

Managing Complex Discharge:

Supporting patients choices to avoid long hospital stays

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MANAGING COMPLEX DISCHARGE POLICY: SUPPORTING PATIENTS' CHOICES TO AVOID DELAYED DISCHARGE

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Promoting equality and addressing health inequalities are at the heart of our values. Throughout the development of the policies and processes cited in this document, we have:

- Given due regard to the need to eliminate discrimination, harassment and victimisation, to advance equality of opportunity, and to foster good relations between people who share a relevant protected characteristic (as cited under the equality act 2010) and those who do not share it; and
- Given regard to the need to reduce inequalities between patients in access to, and outcomes from healthcare services and to ensure services are provided in an integrated way where this might reduce health inequalities

CONTENTS

CONTENTS.....	3
1. INTRODUCTION.....	4
2. PURPOSE.....	5
3. PRINCIPLES.....	5
SUPPORTING PEOPLE TO MAKE DECISIONS	5
TIMELY DISCHARGE FROM ACUTE CARE	7
FUNDING ARRANGEMENTS	7
4. OVERVIEW OF PROCESS.....	8
STEP 1 – PROVIDING STANDARD INFORMATION AND SUPPORT	9
STEP 2 – ASSESSING NEED	10
STEP 3 – PREPARING FOR DISCHARGE	11
STEP 4 – FIVE DAY WINDOW.....	13
STEP 5 – INTERIM PACKAGES AND PLACEMENTS	13
STEP 6 – ESCALATION PROCESS	15
5. MENTAL CAPACITY.....	16
6. CONSULTATION AND APPROVAL PROCESS	16
7. REVIEW, REVISION.....	17
8. MONITORING COMPLIANCE AND EFFECTIVENESS.....	17
APPENDIX 1: GLOSSARY.....	18
APPENDIX 2: HOSPITAL DISCHARGE AND MENTAL CAPACITY ISSUES.....	19
APPENDIX 3: SUMMARY OF LEGAL RESPONSIBILITIES AND RIGHTS.....	21
APPENDIX 4: SUPPORTING TEMPLATE FACTSHEET AND LETTERS	24
FACTSHEET A: The Assessment and Discharge Process	24
CHOICE LETTER B1	26
CHOICE LETTER B2	27
CHOICE LETTER B3	28
CHOICE LETTER B4	29
CHOICE LETTER C1	30
CHOICE LETTER C2	32
CHOICE LETTER C3	34
CHOICE LETTER C4	36
CHOICE LETTER D	38
APPENDIX 5: TRUSTED PROFESSIONAL MODEL	39

1. INTRODUCTION

- 1.1. This policy supports people's timely, effective discharge from an NHS inpatient setting, to a setting which meets their diverse needs and is their preferred choice amongst available options. It applies to all adult inpatients in Southampton City and West Hampshire NHS provider settings (West Hampshire CCG, Southampton City CCG, Solent NHS Trust, Southern Health NHS Foundation Trust, University Hospital Southampton Foundation Trust, Southampton City Council (SCC) and Hampshire County Council (HCC)), and needs to be utilised before and during admission to ensure that those who are assessed as medically fit for discharge can leave hospital in a safe and timely way.
- 1.2. This policy supports existing guidance on effective discharge, such as the 2015 NICE guidance 'Transition between inpatient hospital settings and community or care home settings for adults with social care needs'¹, and is based on existing good practice.
- 1.3. The consequences of a patient² who is ready for discharge remaining in a hospital bed might include:
- Exposure to an unnecessary risk of hospital acquired infection³;
 - Physical decline and loss of mobility / muscle use⁴;
 - Frustration and distress to the patient and relatives due to uncertainty during any wait for a preferred choice to become available;
 - Increased patient dependence, as the hospital environment is not designed to meet the needs of people who are medically fit for discharge⁵;
 - Severely ill patients being unable to access services due to beds being occupied by patients who are medically fit for discharge.
- 1.4. Patients and families can find it difficult to make decisions and/or make the practical arrangements for a range of reasons, such as:
- A lack of knowledge about the options and how services and systems work;
 - Concerns about either the quality or the cost of care;
 - Feeling that they have insufficient information and support;
 - There is uncertainty or conflict about who will cover costs of care;
 - Concerns about moving into interim accommodation and then moving again at a later stage
 - The choices available do not meet the patient's preferences
 - Concerns that their existing home is unsuitable, cold or needs work done to ensure a safe environment for discharge
 - Worry about expectations of what family and carers can and will do to support them.

¹ <https://www.nice.org.uk/guidance/ng27>

² The term 'patient' is used throughout this policy to refer to the individual receiving treatment

³ Hassan, M. et al, 2010. *Hospital length of stay and probability of acquiring infection*. International Journal of Pharmaceutical and Healthcare Marketing. 4(4):324-338.

⁴ Kortebein, P. et al (2008). *Functional impact of 10 days of bed rest in healthy older adults*. J Gerontol A Biol Sci Med Sci. 63(10):1076-81.

⁵ Monk, A. et al. 2006. *Towards a practical framework for managing the risks of selecting technology to support independent living*. Applied Ergonomics, Vol.37(5).

- 1.5. The principles of the 6Cs⁶ should be applied to this process – care, compassion, competence, communication, courage and commitment.

2. PURPOSE

- 2.1. The purpose of this policy is to ensure that choice is managed sensitively and consistently throughout the discharge planning process, and people are provided with effective information and support to make a choice.
- 2.2. This policy sets out a framework to ensure that NHS inpatient beds will be used appropriately and efficiently for those people who require inpatient care, and that a clear escalation process is in place for when patients remain in hospital longer than is clinically required.
- 2.3. Where the patient lacks capacity to make⁷ decisions about discharge from hospital, then the application of the policy should be adapted as explained in Appendix 2, following the Mental Capacity Act 2005.
- 2.4. When implemented consistently, this policy should reduce the number and length of delayed discharges and result in patients being successfully transferred to services or support arrangements where their needs for health and care support can be met. Ultimately it aims to improve outcomes for patients.
- 2.5. This policy includes patients with very complex care needs, who may have been in hospital for many months or years, and people at the end of life.

3. PRINCIPLES

SUPPORTING PEOPLE TO MAKE DECISIONS

- 3.1. Patients should not be expected to make decisions about their long-term future while in hospital; home care, reablement or intermediate care or other supportive options should be explored first, where that is appropriate to their needs.
- 3.2. Where it is what the patient wants and where appropriate, all possible efforts should be made to support people to return to their homes instead of residential placements, with options around home care packages and housing adaptations considered.
- 3.3. People should be provided with high quality information, advice and support in a form that is accessible to them⁸, as early as possible before or on

⁶ <https://www.england.nhs.uk/nursingvision/compassion/>

⁷ Due to their difficulty understanding, retaining or using information given, or in communicating their views, wishes or feelings, as a result of a disturbance or impairment in the functioning of the mind or brain, as set out in the Mental Capacity Act 2005

admission and throughout their stay, to enable effective participation in the discharge process and in making an informed choice.

- 3.4. Patients should be involved in all decisions about their care, as per the NHS Constitution, and should be provided with high quality support and information in order to participate, where possible. In the context of a discharge decision, the information relevant to the decision will include an understanding of their care needs on discharge, the process and outcome of the assessment of needs, offers of care and options available.
- 3.5. Where it is identified that the patient requires a needs assessment under the Care Act 2014, but would have substantial difficulty in engaging in the assessment and care planning process, the local authority must consider whether there is anyone appropriate who can support the individual to be fully involved. If there is not then the local authority must arrange for an independent Care Act advocate.
- 3.6. Many patients will want to involve others to support them, such as family or friends, carers or others. Where the patient has capacity to make their own decisions about confidentiality and information sharing, confidential information about the patient should only be shared with those others with the patient's consent.
- 3.7. Where the patient has been assessed as lacking capacity in this respect, information may be shared in his or her best interests in accordance with requirements set out in the Mental Capacity Act 2005 Code of Practice and Appendix 2 of this document.⁹
- 3.8. Where someone is providing care or considering providing care post-discharge, unpaid as a carer, they must be informed and invited to be involved in the discharge process and informed about their rights and sources of support. People have a choice about whether or not to provide care for other adults and people must be informed about their choices when establishing whether they are willing and able to provide care.
- 3.9. Carers must be offered the information, training and support they need to provide care following discharge¹⁰, including a carer's assessment.
- 3.10. The process of offering choice of care provider and/or discharge destination will be followed in a fair and consistent way and there will be an audit trail of choices offered to people.
- 3.11. Interactions with patients will acknowledge and offer support to address any concerns.
- 3.12. If a patient is not willing to accept any of the available, appropriate alternatives, then it may be that they are discharged, after having had

⁸ Equality Act 2010 and Human Rights Act 1998, regarding disability and heritage languages; [Accessible Information Standard](#) to be introduced in July 2016

⁹ Mental Capacity Act 2005 Code of Practice available at:

<https://www.gov.uk/government/publications/mental-capacity-act-code-of-practice>

¹⁰ Care Act 2014 s10

appropriate warning of the risks and consequences of doing so. This option would only be pursued following the offer and rejection of available, appropriate options of care and appropriate safeguards and risk assessments (see section 4.50). For patients who may lack capacity to make their own discharge decisions, see Appendix 2.

