University Hospitals of Derby and Burton NHS Foundation Trust

TRUST CHOICE POLICY FOR Staffordshire Patients

Reference Number	**Version:**	**Status**	**Author:**
POL-CL/3191/19	V1.2.0 V5.7	Draft UHDB Final Staffs STP	Representatives from the following organisations: • University Hospital of North Midlands Trust • North Staffordshire Combined Healthcare Trust • Midlands Partnership NHS Foundation Trust • Stoke-on-Trent City Council • Staffordshire County Council • North Staffordshire Clinical Commissioning Group • Stoke-on-Trent Clinical Commissioning Group • Stafford & Surrounds Clinical Commissioning Group • University Hospitals of Derby and Burton Foundation Trust Other CCGs

Version / Amendment History	Version	Date	Author	Reason
	V1,1	4th Jan 2019		Staffs STP have agreed a policy for Staffordshire Patients with the above partner organisations. UHDB needs to align policies to this and approve through each partners formal governance processes. This is for Staffordshire Patients only.

Intended Recipients: Health and social care staff involved in discharge planning of Staffordshire and Stoke-on-Trent residents from NHS acute hospitals and NHS funded community beds.

Training and Dissemination: Training will be provided through a variety of mediums including eLearning, face to face and classroom session.	
To be read in conjunction with: Discharge documentation from Queens, SJH and SRP http://bhftintranet.burtonft.nhs.uk/Departments/discharge/	
In consultation with and Date: Anne Parker Discharge Liaison Matron, Duncan Bedford Managing Director Queens Hospital, Urgent Emergency Care Board	
EIRA stage One Completed Yes / No *Delete as appropriate* stage Two Completed Yes / No *Delete as appropriate*	
Procedural Documentation Review Group Assurance and Date	Yes / No and Date
Approving Body and Date Approved	27th May 2020
Date of Issue	January 2019
Review Date and Frequency	To be reviewed every 12 months to inform updates to the Policy. Reviews 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
Contact for Review	Managing Director Queens Hospital Burton on Trent and Discharge Liaison Matron
Executive Lead Signature	
Approving Executive Signature	

1. Introduction

1.1 This Policy supports people's timely, effective discharge from NHS funded beds, to a setting which meets their needs. It applies to all adult residents of Staffordshire and Stoke on Trent in NHS acute hospitals and NHS funded community beds, and needs to be utilised before and during admission to ensure that those who are assessed as ready for transfer can leave in a safe and timely way.

1.2 This Policy is based on 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 the 8 High Impact Changes.

1.3 The majority of acute hospital discharges (at least 80% and ideally 95%) should be 'simple and timely': people should leave hospital with support from the family and friends, and/or follow up from their GP if necessary and without referral to other health and care services.

1.4 For people who need rehabilitation and support to enable acute hospital discharge they should be supported to return to their home wherever possible with reablement/intermediate care and if necessary assessment of any ongoing needs. If required they should be transferred to a 'step down' NHS funded bed. This 'discharge to assess' (D2A) model is crucial to allowing timely discharge from acute hospitals.

1.5 The consequences of a person[2] who is ready for transfer remaining in acute hospital include:
Exposure to an unnecessary risk of hospital acquired infection[3];

- Physical decline and loss of mobility / muscle use[4];
- Frustration and distress to the patient and relatives due to uncertainty during any wait for a preferred choice to become available;
- Increased dependence, as the hospital environment is not designed to meet the needs of people who are medically fit for discharge and ready to transfer to another environment[5];

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[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).

- Severely ill people being unable to access services due to beds being occupied by patients who are ready to transfer.

1.6 People 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 their options and how services and systems work;
- Worry about expectations of what family and carers can and will do to support them; Concerns that their existing home is unsuitable, cold or needs work done to ensure a safe environment for discharge;
- Concerns about moving to interim accommodation and moving again at a later stage; Concerns about either the quality or the cost of care;
- The choices available do not meet their preferences;

1.7 The principles of the 6Cs[6] 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 people can be discharged quickly and that choice is managed as sensitively and consistently as possible throughout the discharge process.

