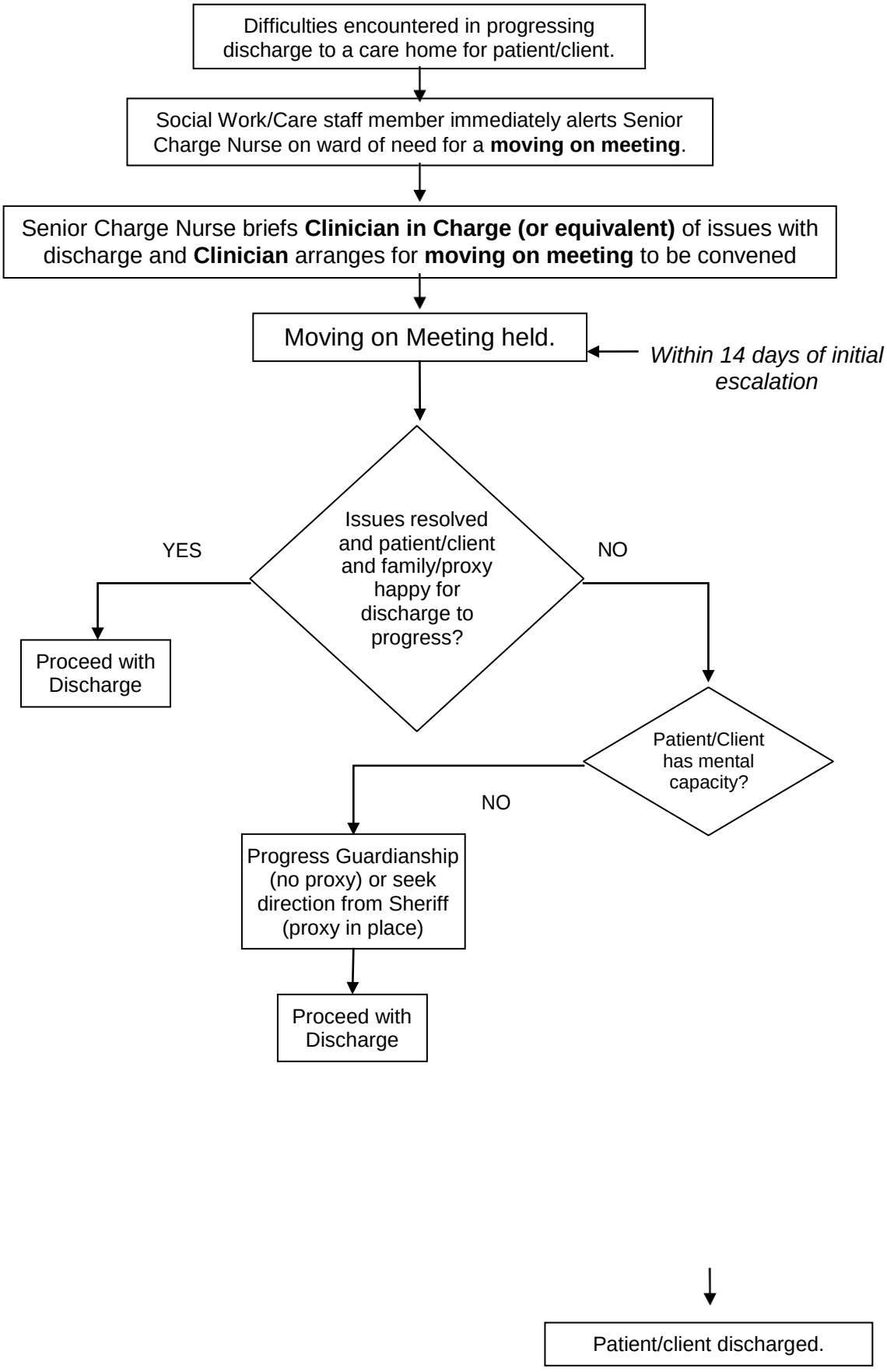
a. The patient/client lacks capacity in regards to care and welfare. **Incapacity Certification / Section 47 does not meet this criteria. Then the actions** detailed in **section 5 of this document** should be progressed.

b. In all other cases where the patient/client has capacity, the **Clinician in Charge** will refer the matter to the **Medical Director (or equivalent)** responsible for the hospital in question. The **Medical Director (or equivalent)** will then write to the patient/client/family informing them of the date they will be discharged from NHS hospital care – a template letter is contained in Appendix 4. [The **Medical Director (or equivalent)** will issue the letter within 7 days of the moving on meeting].