TIMELY DISCHARGE FROM ACUTE CARE

- 3.13. If a patient is medically fit for discharge, it is not suitable that they remain in hospital due to the negative impact this can have on their health outcomes.
- 3.14. Patients do not have the right to remain in hospital longer than required¹¹.
- 3.15. Except where a patient with the relevant capacity has made an informed decision to discharge himself/herself against the advice of health or social care professionals, the discharge process must not put the patient or their carers at risk of harm or that could breach their right to respect for private life. It should not create a situation whereby the independence of the carer or the sustainability of their caring role is jeopardised.
- 3.16. Planning for effective transfer of care, in collaboration with the patient and/or representatives and all Multi-Disciplinary Team (MDT) members, should be commenced at or before admission, or as soon as possible after an emergency admission. The SAFER patient flow bundle¹² should be applied to support timely discharge.
- 3.17. The process and timelines within this policy should be clearly communicated to the patient so that by the time a patient is medically fit for discharge they are aware of and understand the discharge process, the decisions and actions that they may need to undertake and the support they will receive.
- 3.18. If a patient's preferred care placement or package on discharge is not available when they become medically fit for discharge, an available alternative which is appropriate to their health and care needs will be offered on an interim basis, whilst they await availability of their preferred choice.

FUNDING ARRANGEMENTS

- 3.19. This policy applies equally to people regardless of the funding arrangements and the nature of their ongoing care.
- 3.20. Those self-funding care will be offered the same level of advice, guidance and assistance regarding choice¹³ as those fully or partly funded by their local

¹¹ *Barnet PCT v X* [2006] EWHC 787. A patient has no right to demand / the NHS has no obligation to provide something not clinically indicated, (*R (Burke) v GMC* [2005] EWCA Civ 1003), including provision of an inpatient bed and a patient who lacks mental capacity for the relevant decisions has no greater right to demand this (*Aintree University Hospitals NHS Foundation Trust v James* [2013] UKSC 67).

¹² <http://www.fabnhsstuff.net/2015/08/26/the-safer-patient-flow-bundle>

¹³ Care Act 2014 s4

authority or NHS Continuing Healthcare (CHC), although it is likely that some of the content will need to differ.

3.21. A full assessment for NHS CHC should only be undertaken where the longer-term needs of the individual are clear.

4. OVERVIEW OF PROCESS

<p>Step 1 - Providing standard information and support (DO, SDO, OPP, NIC)</p>	<ul style="list-style-type: none"> • Start discussions about discharge with patient before or as soon as possible after admission • Determine whether the patient has mental capacity and if not, put in place appropriate measures (see Appendix 2) • Identify discharge coordinator, and other people who have the patient's consent to be involved in discussions and decisions, e.g. carers, relatives • Provide Factsheet A
<p>Step 2 - Assessing need (WARD TEAMS, IDB)</p>	<ul style="list-style-type: none"> • Refer patient and any carers to required health and care services when they are ready to have their needs assessed for discharge • Access this via the Integrated Discharge Bureau (IDB) • Ensure assessments to clarify care needs and carers' needs are completed
<p>Step 3 - Preparing for discharge (DO, SDO, OPP, NIC)</p>	<ul style="list-style-type: none"> • Discuss available and appropriate options with patient • Refer to support services and/or advocacy, as required • Explain the decision-making process, including how to appeal any decisions, to the patient and advise that the hospital will expect discharge within the five day window • Provide Letter B and tailored information on options which are suitable to meet assessed needs and available funding
<p>Step 4 - Five day window (SDO, Ward Leader)</p>	<ul style="list-style-type: none"> • Initiates upon provision of Letter B and information on choices to patient, in advance of the estimated discharge date • Allow up to five consecutive days for the patient to consider their available options • Support the patient to make a decision, respond to concerns and offer advice, support and encouragement
<p>Step 5 - Interim placements and packages (MDT, SDO, Ward Leader)</p>	<ul style="list-style-type: none"> • If decision and/or discharge has not been achieved with five consecutive days, MDT to liaise with patient and arrange the offer of an interim placement or package which meets assessed needs • Advise the patient that an interim arrangement for a given length of time is offered with a proposed date for discharge. Details should be provided of how interim funding arrangements relate to funding of subsequent care. • Give appropriate version of Letter C and offer further support
<p>Step 6 - Escalation (Complex DC Manager, IDB OPS Manager, CGM, Clinical Lead, Matron)</p>	<ul style="list-style-type: none"> • If no agreement has been reached regarding discharge, and/or transfer arrangements are challenged, senior staff to hold formal meeting (step 6 mtg) with patient to understand and resolve issues and reiterate policy • Letter D to be sent following formal meeting or if patient does not engage in formal meeting [note: this applies where reasonable options have been rejected and there are no ground to challenge] • Consult local legal advisors, if necessary
<p>Step 7 - Legal (Exec team and Legal)</p>	<ul style="list-style-type: none"> • If no agreement after formal meeting; escalated to the Executive team and a decision will be made as to whether legal advice is required to progress compulsory discharge

STEP 1 – PROVIDING STANDARD INFORMATION AND SUPPORT

- 4.1. A discharge coordinator¹⁴ will be identified for each patient and they will explain the discharge planning process to the patient on admission. In Step 1, the UHS the discharge coordinator will be the Discharge Officer (DO) or Senior Discharge Officer (SDO) where one exists, or the Older Person's Practitioner (OPP). Where neither of these roles exists the discharge coordinator will be the nurse in charge.
- 4.2. Factsheet A should be given to and discussed with the patient.
- 4.3. The discharge coordinator will ensure that the patient is aware of this policy and of the circumstances in which an interim placement or package might be necessary. All communication will clearly set out the process that the hospital will follow in order to work towards the patient's safe and timely discharge when their need for inpatient treatment ends. It should be made clear that they will receive advice and support in making a decision¹⁵.
- 4.4. All patients will be given an Estimated Date of Discharge (EDD) as soon as possible after admission by a consultant or senior clinician. Regular review and discussion about the EDD as part of daily 'board rounds'¹⁶ will ensure all parties understand when support will be required to facilitate discharge. For patients with a length of stay of less than 2 days, it is also appropriate to plan an expected time of discharge.
- 4.5. Patients should be involved in all decisions about their care¹⁷ and supported to do so, where necessary.
- 4.6. At this point, it should be clearly identified who else the patient wishes to be informed and/or involved in the discussions and decisions regarding discharge, and appropriate consent received (if the patient lacks capacity then other legal basis needs to be established – see Appendix 2). This can include, but is not limited to, any formal or informal carers, friends and family members.
- 4.7. The discharge coordinator will ensure that any carer(s) of the patient are identified and supported through the discharge process. This includes providing information on Carer's Assessments and support services and/or referrals to the relevant support services. Ensuring the carer has adequate support in place will reduce the risk of unnecessary readmission of the patient.

¹⁴ The term 'discharge coordinator' is used throughout this policy to refer to the named individual responsible for coordinating a patient's discharge – this could be a named nurse from the ward, a named social care professional from the local authority, an appropriate person from a voluntary sector organisation contracted to co-ordinate statutory services and act as patient advocate, or a named CHC health professional.

¹⁵ Care Act 2014 s4 Providing Information and Advice

¹⁶ A 'board round' is a rapid review of progress against the care plan, typically involving the consultant, the medical team, the ward manager and therapists (and sometimes a social worker). It is usually held by a wards 'at a glance' white board. The aim is to ensure that momentum is maintained and deteriorations identified and managed promptly.

