Essex Partnership University
NHS Foundation Trust

ESTIMATED TREATMENT DURATION AND DISCHARGE DATE PROTOCOL

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The Director responsible for monitoring and reviewing this policy is:

The Director of Specialist Services

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

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CONTENTS	
Title	**Section No.**
Introduction	**1.0**
Purpose	**2.0**
Objectives	**3.0**
Reference to other Trust policies/procedures	**4.0**
Review and Monitoring	**5.0**
Administrative Management of the Referral Meeting and Information Governance	**6.0**
Derivation of Estimated Treatment Duration (ETD) and Estimated Date of Discharge (EDD).	**7.0**
Calculation of Average Length of Stay (ALOS)	**8.0**
Discharge Planning	**9.0**
Reviews	**10.0**
Monitoring Delays in Discharges	**11.0**
Key Principles	**12.0**
Monitoring of Compliance	**13.0**
APPENDICES	
CQUIN Discharge and Resettlement Definitions	**Appendix 1**
EDD Letter	**Appendix 2**
Revised EDD Letter	**Appendix 3**

SCOPE

Services	Applicable	Comments
Essex	✓	
Luton and Bedfordshire	✓	

ESTIMATED TREATMENT DURATION AND DISCHARGE DATE PROTOCOL

1.0 INTRODUCTION

1.1 The Estimated Treatment Duration (ETD) and Discharge Date (EDD) Protocol for Secure Services supports the bed planning and service development requirements of the East of England Secure Mental Health Services Provider Collaborative (Specialised Commissioning for NHS England and NHS Improvement).

1.2 For the purposes of this policy, the definition of Average Length of Stay (ALOS) and a successful discharge can be found in the MH4 '17/'19 PSS CQUIN Discharge and Resettlement Definitions document (Appendix 1).

2.0 PURPOSE

2.1 Delays in patients' discharge impact significantly and adversely on patient quality of life and upon the availability of specialized inpatient beds for patients on admission waiting lists. Nationally, specialized mental health services are experiencing ongoing capacity and demand pressures for inpatient beds.

2.2 This protocol is appended to the process of admission to Secure Services as detailed in Secure Services Protocols SSOP2 and 3 (Patient Admission and Patient Assessment).

2.3 This protocol sets out the involvement of the patient and his/her MDT at each stage in the reviewing of the ETD (and EDD). This enables the patient and their family or care provider to plan for his/her discharge at the earliest possible point once all treatment outcomes have been met.

3.0 OBJECTIVES

3.1 The EPUT Secure Mental Health Services provides admission, assessment, treatment, rehabilitation and discharge services to specific groups of patients who require these in a setting of medium or low security. Brockfield House provides both medium and low secure wards, Robin Pinto Unit in Bedfordshire and Edward House in North Essex provides low secure beds and Wood Lea clinic provides a low secure facility for patients with learning difficulties.

3.2 This protocol sets out Secure Services agreed standards for safe, effective and timely discharge of inpatients. It provides a framework which aims to:

- Improve the service users' experience and expectation in regards to anticipated discharge dates and length of stay
- Deliver changes to practice across the management of the whole pathway based on care pathway review of each of the phases of the care pathway; assessment/active treatment and discharge planning including management of leave, where relevant
- Improve capacity and access for individuals who need a specialised inpatient mental health bed through the reduction of average length of stay, specifically targeting cases with significantly longer length of stay and/or blockages to discharge.
- Reduce out of area placements due to improved throughput of patients within in-patient specialised mental health services
- Improve access to beds which are geographically closer to the patient's home
- Increase productivity and reduction in cost of individual patient care episodes by reduced length of stay and completed episodes of care.

As part of this protocol providers will be expected to:

- Establish a system for specifying and recording estimated treatment durations (and discharge dates) for all admissions, and informing the service-user,
- Create a system to plan discharges in advance by reference to Care Programme Approach (CPA) reviews and Care and Treatment Reviews (CTR),
- Create a system to review each delay where it arises

4.0 REFERENCE TO OTHER TRUST POLICIES/PROCEDURES

- Record Management - CP9
- CPA Policy - CLP 30
- SSOP 3 – Patient Assessment – Secure Services
- SSOP 2 - Admission Policy – Secure Services
- SSOP 9 -Discharge Policy – Secure Services

5.0 REVIEW AND MONITORING

5.1 This protocol is applicable to all patients admitted into the care of the EPUT Secure Services.

- It is the responsibility of the Responsible Clinician, Ward charge nurses / ward sisters and Integrated Clinical Leads, to ensure that the protocol is followed.