3.14 The patient/client will be discharged on the date specified on the Medical Director (or equivalent's) letter.

3.15 In exceptional cases where all other avenues have been exhausted as per the 2013 CEL 32 guidance, the Health Board can choose as a last resort, to seek enforcement of the discharge through the courts.

3.16 The flowchart below shows how the process should operate.


Difficulties encountered in progressing discharge to a care home for patient/client.
Social Work/Care staff member immediately alerts Senior Charge Nurse on ward of need for a **moving on meeting**.
Senior Charge Nurse briefs **Clinician in Charge (or equivalent)** of issues with discharge and **Clinician** arranges for **moving on meeting** to be convened
Moving on Meeting held.
Within 14 days of initial escalation
Issues resolved and patient/client and family/proxy happy for discharge to progress?
YES
NO
Proceed with Discharge
Patient/Client has mental capacity?
NO
Progress Guardianship (no proxy) or seek direction from Sheriff (proxy in place)
Proceed with Discharge
Patient/client discharged.

4. The 'Moving on' Process – Housing and Other Interim Care Scenarios

4.1 As with care home discharges, prior to a patient/clients "Ready for Discharge Date" appropriate work amongst the MDT should have taken place to ensure that all appropriate assessments and interventions have been undertaken to support a timely discharge. (This should include early clarification of any issues relating to mental capacity).

4.2 As part of this work, if an individual will require **care at home** following discharge, **Social Work** will have lead responsibility for the assessment of care needs and provision of services on discharge from hospital

4.3 the patient/client's outcomes. They will also ensure that discussions have been held at an early point that reinforce that the patient/client **cannot** remain in hospital to wait whilst services are procured. (whilst recognising that appropriate and safe interim measures would need to be in place prior to discharge).

4.4 If an individual requires **rehousing** or **significant adaptations** to their property to support discharge, **housing and/or occupational therapy staff** will lead in regards to progressing the relevant work. As with other interventions to support discharge, discussions will be held at an early point that reinforces that the patient/client **cannot** remain in hospital to wait whilst property/adaptations are put in place, (whilst recognising that appropriate and safe interim measures would need to be in place prior to discharge).

4.5 To assist staff to communicate with non-English speaking patients and their relatives and carers, the "Language Line" telephone interpretation service is available. By prior arrangement, "face to face" interpreters can also be provided. If the patient and their family members and carers have a communication disability, appropriate communication support such as British Sign Language (BSL) interpretation can be provided.