¹⁷ NHS Constitution

STEP 2 – ASSESSING NEED

- 4.8. The likelihood of the patient and any carers needing health (including mental health) care, social care, housing, or other support after discharge will be considered as soon after admission as possible. The patient will join one of the 3 established support levels, see details below.
- 4.9. If the patient is likely to have ongoing health, housing or social care needs after discharge the discharge coordinator will ensure timely referral to these other services for assessment¹⁸. In Step 2 of this policy, the UHS discharge coordinator will be the Discharge Officer (DO) or Senior Discharge Officer (SDO) where one exists, or the Older Person's Practitioner (OPP). Where neither of these roles exists the discharge coordinator will be the nurse in charge. This assessment should be from a holistic and patient-centred perspective of a person's needs and the care and support options (support levels 2 and 3) may include, for example:
- Intermediate care (or step down care), either bed based or community based;
 - Social care assessment;
 - Community nursing services, including community matrons;
 - Reablement;
 - Short-term placement in a care home;
 - Care at home support package;
 - Financial assessment and benefits advice;
 - Eligibility for NHS Continuing Healthcare or Funded Nursing Care;
 - Home assessment for aids, adaptations and / or assistive technology;
 - Other local health, social or voluntary service.
- 4.10. All these services are coordinated via the IDB and accessed via Apex, on completion of an assessment notice (AN) by ward based/nursing staff, with the support from the IDB if needed. This is to be completed when the patient is medically optimised, as opposed to 'medically fit for discharge'. 'Medical optimisation' is the point at which care and assessment can safely be continued in a non-acute setting.
- 4.11. All registered UHS nursing staff have a responsibility to be gain competence and confidence with using Apex in order to ensure the majority of referrals are made without involvement of a Discharge Coordinator.
- 4.12. For patients who require a restart of an existing care package or return to placement, the UHS Trusted Professional model should be followed, see Appendix 5 (this is support level 1 patients).

¹⁸ Care Act 2014, s9 Assessment of an adult's need for care and support; NHS Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) Regulations 2012, reg 21

- 4.13. It should be made clear to the patients (and their carers, where appropriate) what the assessment in hospital is for, and what further assessments they can expect in the places they are transferred to.
- 4.14. Any carers of the patient should be advised of their rights to have a carers' assessment, with appropriate information and support, and referral to relevant support services.
- 4.15. Patients should be actively involved in the assessment process and in the development of care plans to enable full and effective assessments and support planning.
- 4.16. Patients should be informed of the rights they have to complain about an assessment or decisions about their need for support.

STEP 3 – PREPARING FOR DISCHARGE

- 4.17. Letter B (version dependent upon destination) will be prepared and given to the patient by the discharge coordinator. In Step 3, the UHS discharge coordinator will be the Discharge Officer (DO) or Senior Discharge Officer (SDO) where one exists, or the Older Person's Practitioner (OPP). Where neither of these roles exists the discharge coordinator will be the nurse in charge. The Discharge Coordinator will explain the process to the patient and ensure they are aware of all timelines and steps.
- 4.18. The prepared letter will be signed by the lead clinician.
- 4.19. Tailored information should be provided to the patient about the care options available to them, including details of costs. The conditions of funding for interim, intermediate and reablement places, (and the 12 week property disregard¹⁹ of fees for the circumstances when the patient transfers directly to a care home) should be made clear.
- 4.20. The patient will be referred to the relevant local authority adult social care team, or NHS Trust, in order to receive advice and support in making an informed choice, and to develop a person centred care and support plan which focuses on the individual's needs and preferences. This should include a discussion of the option of a personal budget [see 4.22].
- 4.21. The patient should be referred to Hampshire County Council and Southampton City Council for advice and information regarding advocacy, if required.²⁰
- 4.22. If the patient is assessed to have care needs after discharge, the discharge coordinator will advise the patient at the earliest appropriate opportunity about

¹⁹ [Certain circumstances](#) where the local authority should disregard a property from means testing for the first 12 weeks of being a permanent resident in a care home, when it is providing assistance with the placement

²⁰ Care Act 2014, s67 Involvement in Assessment, Plans etc

currently available care providers that can meet their needs and are registered with the Care Quality Commission (CQC). In some cases it is possible that there may be only one appropriate option, and the rationale for this must be explained.

- 4.23. If it is known that the placement / package is to be funded or provided by the NHS, Senior members of the UHS IDB staff and CHC team will advise the patient of their right to look at alternatives that fall within the criteria set by the CCG, based on their individual needs.
- 4.24. If it is known that the placement / package is to be funded by social services, Senior Practitioners from Hampshire County Council and Southampton City Council will advise the patient of their right to look at alternatives that fall within the criteria set by the local authority, based on their individual needs²¹, and the option to top-up. Particular consideration should be given to the timings within this policy to prevent breaches of local authority duties relating to discharge²².
- 4.25. If the patient is interested in taking up the offer of a personal budget (social care), personal health budgets (NHS) or integrated personal budgets, senior members of the UHS IDB, both health and social care staff, will advise them where to get information, who to contact locally and refer them to the lead locally.
- 4.26. Self-funders should be provided with the same level of information, advice and support as people whose care is being funded by the NHS or the local authority²³.
- 4.27. The discharge coordinator should discuss discharge plans with the patient regularly, in some cases this may be as often as daily conversations. The discharge coordinator will endeavour to meet the patient's wishes regarding specific concerns about the appropriateness of a temporary arrangement, if concerns are brought to their attention.
- 4.28. Patients should be informed of the rights they have to complain and provided with details of how to do so.
- 4.29. In order to minimise the need for patients to have recourse to formal complaints procedures, statutory agencies should make every effort to ensure that patients are involved in all stages of decisions that affect them, and that their agreement to such decisions is obtained.

²¹ Care Act 2014 s4 and s30; Care and Support and After-care (Choice of Accommodation) Regulations 2014

²² Care Act 2014 s3, and Care and Support (Discharge of Hospital Patients) Regulations 2014, SI 2014/2823

²³ Care Act 2014

STEP 4 – FIVE DAY WINDOW

- 4.30. Once step 3 is completed by giving appropriate information on packages of care or placements, resolving any disputes and giving Letter B to the patient, the expectation should be that the patient makes a decision about discharge as soon as possible and within 5 consecutive days, and either discharge has happened or arrangements are in place to do so.
- 4.31. If there are particular circumstances, such as an out of area transfer or safeguarding concerns, when it is unreasonable to expect a decision to be made within five days, a longer period may be agreed for an individual. At UHS, at Step 4 of this policy, this decision will be made by the Senior Discharge Officer or Matron and agreed with the relevant Care Group Manager.
- 4.32. Step 3 should be completed well in advance of the EDD, where possible, to prevent avoidable delays to discharge occurring, and in these circumstances more than five days can be given as a timescale to people to make arrangements. This is particularly the case with people whose care will be funded by the local authority to prevent breaches of their responsibilities for discharge²⁴.
- 4.33. Patients do not have the right to remain in hospital longer than required²⁵. However, they do have the right to respect for private life and not to be treated in an inhuman or degrading way. Therefore it is crucial for the hospital to ensure that the proposed transfer is appropriate and in line with human rights legislation.²⁶
- 4.34. The discharge coordinator will advise the patient that the hospital will expect discharge to be achieved within the agreed timescale. At UHS, at Step 4 of this policy, the discharge coordinator will be the Senior Discharge Officer (SDO) where one exists or the Matron.
- 4.35. Implementation of this policy does not impact on the measurement of delayed transfers of care, which should continue to be reported against the guidance laid out by NHS England²⁷.

STEP 5 – INTERIM PACKAGES AND PLACEMENTS

- 4.36 An interim package of care or placement will be offered to a patient where a decision has not been made within five days of completion of step 3,

²⁴ Care Act 2014 s3, and Care and Support (Discharge of Hospital Patients) Regulations 2014, SI 2014/2823

²⁵ Barnet PCT v X [2006] EWHC 787. Case law 'R (Burke) v GMC [2005] EWCA Civ 1003' states that patients have no right to insist on particular treatment which is not clinically indicated. This includes provision of an acute inpatient bed when medically fit for discharge.

²⁶ Human Rights Act 1998

²⁷ <https://www.england.nhs.uk/statistics/wp-content/uploads/sites/2/2015/10/mnth-Sitreps-def-dtoc-v1.09.pdf>

available options have been declined, or where a decision has been made but the specific package, placement, or adaptation is not yet available. Patients do not have the right to remain in hospital to wait for their preferred option to become available.