2.2 This Policy sets out a framework to ensure that NHS funded beds will be used appropriately and efficiently for those people who require care, and that a clear process is in place for when people remain in beds longer than is clinically required.

2.3 Where people lack capacity to make[7] decisions about discharge, 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 transfer of care and result in people 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 people.

2.5 This Policy includes people with very complex care needs, who may have been in hospital for many months or years, and people at the end of life.

3.0 Principles

Supporting people to make decisions

3.1 People should be involved in all decisions about their care, as per the NHS

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[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.

Constitution, and should be provided with high quality information, advice and support in a form that is accessible to them[8], as early as possible before or on admission and throughout their stay, to enable effective participation in the discharge process and in making an informed choice.

3.2 Planning for effective transfer of care, in collaboration with the person 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 bundle[9] should be applied to support timely discharge. Each individual should be told their Expected Date of Discharge (EDD)

3.3 The process and timelines within this Policy should be clearly communicated to people so that by the time they are ready for transfer 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.

Promoting independence and husbandry of resources

3.4 The majority of acute hospital discharges (at least 80% and ideally 95%) should be 'simple and timely': people should leave hospital with support from the family and friends, and/or follow up from their GP, if necessary and without referral to other health and care services. Over prescribing care limits the independence and harms the individual involved, as well as using capacity and compromising the discharge of more complex individuals.

Discharge to Assess and Home First

3.5 People should not normally be expected to make decisions about their long-term care while in an acute hospital. For people who need rehabilitation and support to enable acute hospital discharge, interim care using 'Discharge to Assess' services should be arranged where possible.

3.6 All possible efforts should be made to support people to return to their own homes using 'Home First' reablement/intermediate care services as well as equipment and housing adaptations where appropriate.

3.7 For those people who cannot go straight home, they should be transferred to an interim NHS funded community bed for rehabilitation and/or assessment (which can include a Community Hospital, Care Home or Mental Health bed).

3.8 By exception, there will be a small minority of people who require assessment to be undertaken in an acute hospital – these include:
For individuals with a rapidly deteriorating condition which may be entering a terminal phase' the NHS CHC Fast Track Pathway should be considered.

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

[9] http://www.fabnhsstuff.net/2015/08/26/the-safer-patient-flow-bundle

For individuals who require support and for whom no 'Discharge to assess' capacity is available.

Choice of interim care

3.9 People will be offered the most suitable interim care, either at home or in an NHS funded community bed. They will not normally be given a choice. If no 'Discharge to Assess' capacity is available then they will be assessed under the Care Act and/or NHS CHC and offered the most suitable care available at the time, and may be expected to contribute to the cost of this care.

3.10 If a person is ready for transfer, it is not appropriate that they remain in hospital due to the negative impact this can have on their health outcomes. People do not have the right to remain in hospital longer than required[10].

3.11 If a person is not willing to accept a reasonable offer of care to enable discharge from the acute hospital, then it may be necessary to discharge them without care, after giving appropriate information about the risks and consequences of their decision. 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 5.0). For people who may lack capacity to make their own discharge decisions, see Appendix 2.

3.12 People should be informed of the rights they have to complain and provided with details of how to do so. 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.

Rehabilitation and assessment for ongoing care

3.13 The presumption should always be that with a period of rehabilitation and support people can recover their independence and be discharged from 'Discharge to Assess' services without ongoing care. Over prescribing care limits the independence and harms the individual involved, as well as using capacity in the market and compromising the care of more complex individuals.

3.14 For those people who do require ongoing care, a Care Act and/or NHS Continuing Health Care (CHC) assessment should be carried out. This should be completed once an individual has achieved or is about to achieve their optimum level of independence in a timely way so that

[10] 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).

people's stay in interim care arrangements does not become unduly prolonged.

3.15 For people who require an assessment and who have substantial difficulty in engaging in the assessment and care planning process, the relevant 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.,16 Where the person 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.[11]

3.17 Where someone is considering providing care post-discharge unpaid as a carer, they must be informed and invited to be involved in the assessment 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. Carers must be offered the information, training and support they need to provide care following discharge[12], including a carer's assessment.