- No changes to this protocol shall be undertaken without the authorisation of the Secure Services Policy Group and the Secure Services Senior Managers Group.
- This protocol will be reviewed periodically by the Secure Services Policy Group. Ward sisters and charge nurses are responsible for ensuring that this protocol is carried out on their respective wards.

6.0 DERIVATION OF ESTIMATED TREATMENT DURATION (ETD) AND ESTIMATED DATE OF DISCHARGE (EDD)

6.1 The patient's RC, in collaboration with the MDT and the patient, will derive an **Estimated Treatment Duration (ETD) and Estimated Date of Discharge (EDD)** for each individual patient within the first 12 weeks of admission, in accordance with the specification in the CQUIN Scheme Guidance for Year 1, Trigger 1. To estimate ETD and EDD all members of the MDT will have completed their basic assessments and formulated the treatment pathway and its components that the patient will need to complete whilst an in-patient within the secure services. This ETD will be derived both from the clinical assessment of the patient's mental health (and associated) problems as well as by review of the risks that will need to be reduced before the patient will be in a favourable position for discharge by the Secretary of State or a Mental Health Tribunal / Parole Board or by the RC (where applicable) following successful treatment, rehabilitation and recovery.

6.2 A successful discharge is defined as a movement of a patient out of a specialised mental health ward to either a specialised mental health ward of a lower security level (e.g. medium to low secure) or out of specialised mental health services altogether. Examples of a successful discharge are as follows:

- Movement of a patient from Medium / Low Secure Care to an Adult Acute Ward.
- Movement of a patient from Medium Secure Care to Low Secure Care in the same site (e.g transfer between wards at Brockfield House).
- Transfer from Brockfield House Medium Secure wards to Edward House/Robin Pinto Unit (Low Secure)
- Discharge from secure hospital back to prison
- Discharge from secure hospital direct to the community.

However, if, within 90 days, a patient who has been discharged from hospital (or stepped down to a lower level of security) is subsequently re-admitted to hospital (or transferred back to a higher level of security), then that discharge will not count as a successful one for the purposes of this protocol.

6.3 The estimation of ETD will also take into account the **Average Length of Stay (ALOS**) of patients admitted to the service (see below). This metric is a

measure of patient 'turnover' and reflects the type, risks and complexity of patients admitted to the service, as well as the average time taken for treatment, recovery and discharge / step-down.

6.4 From the ETD an **Estimated Date of Discharge** (EDD) may be derived following the patient's admission which will be communicated to the patient in writing (see Appendix 2) and recorded on the referrals' spreadsheet. The estimated treatment duration (and consequently estimated date of discharge) will be reviewed at every CPA as a minimum and upon transfer from a medium secure to a low secure ward within the service. If the EDD is altered this must be communicated to the patient in writing (See Appendix 3) and recorded on the referrals' spreadsheet. Where an estimated treatment duration cannot be ascertained for sound clinical reasons, or where the RC considers that disclosure of the estimated treatment duration to the patient would result in his or her mental states deterioration, this should be set out and agreed with the NHS England Mental Health case manager.

7.0 CALCULATION OF AVERAGE LENGTH OF STAY (ALOS)

7.1 The calculation of **Average Length of stay (ALOS)** will be based on the number of available bed days in the unit during a given period, divided by the number of patient discharges over the same period.

7.2 The number of available bed days is calculated as the number of commissioned beds multiplied by the number of calendar days in the period and by the percentage occupancy agreed in the commissioning contract.

- For example, a 10 bedded unit with an occupancy rate of 90% for a year will have 365 x 10 x 0.9 = 3,285 available bed days per year. Alternatively, if the same unit has a planned 100% occupancy, the available bed days will be 3,650.

  In the example of a 10 bedded unit with 100% planned occupancy, if 10 patients are discharged in a year, the average length of stay (ALOS) will be 365 x 10 x 100%/10 = **365 days**. This is logical because if 10 patients are discharged from a 10 bedded unit in a year, it has effectively taken 365 days to clear all of the beds once. Calculation of the ALOS for a service (or for a ward within a service) will assist providers in the calculation of ETD (and EDD) although there will be very wide variation for individual patients around this mean - depending on a host of individual factors.