- 4.37 The interim package or placement is distinct from intermediate care or reablement.
- 4.38 Where decision and/or discharge is not achieved within five consecutive days of completion of step 3, members of the MDT will liaise within two working days. The MDT will discuss and seek to agree the recommended interim package or placement with the patient. Consideration of interim arrangements must be accompanied by a risk assessment, including impact on any carers.
- 4.39 The MDT may then advise the patient that an interim package or placement, which meets their assessed needs, is being offered, the reasons why the offer is appropriate, and a proposed date for transfer.
- 4.40 The interim package or placement will be confirmed with letter C (version dependent upon funding arrangements). Letter C will be prepared and given to the patient by the discharge coordinator. In step 5 the UHS discharge coordinator will be the Senior Discharge Officer (SDO), ward leader or care group manager. It is important that the letter is addressed to the patient, is personalised to reflect their circumstances and that the process is also discussed with the patient.
- 4.41 The prepared letter will be signed by the lead clinician.
- 4.42 The interim package / placement will allow further time for the choice of package / placement to be resolved outside of hospital. This interim option would normally be in one of the initial packages / placements offered, if still available.
- 4.43 Interim placements will be funded by the Southampton City Council local authority or Southampton City Clinical Commissioning Group for a maximum of 6 weeks²⁸ and this timescale will be clearly communicated to the patient from the outset. Hampshire County Council and West Hampshire Clinical Commissioning Group will fund the interim placement until the appropriate placement or package of care has been sourced.
- 4.44 Discussions regarding permanent options will continue throughout the interim placement with a designated person from the relevant organisation responsible for leading the discharge plans.

²⁸ Local organisations that have supported the development of this template policy recommend an interim funded placement of 3 weeks in order to ensure the policy works in practice and can be implemented easily by staff. This prevents multiple transfers in quick succession and enables time for full assessments to be completed well. This timescale is specifically for interim placements not intermediate care or reablement pathways.

- 4.45 Self-funders will be required to fund their care in the interim package / placement, based on the outcome of their financial assessment. The exception to this is where the 12 week property disregard applies.
- 4.46 The relevant statutory organisation is responsible for funding the interim placement beyond the 6 week period if the ongoing placement/package is not yet available.

STEP 6 – ESCALATION PROCESS

- 4.47 If no agreement has been reached regarding discharge arrangements after steps 1-5, and transfer arrangements are challenged by the patient, the Care Group Manager, along with the patient's lead clinician will support the discharge coordinator to continue plans for transfer to an interim package or placement. At Step 6 of this policy, the discharge coordinator will be the UHS Complex Discharge Manager, the IDB operational manager, supported by the Matron or divisional Head of Nursing.
- 4.48 The patient will be provided with details of complaints and appeals procedures throughout the process.
- 4.49 The discharge coordinator and care group manager/lead clinician will arrange a formal meeting with the patient. The formal meeting enables all parties to discuss concerns and seek to agree transfer to the most appropriate care provider, at least as an interim option.
- 4.50 The discharge coordinator will send letter D following the formal meeting, summarising the discussion, including discussions around risks, and next steps.
- 4.51 Letter D should also be sent if the patient does not engage in the meeting, including details of the reasons why the patient did not engage.
- 4.52 The prepared letter will be signed by the lead clinician.
- 4.53 The discharge coordinator will continue to work with the patient throughout this process to try and understand and address barriers to a decision being made.
- 4.54 If the patient declines NHS treatment and a care or support package, they may be discharged from hospital²⁹. In those circumstances they will be advised in advance of any discharge on the further NHS or social care support they may be able to access in the community and warned of the risks if they refuse such support.

²⁹ The duty on Trusts and Foundation Trusts to carry out their functions "effectively, efficiently and economically" under NHS Act 2006 (as amended) s26, 63; Criminal Justice and Immigration Act 2008, ss119-121, if the patient is no longer in need of inpatient treatment and their behaviour constitutes a nuisance or disturbance and [NHS protect guidance on this provision](#)

- 4.55 Care should be taken to ensure that the Trust meets its duty³⁰ to serve an assessment notice and a discharge notice as appropriate on the local authority where it appears that the patient's discharge may be unsafe without the provision of appropriate care, and some cases may justify an adult safeguarding referral, including for cases which may amount to self-neglect³¹.
- 4.56 The discharge coordinator, supported by the local director or the patient's Lead Clinician in the hospital will consult local legal advisors and escalate as required to ensure discharge from hospital, in order to safeguard the health and wellbeing of the patient and other patients.

STEP 7 – LEGAL PROCESS

- 4.57. If no agreement has been reached regarding discharge arrangements after steps 1-6, and transfer arrangements are challenged by the patient, the patient's case will be escalated to the Executive team and a decision will be made as to whether legal advice is required, the litigation team will assist in facilitating that advice and will maintain a link with the complex discharge manager and the clinical team. At Step 7 of this policy, the discharge coordinator will be the UHS Complex Discharge Manager, the IDB operational manager, the Matron or divisional Head of Nursing.
- 4.58 The patient will be provided with details of complaints and appeals procedures throughout the process.
- 4.59 The discharge coordinator will be kept informed by the executive and legal teams on the progress towards compulsory discharge being made by the Trust and wider health and social care systems.

5. MENTAL CAPACITY

- 5.1 All patients should be assumed to have mental capacity to make a decision about their ongoing care, including as regards discharge. A capacity assessment should be undertaken at any point during the process if their capacity, in relation to the discussions and decisions on discharge, is in doubt.
- 5.2 Appendix 2 sets out in detail how the application of this policy should be adapted for cases where the patient may lack capacity to make the relevant decisions at the appropriate time.

6. CONSULTATION AND APPROVAL PROCESS

³⁰ Care Act Schedule 3

³¹ Care Act statutory guidance chapter 14

6.1 This policy was developed nationally by a collaboration of partners with input from people working across the system, both locally and nationally.

7. REVIEW, REVISION

7.1 This policy will be reviewed at least every 3 years by the UHS Complex Discharge Manager in conjunction with system wide service leads and local ratification policy and procedure.

8. MONITORING COMPLIANCE AND EFFECTIVENESS

8.1. Monitoring will take place by IDB Operational Manager

8.2. Monitoring in each hospital will be undertaken on a biannual basis, facilitated by the local manager or lead nurse for discharge services.

8.3. Local monitoring will include an audit of:

- Staff training to check that training courses are relevant to the policy and ensure training is undertaken;
- Policy effectiveness;
- Review of when choice information is provided;
- Patient and/or representative feedback and complaints;
- Number of Delayed Transfers of Care;
- Length of Delayed Transfers of Care;
- Equality monitoring.

Particular thanks go to the organisations involved in developing the 'Pan-Dorset Policy for Managing Choice on Hospital Discharge' and the 'Surrey Joint Protocol of Choice for Good Practice to Facilitate Timely Discharge for People needing Long Term Care', which have largely informed the content of this template policy.

APPENDIX 1: GLOSSARY

Advocacy: a service to help people be involved in decisions, explore choices and options, defend their rights & responsibilities, and speak out about issues that matter to them.

CHC: NHS Continuing Healthcare is defined as a package of ongoing care for an individual aged 18 or over which is arranged and funded solely by the NHS where the individual has been found to have a 'primary health need'.

Deprivation of liberty: when an individual without mental capacity to consent is under continuous supervision and control and is not free to leave, and this is imputable to the state. See Appendix 2.

Discharge coordinator: the named individual responsible for coordinating a patient's discharge. This could be a named nurse from the ward, a named social care professional from the local authority, an appropriate person from a voluntary sector organisation contracted to co-ordinate statutory services and act as patient advocate, or a named CHC health professional.

EDD: Estimated or expected date of discharge. This means when the patient is clinically assessed as ready for discharge. The EDD is initially based on average length-of-stay data and may change several times in response to the patient's specific needs.

Independent Mental Capacity Advocate (IMCA): will represent patients assessed as lacking capacity under the Mental Capacity Act 2005 to make important decisions, such as change of accommodation, and who have no family and friends to consult.

Interim care: A provisional placement that is suitable and able to meet the patient's assessed needs whilst they wait for their preferred option.

Intermediate care: Short-term care provided free of charge by the NHS for people who no longer need to be in hospital but may need extra support to help them recover. It lasts for a maximum of six weeks and can be in the patient's home or in a residential setting.

MDT: Multidisciplinary team of health and social care professionals involved in the care and assessment of patients.

Medically fit for discharge: Further inpatient medical care or treatment is no longer necessary, appropriate or offered. Any further care needs can more appropriately be met in other settings, without the need for an acute inpatient hospital bed.

Mental capacity: Being able to make a specific decision at a specific time (see Appendix 2).

Patient: The individual receiving treatment in hospital.