3.18 For those people who are entitled to state funded care under the Care Act and/or NHS CHC assessment then the local authority and/or CCG will identify at least one option for ongoing care that meets their assessed eligible needs. Under the Care Act people are entitled to choose other options and if these are more expensive than the option identified, the local authority can require that they or a third party pay the difference.

3.19 If a person is not willing to accept a reasonable offer that meets their assessed eligible needs, then it may be necessary to transfer them from interim care and support without ongoing care, after giving appropriate information about the risks and consequences of their decision. This option would only be pursued following the offer and rejection of available, appropriate options of ongoing care and appropriate safeguards and risk assessments (see section 5.0). For people who may lack capacity to make their own discharge decisions, see Appendix 2.

3.20 Self funders will need to make their own arrangements for ongoing care and do this within a reasonable timescale. They will be offered the same level of advice, guidance and assistance about choice[13] as those fully or partly funded by their local authority or NHS CHC, although it is likely that some of the content will need to differ. They will be expected to have ongoing care in place within a reasonable timescale, and if they fail to do so then it may be necessary to discharge them from interim arrangements.

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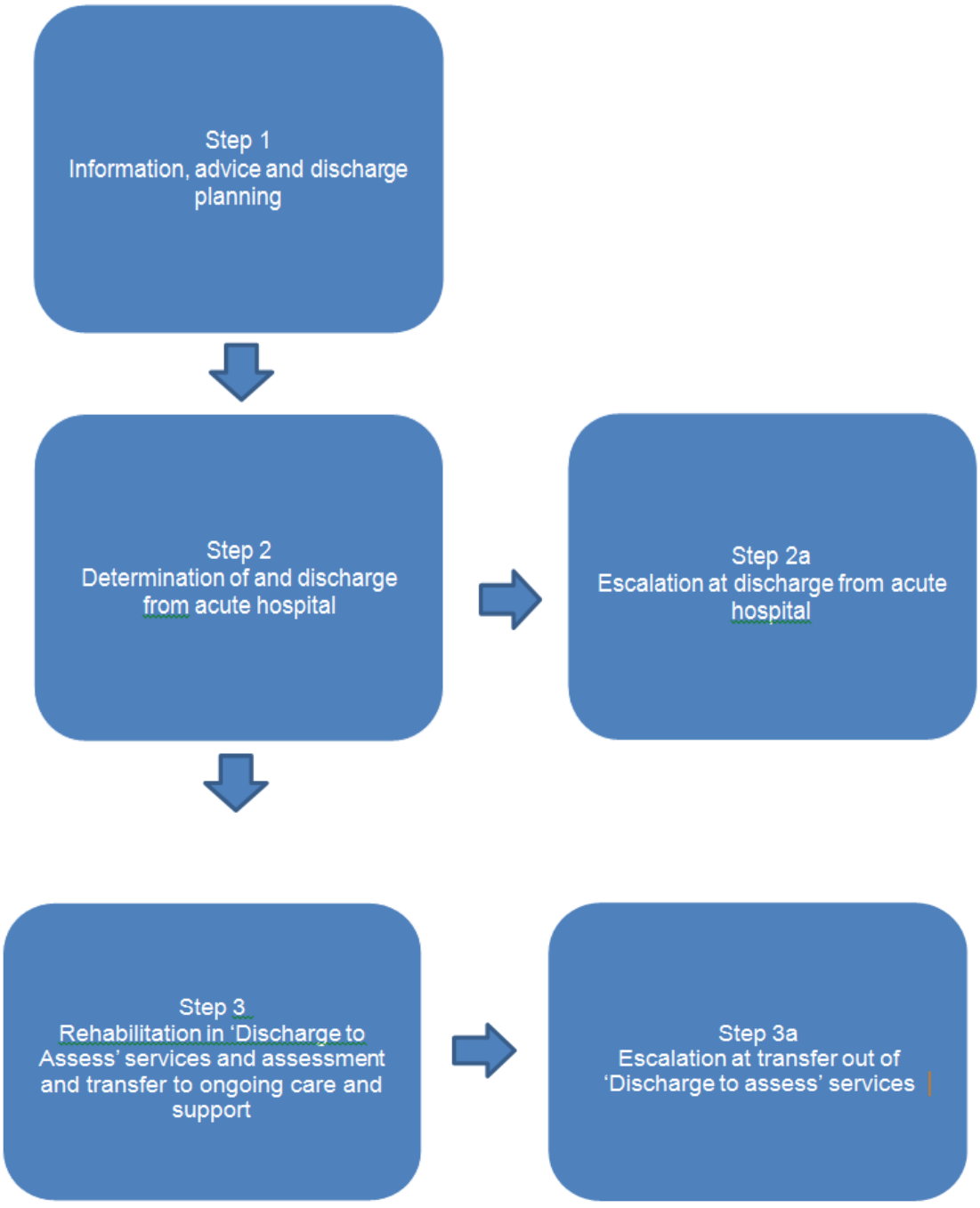
[11] Mental Capacity Act 2005 Code of Practice available at: https://www.gov.uk/government/publications/mental-capacity-act-code-of- practice