8.0 DISCHARGE PLANNING

8.1 All preparations for discharge must be considered within the first twelve weeks of admission.

8.2 Community Teams should be encouraged not take a step back upon admission but should continue to be involved with the patient pathway, particularly discharge planning, from admission.

Discharging into the community

8.3 Discussions with the patient must include where the patient wishes to reside when discharged to the community in order that their wishes can be met if appropriate and possible to do so.

8.4 Patient expectations must continually be managed in order to ensure they know what to expect when asked to accept accommodation proposals.

8.5 Links with the responsible Local Authority should be made as early as possible in order to ensure responsibility is agreed prior to discharge.

8.6 Links should be made with Housing Authorities as early as possible in order to ensure suitable accommodation is secured prior to discharge.

8.7 If the date of discharge is likely to be delayed due to key domestic items being unavailable (such as a cooker, fridge or washing machine etc.), the item/s can be purchased from the *Essential Living Fund* for patients where s117 responsibilities are held by Essex, Thurrock or Southend.

9.0 REVIEWS

9.1 An initial CPA should be scheduled within three months of all patients' admission and every six months thereafter (in accordance with Best Practice Standards for MSU and LSU services). A full multi-disciplinary and comprehensive assessment must be completed before the first CPA review. The RC, in discussion with the MDT and the patient (and where appropriate their carers/families) will provide an Estimated Treatment Duration (and therefore EDD). This will be communicated to the patient in writing following this initial CPA review **(see Appendix 2 letter)**. The patient information leaflet will also include information about the Estimated Treatment Duration.

9.2 ETDs will be reviewed regularly at CPA's or ward rounds as relevant. A change in a patient's ETD (and EDD) due to clinical reasons (such as the patient's failure to participate in treatment or the persistence or recurrence of risk factors) should be clearly communicated by the Consultant to the patient in writing (**see Appendix 3 letter**) and to the SCFT Care Co-Ordinator, where the SCFT is involved.

9.3 Where there is an indication that the Estimated Treatment Duration will need to be changed or extended, this must be communicated to the patient and where relevant, their families/carers, with specific reasons or causes for the extension. This may be due to complications or setbacks in the patient's treatment pathway or external factors, beyond the control of the patient or

MDT, such as delayed discharge funding or MOJ processes. The Case Manager must be informed of all extended EDD and the reasons for these delays.

9.4 Where a patient (or their carers) disputes the Estimated Duration of Treatment and Discharge Date (EDD) this can be managed via the Tribunal/Hospital Manager's appeals or a referral to advocacy services.

10.0 MONITORING DELAYS IN DISCHARGES

10.1 Monitoring and regular reviewing of the ETD (and EDD) will help improve the patient's journey and experience by involving the patient in their own treatment, recovery and discharge – encouraging them to become an active participant in their own recovery and risk reduction.

10.2 A patient will be classed as a 'delayed discharge' once it is agreed at a CPA that the patient is clinically and legally ready for discharge but there are recognised delays outside the control of the patient or their MDT.

10.3 All delayed discharges must be reported to the relevant MH Case Managers, with an outline of reasons for the delay and what actions are proposed to facilitate discharge.

11.0 KEY PRINCIPLES

Principle 1: ETD will be set by the patients Consultant (RC) in partnership with the MDT, the patient and, where appropriate, the patient's family/carers.

Principle 2: An EDD will reflect when the patient is expected to be clinically and legally ready for discharge.

Principle 3: Patients and their families, or care providers, will be informed of the initial EDD and involved in subsequent reviews to their EDD.

Principle 4: ETDs must be calculated early in the patient journey. All patients must have their EDD communicated to them, in writing, within 12 weeks of their admission.

Principle 5: ETDs must be reviewed at every CPA or, if appropriate, at ward rounds.

Principle 6: ETD will be incorporated within the patient's Care Plans and will reflect the clinical assessments of progress by the MDT members measured against the patient's treatment targets and expected outcomes.

12.0 MONITORING OF COMPLIANCE

12.1 Compliance with this protocol will be evidenced to the NHS Commissioners. An audit tool will be developed by the medical and clinical leads for secure services to assess this compliance.

END