Reablement: Reablement services are meant to help people adapt to a recent illness or disability by learning or relearning the skills necessary for independent daily living at home. Reablement should be provided free of charge by the local authority for up to six weeks. It can be extended at the local authority's discretion.

Self-funder: A person who financially meets the full cost of their social care needs (apart from reablement care and the 12 week property disregard), because their financial capital exceeds the threshold for adult services funding, their level of need is not deemed to be high enough for local authority funding, or because they or a representative choose to pay for their care.

APPENDIX 2: HOSPITAL DISCHARGE AND MENTAL CAPACITY ISSUES

All staff must follow the five guiding principles of the Mental Capacity Act 2005 ("MCA"). This means:

- Presume that adults from 16 are mentally capable of making their own decisions;
- Do not determine the person lacks capacity until all practicable steps to support them have been taken without success;
- Do not consider someone to lack capacity because they make a decision we consider to be unwise;
- When the patient is assessed to lack capacity we must act in their best interests;
- Before taking any action or decision on their behalf we must consider if it can be achieved in a less restrictive way.

Capacity is specific to the decision that must be made, at the relevant time, and so it is possible that a patient who has been assessed as having capacity to consent to or refuse the treatment they have had as an inpatient may lack capacity to make decisions around discharge and care planning (and vice versa). Where there is a reason to doubt capacity for a particular decision, it must be specifically assessed, in accordance with the MCA, the MCA Code of Practice and relevant case law and documented appropriately.

All practicable steps must be taken to support the patient to make the decision before concluding that they are unable to make it themselves. This might involve taking a number of steps such as providing information in a different format or breaking information down into smaller chunks.

If a person is assessed to lack capacity this means that staff have tested whether they can:

- Understand the information relevant to the decision,
- Retain the information long enough to make a decision,
- Use and weigh the information as part of the decision making process and
- Communicate the decision they want to make.

In the context of a discharge decision, the information relevant to the decision will include an understanding of their care needs on discharge, the process and outcome of the assessment of needs, offers of care and options available, with the person being given concrete information to consider, not starting with a blank sheet approach.

Options which are not available (e.g. placements which are not available, care which is not considered clinically appropriate, or care which will not be funded) should not be considered in either capacity assessments or in best interest decision-making. A patient with capacity cannot insist on staying in hospital after they are medically fit for discharge and so neither is it an option for a patient who lacks capacity for the discharge decision.

Where a patient, despite all reasonable efforts to support them, lacks capacity for discharge decisions, the decision must be made in their best interests (see MCA s4).

It is important to identify who the decision maker is as it could be a number of different people. The decision maker may be an attorney (if a health and welfare Lasting Power of Attorney has been granted, and is valid, applicable and registered) or a Deputy (if a health and welfare Deputy has been appointed by the Court). If neither of these are appointed then it will be the health or care professional who needs to make the decision in question. The wishes and feelings of the patient are paramount, but this does not mean they will always get what they want, anymore than a patient with capacity would.

“Best interests” is interpreted widely, and goes beyond medical risk and benefit to include social, psychological and emotional factors. Before making a best interest decision, it should be tested by asking whether the patient’s best interests can be achieved in a way which is less restrictive of their rights and freedoms.

A patient is entitled to an Independent Mental Capacity Advocate (IMCA) where it is proposed that an NHS body or a local authority provides accommodation in a care home for 8 weeks or longer unless there is someone to consult about their best interests other than a paid professional (MCA s38-39).

If the proposed placement or care package on discharge puts a patient without capacity to consent to it at risk of being deprived of liberty (Article 5, European Convention of Human Rights), currently as interpreted by the Supreme Court in *Cheshire West* [2014] UKSC 19 to mean “under continuous supervision and control and not free to leave” then additional safeguards are required to ensure that the deprivation is lawful.

Where the proposed deprivation of liberty is in a hospital or a registered care home, a referral must be made for a standard authorisation under the Deprivation of Liberty Safeguards (DoLS). However, DoLS do not extend to other placements, such as supported living or domiciliary care and so any proposed deprivation of liberty there can only be authorised by the Court of Protection. [In either case, case law has found that it is preferable for any proposed deprivation of liberty to be authorised in advance by a prior referral to DoLS or Court application – see for example *Re AJ* (DoLS) [2015] EWCOP 5, or *Re AG* [2015] EWCOP 78]

[It may be appropriate to seek legal advice on cases where deprivation of liberty after discharge appears to be an issue.]

APPENDIX 3: SUMMARY OF LEGAL RESPONSIBILITIES AND RIGHTS

This appendix includes a brief summary of selected key legal responsibilities held by participating organisations and the rights that patients have in relation to the specific topic of this policy, with references to specific legislation and case law.

This list does not cover all of the legal complexities in relation to this issue – it is only provided as a guide to the people reading this policy and should not be used in place of legal advice.

	Responsibility or right in relation to choice at discharge	Relevant legislation / case law
Hospital (NHS Trust)	<p>No clinician or Trust is obliged to offer anything which is not clinically indicated. This includes provision of an acute inpatient bed.</p> <p>A Trust is obliged to carry out its functions “effectively, efficiently and economically”, which is not consistent with prolonged occupation of inpatient beds by patients who are medically fit for discharge</p> <p>In some cases, where the patient’s refusal to leave hospital when medically fit for discharge constitutes a nuisance or disturbance, an offence may be committed and there is a power to remove the patient</p> <p>Alternatively, other remedies may be available to Trusts under property law</p> <p>Where appropriate, where the Trust considers it will not be safe to discharge a patient unless arrangements for care and support are in place it must give notice to local authority, including provision in some circumstances for a financial remedy against the local authority where discharge is delayed as a result of failure to meet needs</p> <p>Responsibility to seek authorisation for any deprivation of liberty occurring in the hospital</p>	<p>R (Burke) v GMC [2005] EWCA Civ 1003; Aintree University Hospitals NHS FT v James [2013] UKSC 67</p> <p>NHS Act 2006 (as amended) s26, 63</p> <p>Criminal Justice and Immigration Act 2008, ss119-121 [and see NHS Protect guidance]</p> <p>Barnet PCT v X [2006] EWHC 787</p> <p>Care Act 2014, Schedule 3, Care and Support (Discharge of Hospital Patients) Regulations 2012, and Delayed Discharge (Continuing Healthcare) Directions 2013</p> <p>MCA Schedule A1, paras 1-3 , 24 and 76</p>
Local Authority	Responsibility to assess a patient’s needs for care and support where it appears to the local authority that the patient may have such needs	Care Act 2014 s9

	<p>Responsibility to assess a carer's needs for support and choice about caring</p> <p>Responsibility to provide patient's choice of accommodation in care home / shared lives / supported living, where this is to be arranged by the local authority, in some circumstances</p> <p>Responsibility to provide information and support on choices</p> <p>Responsibility to offer choices / involve the patient in preparation of a care and support plan</p> <p>Responsibility to provide a Care Act advocate if a patient would experience substantial difficulty in participating in the assessment of need or care planning process unless there is another (unpaid) appropriate person to fill this role</p> <p>Responsibility to authorise deprivation of liberty in care homes and hospitals</p>	<p>Care Act 2014 s10</p> <p>Care Act 2014 s30, Care and Support and After-care (Choice of Accommodation) Regulations 2014</p> <p>Care Act 2014 s4</p> <p>Care Act 2014 s25</p> <p>Care Act 2014, s67</p> <p>MCA Schedule A1 paras 21, 50</p>
Clinical Commissioning Group [and NHS England]	<p>Responsibility to ensure an assessment for eligibility for NHS funded Continuing Healthcare where it appears that there may be a need for such care. [This is the responsibility for NHS England for military personnel and prisoners]</p>	<p>NHS Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) Regulations 2012, reg 21</p>
Patient	<p>Right to assessment for care and support by local authority and for NHS Continuing Healthcare as appropriate</p> <p>No right to insist on particular treatment which is not clinically indicated, including provision of an acute inpatient bed when medically fit for discharge</p> <p>Right to be involved in decision making about care</p> <p>Right to choice of accommodation in care home / shared lives / supported living, where this is to be arranged by the local authority, in some circumstances (but no right to remain in hospital when medically</p>	<p>Care Act 2014, s9 and NHS Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) Regulations 2012, reg 21</p> <p>Barnet PCT v X [2006] EWHC 787; R (Burke) v GMC [2005] EWCA Civ 1003</p> <p>NHS Constitution</p> <p>Care Act 2014 s30, Care and Support and After-care (Choice of Accommodation) Regulations 2014</p>

	<p>fit for discharge while preferred choice is awaited)</p> <p>Right to respect for family life and to not be treated in an 'inhuman or degrading' way</p>	<p>Human Rights Act 1998 s6 in relation to Articles 3 and 8 of the European Convention of Human Rights</p>
Carer	<p>Right to carer's assessment / support and choice about caring i.e. willingness to provide care</p>	<p>Care Act 2014 s10</p>

APPENDIX 4: SUPPORTING TEMPLATE FACTSHEET AND LETTERS



FACTSHEET A: The Assessment and Discharge Process

We want to give you the support you need to get home as quickly as possible. Following a hospital admission, most patients are able to return home, sometimes with a care package or adaptations made to their home. However, some patients are unable to return home and need the added support only available in a care home.