[12] Care Act 2014 s10

[13] Care Act 2014 s4

4. OVERVIEW OF PROCEDURE



Step 1 – Information, Advice and Discharge Planning

4.1 Discussions about discharge from acute hospital should start before or as soon as possible after admission.

4.2 A Discharge Coordinator[14] will be identified for each individual and they will explain the discharge planning process to the person on admission.

4.3 The Discharge Co-ordinator and other members of the Multi-Disciplinary Team (MDT) will ensure that the person is aware of this Policy, the discharge process including Discharge to Assess services and the circumstances in which interim care might be necessary. All communication will clearly set out the process that the hospital will follow in order to work towards the person'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 decision[15].

4.4 Discharge Co-ordinators and the MDT will issue **Factsheet A** and discuss this with the individual.

4.5 Discharge Co-ordinators and the MDT will give each person an Estimated Date of Discharge (EDD) as soon as possible after admission, which has been agreed by a consultant or senior clinician. Discharge Co-ordinators and the MDT will regularly review and update the EDD as part of 'board rounds'[16] to ensure parties understand when support will be required to facilitate discharge.

4.6 Discharge Co-ordinators and the MDT will aim for simple and timely discharges wherever possible and resort to using services to facilitate discharge only where absolutely necessary.

4.7 Discharge Co-ordinators and the MDT will involve people in all decisions about their care[17] and support them where necessary.

4.8 Discharge Co-ordinators and the MDT will clearly identify who else the person 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

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[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

Appendix 2). This can include, but is not limited to, any formal or informal carers, friends and family members.

Step 2 – Determination and transfer from acute hospital

4.9 If the person is likely to have ongoing health, housing or social care needs after discharge the Discharge Co-ordinators and MDT will refer them to the team co-ordinating complex discharges for the site – this is currently the Track and Triage team for in-county hospitals and MPFT local teams for out of county hospitals.

4.10 The team co-ordinating complex discharges will determine:
Whether the individual needs rehabilitation and support to enable acute
Whether they can return home with reablement/intermediate care.
hospital discharge.
Whether they need an interim NHS funded community bed.
Whether capacity is available in the 'Discharge to Assess' services required.

4.11 The team co-ordinating complex discharges will determine the most suitable option, ensure that the information required by the relevant 'Discharge to Assess' services is available and co-ordinate the handover of care. If the person agrees to the discharge arrangements then these should proceed accordingly; if the person indicates that they are unwilling to agree then the Discharge Co-ordinator and MDT should issue Choice Letter B1 or B2 – go to 4.21.