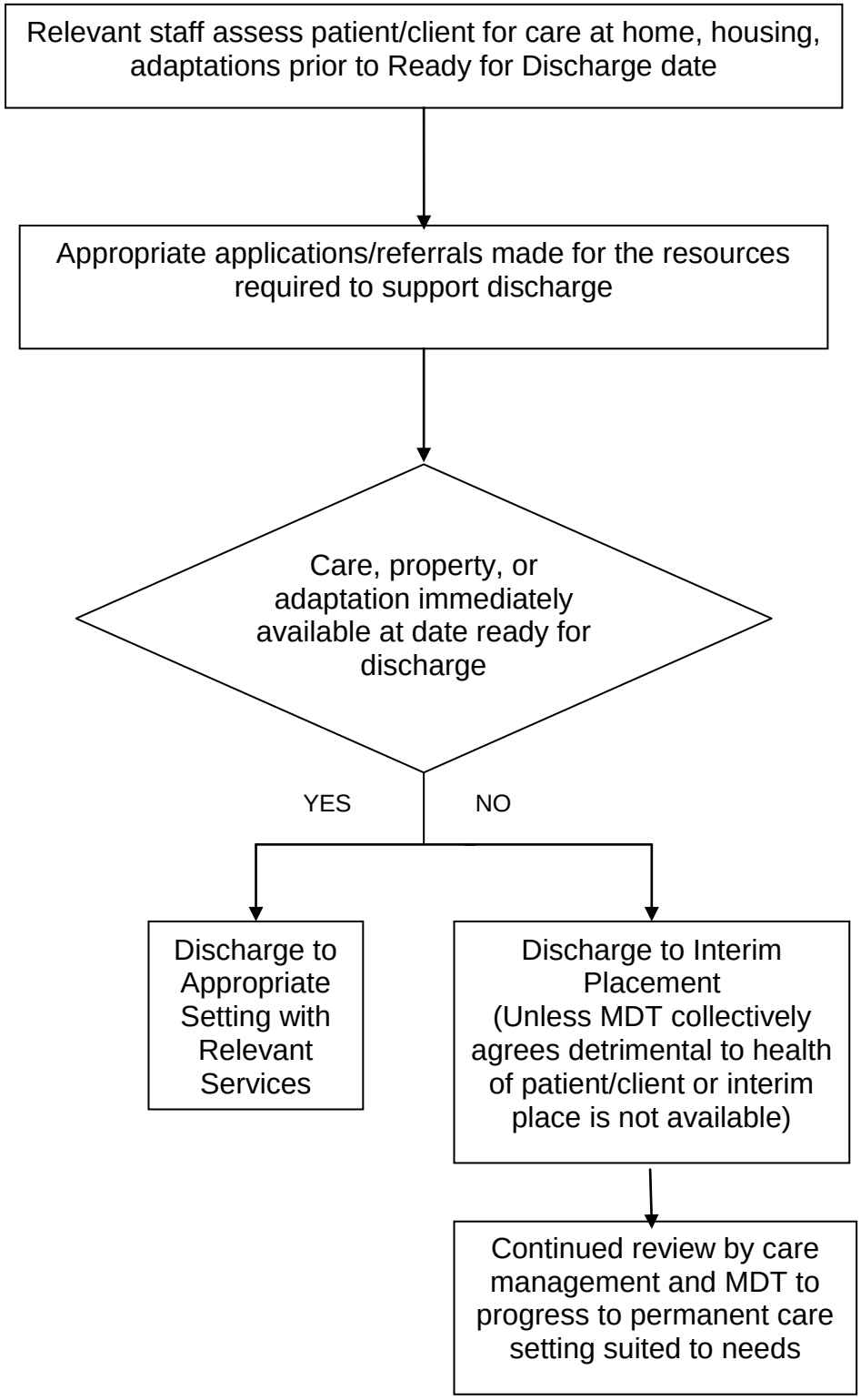
4.6 All staff involved in caring for the patient/client (including **Clinician, Senior Charge Nurse, Ward Staff, and other professionals**) will endorse and publicly support the view that waiting in hospital is not an option once clinically ready for discharge.

4.7 **Staff** actively involved in arranging discharge will all consistently make clear the current position across Grampian in regards to discharge arrangements, namely:

- The patient/client cannot remain in hospital to wait for care at home, adaptations, or re-housing once they are clinically fit for discharge.

- If services/property are not in place and available at the time of the patient/client's "Ready for Discharge" date, they may be required to wait in an appropriate interim setting.

4.8 The following flowchart sets out how the process **should** work all other things being equal:



4.9 Issues may arise with this process via the patient/client, family or proxy either:

- disputing the decision to discharge, or
- refusing to make a choice of appropriate housing, or
- being unwilling to accept a move to an interim setting, or
- any other dispute affecting timely discharge

4.10 In such circumstances, if informal discussions do not resolve matters, **social work/care staff** will take responsibility for informing the **Senior Charge Nurse** on the patient/client's ward of the need for a **moving on meeting** to be convened.

4.11 The **Senior Charge Nurse** and **Clinician in Charge (or equivalent)** will contact the Operational Manager who will ensure arrangements are put in place for the **moving on meeting**. A template letter for inviting the patient/client, family or proxy to such a meeting is included in Appendix 2. [The **moving on meeting** will be convened within one week of the concerns first being escalated].

4.12 At the **moving on meeting** all of those involved with the care of the patient/client will discuss the reasons why discharge is not progressing and attempt to find a way forward that is acceptable to all parties.

4.13 However, the primary purpose of a **moving on meeting** is to make clear that refusing to choose appropriate housing and/or accept an interim move **does not mean the patient/client** can remain indefinitely in hospital. The **moving on meeting** will be clear that if no progress is made, the patient/client **will** be discharged to an appropriate interim setting with a vacancy - until care, adaptations or property are secured. The **moving on meeting** should be minuted, and a letter sent to all parties which documents the outcome of the meeting (a template letter is contained in Appendix 3).

4.14 If no progress is made following the **moving on meeting** the next steps will depend on whether the lack of progress relates to a patient/client with capacity, or the patient/client lacks mental capacity to make decisions relating to discharge.

a. If the patient/client lacks capacity, then the actions detailed in **section 5 of this document** should be followed.