We will involve you in all decisions about your care, treatment and discharge, and give you all the information and support you need to make the best decisions

What can you expect to happen?

- We will tell you when your treatment is due to end and when you would be considered well enough to leave hospital (this is called an estimated discharge date) – we aim to tell you this within 48 hours of you being admitted and will discuss with you if this changes.
- We will provide you with a named staff member who will support you throughout your time in hospital and make sure that things happen when they are supposed to.
- We will tell you how to access information, advice and support to help you make your discharge decision. This will include helping you to understand your care needs, the process of assessing your needs and the care options available to you.
- With your permission, we will request assessment(s) to find out what needs you have and the services you might need to be safely discharged from hospital. The assessments could be for social care, home assessment for any adaptations, eligibility for NHS continuing healthcare, etc.
- It may also be necessary to assess how any ongoing care will be funded, although in most circumstances to avoid any delay this will be carried out after you have been discharged. It is important to note that whilst NHS care is free to everyone, social care is not.
- Once you have received information about the discharge choices that are available to you, we request that you make a decision within 5 days. You may wish to arrange for yourself or a family member to meet with the care providers during this time. We will do our best to help make this possible for you and you will be able to speak with a Social Worker, Senior Discharge Officer, Older Persons Practitioner or the Nurse in Charge of your care about these choices.

- If your preferred choice is not available when you are ready for discharge, an alternative option can be arranged for you temporarily. It is not possible for you to wait in this hospital, once you no longer need hospital care.
- If you wish to make a complaint or appeal against any part of the discharge process then contact the nurse in charge at any point, or the Patient Support Services on patientsupportservices@uhs.nhs.uk. You can also call us on ext. 6325.

If you would like a copy of this factsheet to be given to someone else or you have any questions, please speak to one of the nurses on your ward or any member of the team caring for you.

Please do not hesitate to ask questions about your discharge at any time during your hospital stay.

With best wishes for a speedy recovery,

The team caring for you at this hospital

On behalf of NHS healthcare and local authority services in Southampton and West Hampshire



CHOICE LETTER B1

Date:

Dear <Name>

You now need to choose a care package at home

In order for you to receive the right on-going care we request that you take the following actions:

1. Consider the care at home options currently available to you;
 2. Choose one of these care at home options;
- OR
- Advise us of an alternative option that you have arranged.

We request that you make your decision within 5 days of receiving this letter {or insert a longer timeframe if letter is sent more than 5 days before the EDD}. We will arrange for a temporary package of care or accommodation to be made available to you if you need longer than 5 days to make your decision, or need to wait for your preferred care provider.

Additional information to help you

The recent assessment looked at your care needs and wellbeing and showed that you will need a care package at home following discharge on {*insert estimated discharge date*}.

We want to help you leave this hospital as soon as possible because home is the best place for you to recuperate, and will give you more independence than being on a hospital ward.

To support you at this time we will ensure that:

- You now have all of the information about the choices currently available to you, including details of any costs, and you have spoken about this with a member of the team;
- You have access to further high quality information, advice and support to make your decisions [*include details of where this can be accessed*];
- This includes [*include details of support service*] and the option to involve your family, friends and carers to support you, as you wish.
- You can make a complaint or appeal at any stage of the discharge process by contacting the Patient Support Services on patientsupportservices@uhs.nhs.uk. You can also call us on ext. 6325.

Please do not hesitate to ask one of the nurses on your ward, or to any member of the team caring for you, if you have any questions or if you would like a copy of this letter to be given to someone else.

Yours sincerely,

[*letter to be signed by senior clinician*]



CHOICE LETTER B2

Date:

Dear <Name>

You now need to choose a care home.

In order for you to receive the right on-going care we request that you take the following actions:

1. Consider the care home options currently available to you, including visiting any care homes;
2. Choose one of these care homes;
OR
Advise us of an alternative option that you have arranged.

We request that you make this decision within 5 days of receiving this letter {or insert a longer timeframe if letter is sent more than 5 days before the EDD}. We will arrange for temporary accommodation to be made available to you if you need longer than 5 days to make your decision, or need to wait for your preferred choice if it has no current vacancies.

Additional information to help you

The recent assessment looked at your needs and wellbeing and showed that you will need to be discharged to a care home {insert for how long if a temporary placement} on {insert estimated discharge date}.

We want to help you leave this hospital as soon as possible because a care home is the best place for you to recuperate, and will give you more independence than being on a hospital ward.

To support you at this time we will ensure that:

- You now have all of the information about the choices currently available to you including details of any costs, and you have spoken about this with a member of the team;
- You have access to further high quality information, advice and support to make your decisions [include details of where this can be accessed];
- This includes [include details of support service] and the option to involve your family, friends and carers to support you, as you wish.
- You are able to make a complaint or appeal at any stage of the discharge process by contacting the Patient Support Services on patientsupportservices@uhs.nhs.uk. You can also call us on ext. 6325.

Please do not hesitate to ask one of the nurses on your ward, or to any member of the team caring for you, if you have any questions or if you would like a copy of this letter to be given to someone else.

Yours sincerely,
[letter to be signed by senior clinician]



CHOICE LETTER B3

Date:

Dear <Name>

You now need to choose an available housing option.

In order for you to receive the right on-going care we request that you take the following actions:

1. Consider housing support options currently available to you, including undertaking any visits;
2. Choose or agree to one of these housing support options;
OR
Advise us of an alternative option that you have arranged.

We request that you make this decision within 5 days of receiving this letter {or insert a longer timeframe if letter is sent more than 5 days before the EDD}. We will arrange for temporary accommodation to be made available to you if you need longer than 5 days to make your decision, or need to wait for your preferred choice if it has no current vacancies.

Additional information to help you

Your recent assessment looked at your care needs and wellbeing. It showed that you will need support from housing support services before being discharged on {insert estimated discharge date}.

We want to help you leave this hospital as soon as possible because supported housing is the best place for you to recuperate, and will give you more independence than being on a hospital ward.

To support you at this time we will ensure that:

- You now have all of the information about the choices currently available to you, including details of any costs, and you have spoken about this with a member of the team;
- You have access to further high quality information, advice and support to make your decisions [include details of where this can be accessed];
- This includes [include details of support service] and the option to involve your family, friends and carers to support you, as you wish.
- You are able to make a complaint or appeal at any stage of the discharge process by contacting the Patient Support Services on patientsupportservices@uhs.nhs.uk. You can also call us on ext. 6325.

Please do not hesitate to ask one of the nurses on your ward, or to any member of the team caring for you, if you have any questions or if you would like a copy of this letter to be given to someone else.

Yours sincerely,
[letter to be signed by senior clinician]



CHOICE LETTER B4

Date:

Dear <Name>

You now need to choose an available rehabilitation option.

In order for you to receive the right on-going care we request that you take the following actions:

1. Consider the rehabilitation options currently available to you,
2. Choose or agree to one of these rehabilitation options;

OR

Advise us of an alternative option that you have arranged.

We request that you make this decision within 5 days of receiving this letter {or insert a longer timeframe if letter is sent more than 5 days before the EDD}. We will arrange for temporary accommodation to be made available to you if you need longer than 5 days to make your decision, this may be in an available rehabilitation bed or nursing home whilst you wait for your preferred choice if it has no current vacancies.

Additional information to help you

Your recent assessment looked at your care needs and wellbeing. It showed that you will need support from rehabilitation services before being discharged on {insert estimated discharge date}.

We want to help you leave this hospital as soon as possible because receiving rehabilitation out of acute hospital is the best place for you to recuperate, and will give you more independence than being on an acute hospital ward.