4.12 If no capacity is available in 'Discharge to Assess' services then the team co-ordinating complex discharges will refer the person for a Care Act and/or NHS CHC assessment. They will advise any carers of their rights to have a Carer's Assessment and refer them to relevant information, advice and support services where appropriate. Note that if capacity in 'Discharge to Assess' services subsequently becomes available whilst the person remains in the acute hospital then the team co-ordinating complex discharges should consider whether this offers a faster and more suitable route to discharge than completing the assessment and arranging ongoing care and support as below.

4.13 The relevant local authority and/or CCG will complete the Care Act and/or NHS CHC assessment. People should be involved in their assessment and directed to a local advocacy service for advice and information regarding advocacy, if required.[18]

4.14 On completion of a Care Act and/or NHS CHC assessment for those people who are entitled to state funded care the relevant local authority and/or CCG (using the ADAM[19] process) will identify at least one option for ongoing care and support that meets their assessed eligible needs. The local authority

[18] Care Act 2014, s67 Involvement in Assessment, Plans etc

[19] Refer to Adam Policy and Criteria

and/or CCG will communicate this option to the person including full details about funding arrangements and the extent to which they are likely to have to contribute to the cost of their care. If the person agrees to the discharge arrangements then these should proceed accordingly; if the person indicates that they are unwilling to agree then the Acute Trust Discharge Co-ordinator should issue Choice Letter B3 or B4 – go to 4.21 For local authority funded people they will be advised of their right to choose an alternative option and for them or a third party to pay a top-up[20],[21]. If they choose an alternative, agree to pay the top-up and are deemed able to afford the top-up then the discharge should proceed accordingly. If they choose an alternative but either refuse to pay the top-up or are deemed unable to afford the top-up then the discharge should default to the option(s) offered by the local authority.

4.15 People who are funding their own care will need to make their own arrangements. The Acute Trust Discharge Co-ordinator should issue Choice Letter B5 along with details of where they can find information about care providers who may be able to meet their can meet their needs – go to 4.25

Step 3 – Rehabilitation in discharge to assess services and assessment and transfer to ongoing care and support

4.16 'Discharge to Assess' services will aim to achieve recovery to full independence wherever possible.

4.17 Where necessary the team co-ordinating complex discharges and/or 'Discharge to Assess' services will refer people for a for Care Act and/or NHS CHC assessment once an individual has achieved or is about to achieve their optimum level of independence. Referrals will be made in a timely way to avoid over prolonging the 'Discharge to Assess' period. They should explain to the person that on completion of the assessment the expectation will be that they transfer to ongoing care arrangements within seven days.

4.18 The relevant local authority and/or CCG will complete the Care Act and/or NHS CHC assessment. People should be involved in their assessment and directed to a local advocacy service for advice and information regarding advocacy, if required.[22]

4.19 On completion of a Care Act and/or NHS CHC assessment for those people who are entitled to state funded care the relevant local authority and/or CCG (using the ADAM[23] process) will identify at least one option for ongoing care that meets their assessed eligible needs. The local authority and/or CCG will communicate this option to the person including full details about funding arrangements and the extent to which they are likely to have to contribution to the cost of their care. If the person is happy to transfer to the ongoing care

[20] Care Act 2014 s4 and s30; Care and Support and After-care (Choice of Accommodation) Regulations 2014
[21] Care Act 2014 s3, and Care and Support (Discharge of Hospital Patients) Regulations 2014, SI 2014/2823
[22] Care Act 2014, s67 Involvement in Assessment, Plans etc
[23] Refer to Adam Policy and Criteria

and support then this should proceed accordingly; if the person indicates that they are unwilling to transfer then Choice Letter E1 or E2 should be issued – go to 4.30 – for NHS provided 'Discharge to Assess' services this will be by the service; for independently provided 'Discharge to Assess' services this will be by the CCG. For local authority funded people they will be advised of their right to choose an alternative option and for them or a third party to pay a top-up[24],[25]. If they choose an alternative, agree to pay the top-up and are deemed able to afford the top-up then the discharge should proceed accordingly. If they choose an alternative but either refuse to pay the top-up or are deemed unable to afford the top-up then the discharge should default to the option(s) offered by the local authority.