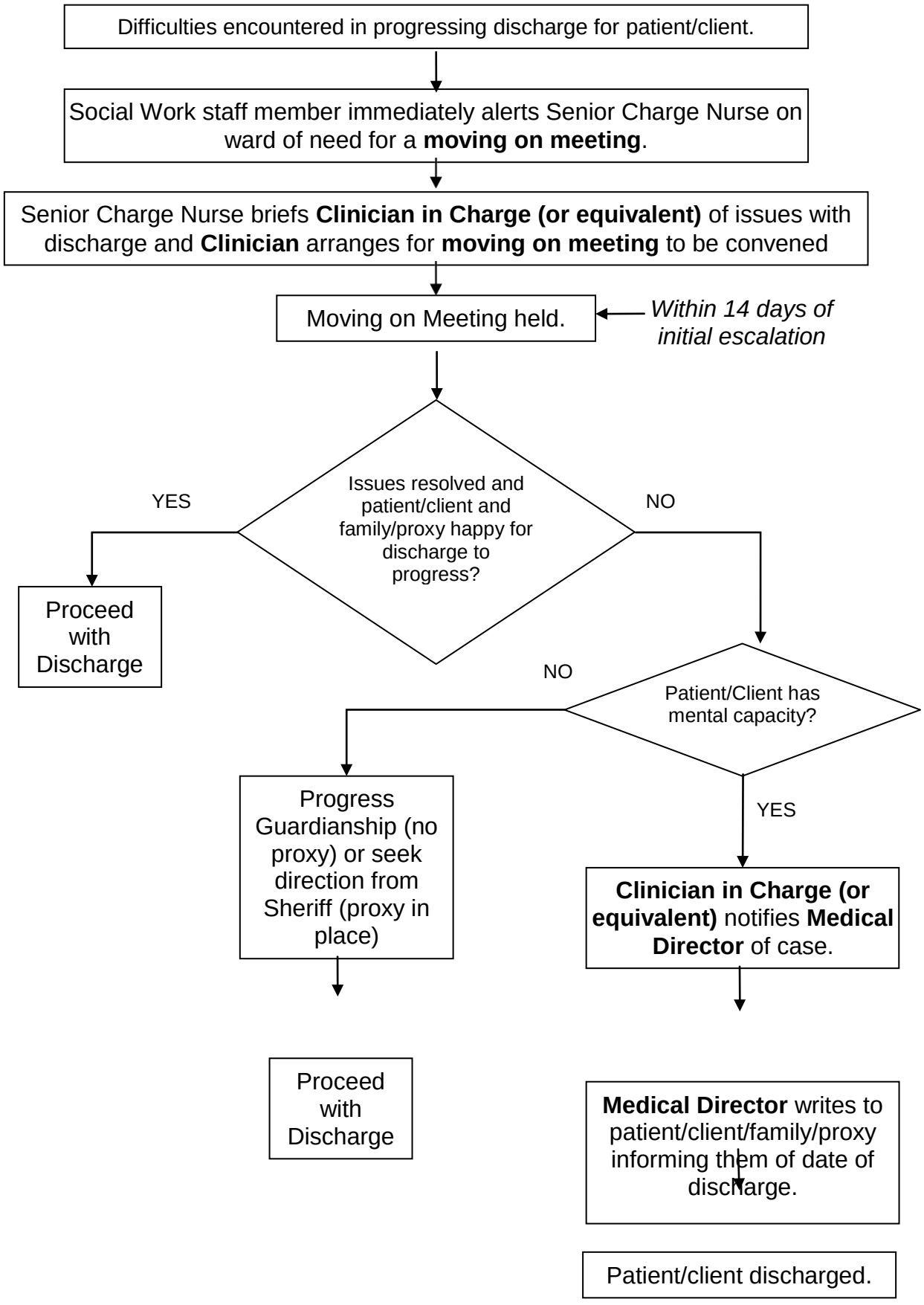
b. In all other cases, where the patient/client has capacity, the **Clinician in Charge (or equivalent)** will refer the matter to the **Medical Director** responsible for the hospital in question. The **Medical Director** will then write to the patient/client/family informing them of the date they will be discharged from NHS hospital care – a template letter is contained in Appendix 4. [The **Medical Director** will issue the letter within 7 days of the moving on meeting].

4.15 The patient/client will be discharged on the date specified on the Medical Director's letter.

4.16 In exceptional cases where all other avenues have been exhausted, as per the

2013 CEL 32 guidance, the Health Board can choose, as a last resort, to seek enforcement of the discharge through the courts.