To support you at this time we will ensure that:

- You now have all of the information about the choices currently available to you, including details of any costs, and you have spoken about this with a member of the team;
- You have access to further high quality information, advice and support to make your decisions [include details of where this can be accessed];
- This includes [include details of support service] and the option to involve your family, friends and carers to support you, as you wish.
- You are able to make a complaint or appeal at any stage of the discharge process by contacting the Patient Support Services on patientsupportservices@uhs.nhs.uk. You can also call us on ext. 6325.

Please do not hesitate to ask one of the nurses on your ward, or to any member of the team caring for you, if you have any questions or if you would like a copy of this letter to be given to someone else.

Yours sincerely,

[letter to be signed by senior clinician]



CHOICE LETTER C1

Date:

Dear <Name>

Notification of plan to transfer to interim care whilst waiting for a preferred home

We understand that you are well enough to leave hospital and move to a care home, but <you have not yet found one that you like> OR <the one you prefer is not able to offer you a room at this time>.

We do not wish to cause you or your family additional concern, but unfortunately you will not be able to stay at this hospital whilst you continue to <search> OR <wait> for a care home.

- Staying in a care home will allow you to recuperate and give you more independence than being on a hospital ward;
- A care home is the best place for you to continue your recovery once your acute illness is over;
- Severely ill patients may be unable to access services, if beds in this hospital are occupied with patients who are medically fit for discharge.

As it has taken longer than 5 days to organise your discharge, we are now offering to transfer you to temporary accommodation in the following location, which has been assessed as suitable to meet your short-term needs because <insert reason for decision>. This will be funded by <insert organisation(s)> for <x> weeks³². Beyond <x> weeks the costs of this care will need to be met by <insert responsible organisation or by you>.

Discharge destination:	<Name of location>
Address:	<Address of location>
Tel number:	<Phone number of location>
Proposed date of transfer/discharge:	<Discharge date>

You will be offered further support there with any decisions you need to make and you can wait there until transfer to a preferred home can be arranged.

Please discuss discharge plans with <insert name and contact details>. You will need to either transfer to the temporary accommodation outlined above or inform us of an alternative arrangement to leave the hospital without further delay.

If you would like a copy of this letter to be given to someone else or you have any questions please speak to one of the people below or any member of the team caring for you.

³² Local organisations that have supported the development of this template policy recommend a funded placement of 3 weeks in order to ensure the policy works in practice and can be implemented easily by staff. This prevents multiple transfers in quick succession and enables time for full assessments to be completed well.

If you would like to make a complaint or appeal against this decision then please contact the Patient Support Services on patientsupportservices@uhs.nhs.uk. You can also call us on ext. 6325.

Please do not hesitate to ask if you have any questions.

Yours sincerely, [letter to be signed by senior clinician]



CHOICE LETTER C2

Date:

Dear <Name>

Notification of plan to transfer to interim care whilst waiting for preferred care at home services

We understand that you are well enough to leave hospital with care at home but <you have not yet found a care service that you like> OR <the care service you prefer is not able to accommodate you at this time>.

We do not wish to cause you or your family additional concern but unfortunately you will not be able to stay at this hospital whilst you continue to <search> OR <wait> for a care at home package.

- Leaving hospital will allow you to recuperate and give you more independence than being on a ward;
- Severely ill patients may be unable to access services, if beds in this hospital are occupied with patients who are medically fit for discharge.

As it has taken longer than 5 days to organise your discharge, we are now offering to transfer you to temporary accommodation in the following location, which has been assessed as suitable to meet your short-term needs because <insert reason for decision>. This will be funded by <insert organisation(s)> for <x> weeks³³. Beyond <x> weeks the costs of this care will need to be met by <insert responsible organisation or by you>.

Discharge destination:	<Name of location>
Address:	<Address of location>
Tel number:	<Phone number of location>
Proposed date of transfer/discharge:	<Discharge date>

You will be offered further support there with any decisions you need to make and you can wait there until your preferred care at home package can begin.

Please discuss discharge plans with <insert name and contact details>. You will need to either transfer to the temporary accommodation outlined above or inform us of an alternative arrangement to leave the hospital without further delay.

If you would like a copy of this letter to be given to someone else or you have any questions please speak to one of the people below or any member of the team caring for you.

If you would like to make a complaint or appeal against this decision then please contact the Patient Support Services on patientsupportservices@uhs.nhs.uk. You can also call us on ext. 6325.

Please do not hesitate to ask if you have any questions.

³³ Local organisations that have supported the development of this template policy recommend a funded placement of 3 weeks in order to ensure the policy works in practice and can be implemented easily by staff. This prevents multiple transfers in quick succession and enables time for full assessments to be completed well.

Yours sincerely,
[letter to be signed by senior clinician]



CHOICE LETTER C3

Date:

Dear <Name>

Notification of plan to transfer to interim care whilst waiting for housing support services

We understand that you are now well enough to leave hospital but require housing support services <that are not yet completed> OR <that you have not yet decided upon>.

- We do not wish to cause you or your family additional concern but unfortunately you will not be able to stay at this hospital whilst you continue to <wait> OR <decide> upon housing support services.
- Leaving hospital will allow you to recuperate and give you more independence than being on a ward;
- Severely ill patients may be unable to access services, if beds in this hospital are occupied with patients who are medically fit for discharge.

As it has taken longer than 5 days to organise your discharge, we are now offering to transfer you to temporary accommodation in the following location, which has been assessed as suitable to meet your short-term needs because <insert reason for decision>. This will be funded by <insert organisation(s)> for <x> weeks³⁴. Beyond <x> weeks the costs of this care will need to be met by <insert responsible organisation or by you>.

Discharge destination:	<Name of location>
Address:	<Address of location>
Tel number:	<Phone number of location>
Proposed date of transfer/discharge:	<Discharge date>

You will be offered further support there with any decisions you need to make and you can wait there until the housing support services <are completed> OR <are available>.

Please discuss discharge plans with <insert name and contact details>. You will need to either transfer to the temporary accommodation outlined above or inform us of an alternative arrangement to leave the hospital without further delay.

If you would like a copy of this letter to be given to someone else or you have any questions please speak to one of the people below or any member of the team caring for you.

³⁴ Local organisations that have supported the development of this template policy recommend an interim funded placement of 3 weeks in order to ensure the policy works in practice and can be implemented easily by staff. This prevents multiple transfers in quick succession and enables time for full assessments to be completed well. This timescale is specifically for interim placements not intermediate care or reablement pathways.

If you would like to make a complaint or appeal then please contact the Patient Support Services on patientsupportservices@uhs.nhs.uk. You can also call us on ext. 6325.

Please do not hesitate to ask if you have any questions.

Yours sincerely, [*letter to be signed by senior clinician*]

CHOICE LETTER C4

Date:

Dear <Name>

Notification of plan to transfer to interim care whilst waiting for rehabilitation services

We understand that you are now well enough to leave hospital but require rehabilitation services <that are not yet completed> OR <that you have not yet decided upon>.

- We do not wish to cause you or your family additional concern but unfortunately you will not be able to stay at this hospital whilst you continue to <wait> OR <decide> upon rehabilitation services.
- Leaving hospital will allow you to recuperate and give you more independence than being on a ward;
- Severely ill patients may be unable to access services, if beds in this hospital are occupied with patients who are medically fit for discharge.

As it has taken longer than 5 days to organise your discharge, we are now offering to transfer you to temporary accommodation in the following location, which has been assessed as suitable to meet your short-term needs because <insert reason for decision>. This will be funded by <insert organisation(s)> for <x> weeks³⁵. Beyond <x> weeks the costs of this care will need to be met by <insert responsible organisation or by you>.

Discharge destination:	<Name of location>
Address:	<Address of location>
Tel number:	<Phone number of location>
Proposed date of transfer/discharge:	<Discharge date>

You will be offered further support there with any decisions you need to make and you can wait there until the rehabilitation services <are completed> OR <are available>.

Please discuss discharge plans with <insert name and contact details>. You will need to either transfer to the temporary accommodation outlined above or inform us of an alternative arrangement to leave the hospital without further delay.

If you would like a copy of this letter to be given to someone else or you have any questions please speak to one of the people below or any member of the team caring for you.

³⁵ Local organisations that have supported the development of this template policy recommend an interim funded placement of 3 weeks in order to ensure the policy works in practice and can be implemented easily by staff. This prevents multiple transfers in quick succession and enables time for full assessments to be completed well. This timescale is specifically for interim placements not intermediate care or reablement pathways.

If you would like to make a complaint or appeal then please contact the Patient Support Services on patientsupportservices@uhs.nhs.uk. You can also call us on ext. 6325.

Please do not hesitate to ask if you have any questions.

Yours sincerely, [*letter to be signed by senior clinician*]



CHOICE LETTER D

Date:

Dear <Name>

Confirmation of discharge plans following formal meeting

Thank you for meeting with us on <insert date> to discuss your discharge arrangements from this hospital and on-going care requirements.

OR

{Dr ??} and the discharge team met in your absence on <insert date> to discuss your discharge arrangements from this hospital and on-going care requirements.

Discharge options discussion

We want to help you leave this hospital as soon as possible now you no longer need hospital care. A hospital ward is not the best place for you to continue your recovery and other types of services are now better equipped to support your needs. In addition we have a responsibility to make sure that beds on our wards are available for people who need treatment that can only be provided in a hospital.

At the meeting we discussed the following points:

<insert summary discussion here>.

We discussed the following options to enable the discharge process to proceed:

<insert options provided here>.

Discharge plan discussion

The following discharge plan was agreed:

<insert agreed next steps here>.

OR

We noted the reasons why you are unwilling to engage with this process:

<insert reasons here>.

The risks of you refusing the care options provided after being discharged from NHS hospital care were also discussed and identified:

<insert risks identified here>.

We will continue to work with you to try to come to a mutually agreeable solution. However, in the meantime the hospital will now need to consult our legal advisers about your situation and how we can arrange for you to be safely discharged from this hospital as soon as possible. We have a responsibility to consider and to ensure your health and wellbeing throughout this process. You also have the right to consult with your own legal advisers.

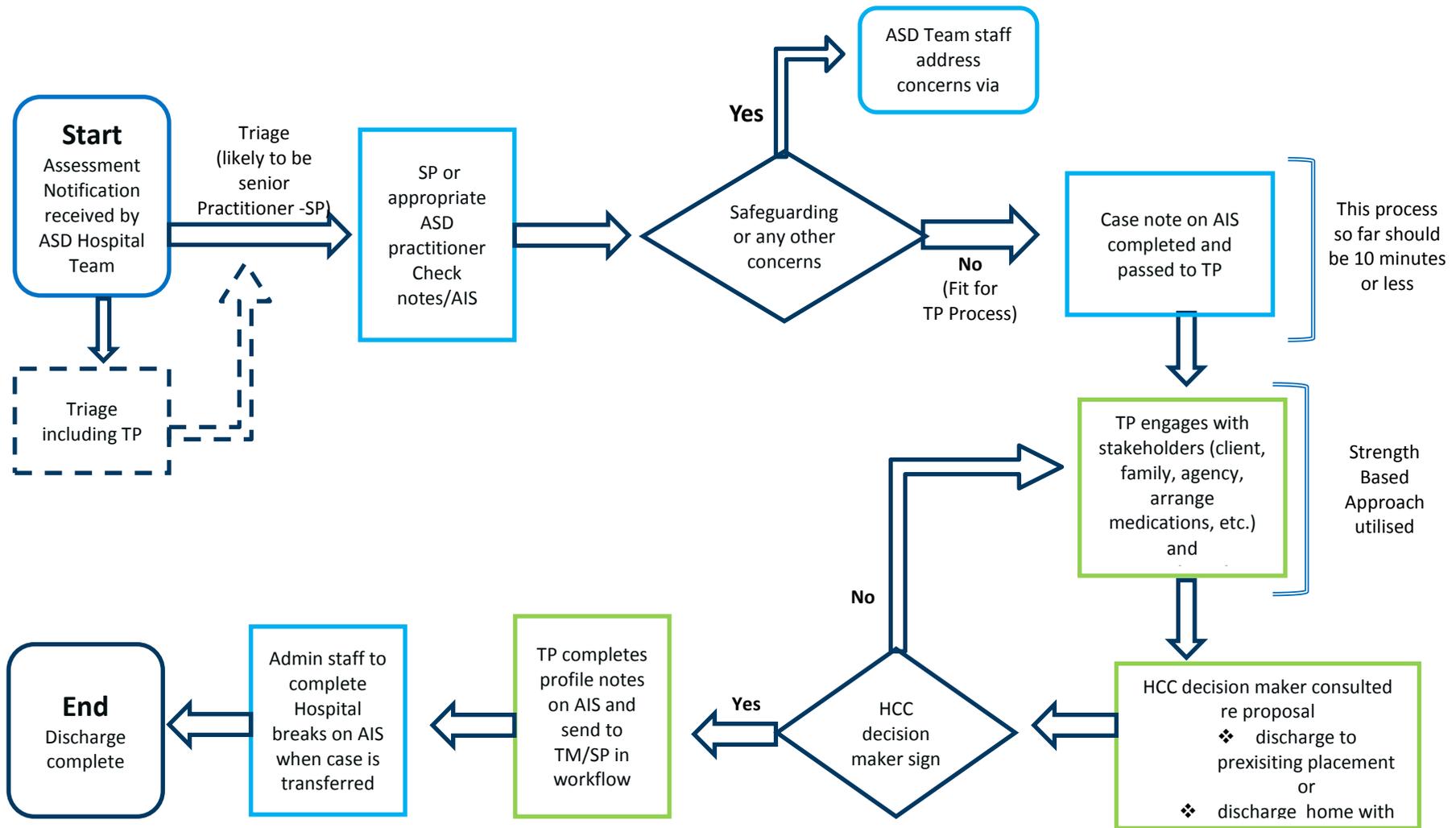
If you would like a copy of this letter to be given to someone else or you have any questions please speak to one of the people below or any member of the team caring for you.

If you would like to make a complaint or appeal against any part of the discharge process then please [insert details of local complaints and appeals procedures].

Please do not hesitate to ask if you have any questions.

Yours sincerely, [letter to be signed by senior clinician]

APPENDIX 5: TRUSTED PROFESSIONAL MODEL



Managing Complex Discharge Flow Process

Step 1 - Providing standard information and support (Nursing/Therapy)

- Start discussions about discharge with patient before or as soon as possible after admission
- Determine whether the patient has mental capacity and if not, put in place appropriate measures (see Appendix 2)
- Identify other people who have the patient's consent to be involved in discussions and decisions, e.g. carers, relatives. If possible identify need for possible Care Manager (CM)/ Social Worker (SW) support.
- Provide **Factsheet A** within 48 hours of admission.

Step 2 - Assessing need (MDT)

- Refer patient and any carers to required health and care services when they are ready to have their needs assessed for discharge
- Ensure assessments to clarify care needs and carers' needs are completed.
- **Identification of Care Manager/Social Worker involment <7 days**

Step 3 - Preparing for discharge (MDT/CM/SW)

- Discuss available and appropriate options with patient
- Refer to support services and/or advocacy, as required
- Explain the decision-making process, including how to appeal any decisions, to the patient and advise that the hospital will expect discharge within the five day window
- MDT to establish PDD with clear communication to patient and carers.
- **Provide Letter B** and tailored information on options which are suitable to meet assessed needs and available funding

Step 4 - Five day window (Ward Lead/SW/CM)

- **Initiates upon provision of Letter B** and information on choices to patient, in advance of the estimated discharge date
- Allow up to five consecutive days for the patient to consider their available options
- Support the patient to make a decision, respond to concerns and offer advice, support and encouragement

Step 5 - Interim placements and packages (MDT/Ward Lead/SW/CM)

- If decision and/or discharge has not been achieved with five consecutive days, MDT to liaise with patient and arrange the offer of an interim placement or package which meets assessed needs
- Advise the patient that an interim arrangement for a **given length of time** is offered with a proposed date for discharge. Details should be provided of how interim funding arrangements relate to funding of subsequent care.
- Give appropriate **version of Letter C** and offer further support

Step 6 - Escalation (Ward Matron/Ward Lead/Clinical Lead)

- If no agreement has been reached regarding discharge, and/or transfer arrangements are challenged, senior staff to hold formal meeting (**step 6 mtg**) with patient to understand and resolve issues and reiterate policy
- **Letter D** to be sent following formal meeting or if patient does not engage in formal meeting [note: this applies where reasonable options have been rejected and there are no ground to challenge]
- Consult local legal advisors, if necessary (SNHS.LegalServicesSolent@nhs.net). Involve/inform Integrated Service Manager and Operations Director

Step 7 - Legal (Exec team and Legal)

- If no agreement after formal meeting; escalated to the Executive team and a decision will be made as to whether legal advice is required to progress compulsory discharge. (Soton- David Noyce, 02381-031117. David.noyes@solent.nhs.uk) (Ports Sarah Austin- 023810-32049 Sarah.austin4@nhs.net) Involve/inform Integrated Service Manager and Operations Director .