4.17 The flowchart below shows how the process should operate.



5. Patients/Clients Who Lack Capacity to Make Decisions Regarding Their Welfare Including Care Arrangements

5.1 It should be noted that there are many complexities, both legal and ethical, in relation to progressing discharges for patients/clients who lack welfare capacity. This 'moving on' policy does not attempt to capture any of the intricacies or detailed considerations of discharging patients/clients who lack capacity. Rather this policy shows only the broad options for progressing discharge.

5.2 Staff are directed to the specific good practice guidance issued by the Scottish Government, "**Discharging Patients Who May Lack Capacity" (2014)**, which covers in some depth the complexities and challenges of this area of work.

5.3 In addition, each Partnership area within Grampian, (Aberdeen City, Aberdeenshire, and Moray), will have their own detailed operational procedures relating to the duties and responsibilities pertaining to the Adults with Incapacity (Scotland) Act 2000. These procedures should be followed by all relevant staff.

Patient lacks capacity and has no proxy decision-maker

5.4 If an incapable adult has no proxy with suitable powers, it may be necessary for someone to apply to the court for a guardianship order on the adult's behalf. **Social Work Staff** will take lead responsibility for progressing this – either via direct application to the courts or via liaison with a family that wishes to apply privately for proxy decision making powers for their family member.

5.5 Where a private application for Guardianship is being progressed, a realistic timescale for processing the application should be agreed with the family. Families should be given two weeks to commence the application process by contacting a solicitor. If this is not adhered to the Local Authority may consider applying for Guardianship itself.

Patient lacks capacity and has a proxy decision-maker

5.6 When a proxy is making decisions on someone's behalf they must follow the principles laid down by the Adults with Incapacity Act.

5.7 A proxy's power does not extend to insisting that the patient remains indefinitely in hospital, once they are clinically ready for discharge. In situations where a proxy refuses to agree to discharging the patient, on grounds of choice, they should be reminded of the principles of the AWI legislation, and their duty to follow them. If the disagreement continues, they should be informed of their right and the Local Authority's right to seek direction from the Sheriff and Office of Public Guardianship.

5.8 The AWI Act states that "On application by any person (including the adult himself) claiming an interest in the property, financial affairs or personal welfare of an adult, the sheriff may give such directions to any person exercising functions conferred by this Act" [Section 3(3) of the Adults with Incapacity (Scotland) Act 2000].

5.9 This means that any individual involved in patient's care can apply to the Sheriff at any time for direction on the decision to discharge the patient/client. For professionals this would involve their agreed pathway.

5.10 Any decisions on which professionals may seek a direction from a Sheriff will be on a case-by-case basis, based on the particular circumstances of a situation.

6 Glossary

CEL 32	The “Chief Executive’s Letter” issued in 2013 giving updated national guidance to Health Boards and Local Authorities on the process for choosing care homes from hospital.
Care Home	A service registered with the Care Inspectorate that provides accommodation which includes nursing care, personal care or personal support to adults.
Care at Home	A service (normally registered with the Care Inspectorate) that provides personal care or personal support to an adult in their own home.
Carer	A carer is someone of any age who provides unpaid support to family or friends who could not manage without this help. This could be caring for a relative, partner or friend who is ill, frail, disabled or has mental health or substance misuse problems.
Delayed Discharge	A hospital inpatient who is clinically ready for discharge from inpatient hospital care and who continues to occupy a hospital bed beyond the ready for discharge date.
Family	Family member of a patient/client.
Interim Placement	A time limited housing or care setting that appropriately meets the assessed needs of a patient/client whilst they await the availability of their housing/care setting of choice.
Intermediate care	Intermediate care is an ‘umbrella’ term describing an approach involving a collection of services that provide a set of ‘bridges’ at key points of transition in someone’s life. i.e. from hospital to home; from illness/injury to recovery etc.
Medically Fit for Discharge	An individual is “medically fit” when the responsible consultant or other authorised individual agrees in conjunction with multi-disciplinary colleagues that the patient is clinically fit to leave hospital care.
Multidisciplinary Team	A group of professionals from one or more disciplines who together make decisions regarding recommended care and treatment of an individual.
Patients/Clients	Hospital in-patient in receipt of healthcare/social work/Occupational Therapy or Housing interventions/support.

Proxy	An individual with ‘legal proxy’ decision making powers for a patient/client. These are powers normally granted under the auspices of the Adults with Incapacity (Scotland) Act 2000.

7 References

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Mudge AM, O'Rourke P, Denaro CP. Timing and risk factors for functional changes associated with medical hospitalization in older patients. J Gerontol A Biol Sci Med Sci. 2010;65:866–72

CEL 32 (2013) GUIDANCE ON CHOOSING A CARE HOME ON DISCHARGE FROM HOSPITAL. http://www.sehd.scot.nhs.uk/mels/CEL2013_32.pdf

GOOD PRACTICE GUIDE: DISCHARGING PATIENTS WHO LACK CAPACITY (2014). http://www2.gov.scot/Resource/0045/00454245.pdf

8 Distribution list

This policy will be made available to all staff in NHS Grampian, Aberdeen City Health and Social Care Partnership, Aberdeenshire Health and Social Care Partnership and Moray Health and Social Care Partnership.

Appendix 1 – Development Group

Name	Role	Organisation
Fiona Abbott	**Community Hospitals Manager**	**Moray HandSCP**
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Susan Duncan	**Older Person Assessment and Liaison Nurse**	**NHS Grampian**
Alison Knight	**Community Health in Partnership (CHiP) Manager**	**Aberdeenshire Voluntary Action**
Anne Munro	**Flow Coordinator**	**NHS Grampian**
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Caroline Thom	**Senior Care Manager**	**Aberdeen City H&SCP**
Beth Thomson	**Lead Occupational Therapist**	**Aberdeen City H&SCP**

Review Group
Discharge Expert Group June 2021

Appendix 2 – Template Letter Inviting Individual to a "Moving On" Meeting

Date:

Dear

I am aware that my colleagues have recently had discussions with you about arrangements for you/your relative leaving hospital.

Prolonged hospital stays once an individual is fit to be discharged can be very detrimental to their health and wellbeing. As a result, it is always our intention that patients' that no longer require the treatment and facilities of a hospital should be discharged as soon as possible, either to their own home or to an appropriate care setting.

On *(date) (clinician name)* decided that you/your relative *(name)* was well enough to be discharged to *(location),* where you/he/she will receive the care that is most appropriate for your/his/her needs. I am also aware that you do not agree with this decision.

In line with our discharge choice policy, the staff involved in this decision, including myself, will arrange to meet with you, to explain fully the course of action proposed. You can choose to be accompanied and supported by a family member, friend or an advocate.

A vital part of this process is to help us understand why you do not agree with the proposals. The team will listen to the reasons for your objections and will work with you and your family to reach a positive and acceptable outcome.

Please be assured that we would not ask you/your relative *(name)* to move if we were not certain that you/he/she are fit enough and that it would be in your/his/her best interests to do so.

I look forward to meeting with you soon.

Yours sincerely

Clinician in Charge (or equivalent) of Patients Care

Appendix 3 – Template Letter Confirming Outcome of "Moving On" Meeting

Date:

Dear

A meeting took place on [INSERT DATE] to discuss progress in discharge planning for you/your relative. Following this discussion the consensus of all members of the multidisciplinary team was that that [you/your relative] are now ready to be discharged from inpatient hospital care and that an appropriate [care/housing] setting is available for you at [INSERT DETAILS OF PLACEMENT].

It will therefore be our intention to discharge [you/your relative] from NHS hospital care. A member of the multidisciplinary team will be in contact imminently to confirm the date of discharge.

If you are unhappy with the decision of the moving on meeting, you can give feedback through the formal NHS Complaints process. Please note this will not delay the discharge date but will enable your concerns to be investigated. Please submit your response as soon as possible to:

Feedback Service
NHS Grampian
Summerfield House
Eday Road
ABERDEEN
AB15 6RE
e-mail: nhsgrampian.feedback@nhs.net

I hope that the content of this letter is clear and that we can work together to obtain a positive outcome. If however you have any questions please feel free to contact me using the details above.

Chair of Moving on Meeting

Appendix 4 – Template Letter from Medical Director Confirming Decision to Discharge

Date:

Dear

In line with our discharge choice policy, staff involved with the care of you/your relative met with you on (date) to explain why [you/your relative] was now well enough to be discharged from hospital.

Following this meeting, I am writing to confirm that you/your relative will be discharged from NHS hospital care on [insert agreed date].

An appropriate placement where you/your relative will receive care and support has been made available at [insert name of care home/interim resource].

Yours sincerely

Medical Director