Step 2a – Escalation at discharge from acute hospital

4.21 The MDT team should meet with the individual (and their representatives if appropriate) daily to discuss the discharge and attempt to reach a solution that avoids further action. People do not have the right to remain in a NHS bed longer than required[26]. 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 discharge is suitable and in line with human rights legislation.[27] The individual should also be provided with details of relevant complaints and appeals procedures.

4.22 For those people for whom discharge to assess services or other ongoing care and support has been arranged, escalation should begin a **maximum of three** days after issuing Choice Letters B1, B2, B3 or B4. 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 three days, a longer period may be agreed for an individual.

4.23 Escalation should begin with consideration of the risks of discharging the person without care and support. They should be told that they cannot stay in the acute hospital and must accept the care and support offered or make their own arrangements.

4.24 The Acute Trust Discharge Co-ordinator should issue Choice Letter C1. If the person agrees to then the discharge should proceed as planned. If the person still refuses then the case should be referred to senior management – go to 4.28.

4.25 For people who are funding their own care, if they have not made arrangements then escalation should begin **a maximum of three** days after issuing Choice Letter B5. If there are particular circumstances, such as an

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

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

[26] 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.

[27] Human Rights Act1998

out of area transfer or safeguarding concerns, when it is unreasonable to expect a decision to be made within three days, a longer period may be agreed for an individual.

4.26 Escalation should begin with consideration of the risks of discharging the person without care. They should be told that they cannot stay in the acute hospital and must expedite arrangements for their ongoing care and support.

4.27 The Acute Trust Discharge Co-ordinator should issue Choice Letter C2. If the person has arrangements in place then the discharge should proceed according to their preference. If the person still has not made arrangements then the case should be referred to senior management – go to 4.28.

4.28 A senior manager from the acute trust should meet with the individual (and their representatives if appropriate). They should discuss the discharge arrangements and consider any concerns about the offer of care and support. If they deem the offer reasonable in the context of usual practice local availability of services then they should confirm this verbally and follow it up in writing – go to 4.29. If they deemed that the concerns are legitimate then they should ask for alternative care and support to be sourced – go to 4.10.

4.29 The senior manager should issue Choice Letter D1 or D2. They should meet with the individual (and their representatives if appropriate) daily to discuss progress. They should also discuss with the MDT and the Trust's legal team about whether it is appropriate to invoke powers under the Criminal Justice and Immigration Act 2008 to remove a person from NHS premises.

Step 3a – Escalation at Discharge out of discharge to access services

4.30 A manager (Home First services: service manager; Community Hospital: site manager; CCG beds: CCG officer) should contact the individual (and their representatives if appropriate) daily to discuss the discharge and attempt to reach a solution that avoids further action. People do not have the right to remain in a NHS bed longer than required[28]. 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 to ensure that the proposed transfer is suitable and in line with human rights legislation.[29] The individual should also be provided with details of relevant complaints and appeals procedures.

4.31 For those people for whom ongoing care and support has been arranged by the local authority or NHS, escalation should begin **a maximum of three** days after issuing Choice Letters E1 or E2.

[28] 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.

[29] Human Rights Act 1998

4.32 Escalation should begin with consideration of the risks of discharging the person without care and support as well as the consequences of levying charges if they remain in 'Discharge to Assess' services. They should be told that they cannot stay in 'Discharge to Assess' services and must accept the care and support offered or make their own arrangements.

4.33 Choice Letter F1 should be issued: for NHS provided 'Discharge to Assess' services this will be by the service; for independently provided 'Discharge to Assess' services this will be by the CCG. If the person agrees to the transfer then it should proceed as planned. If the person still refuses then the case should be referred to senior management – go to 4.37.

4.34 For people who are funding their own care, if they have not made arrangements then escalation should begin **a maximum of three** days after issuing Choice Letter E3.

4.35 Escalation should begin with consideration of the risks of discharging the person without care as well as the consequences of levying charges if they remain in 'Discharge to Assess' services. They should be told that they cannot stay in 'Discharge to Assess' services and must expedite arrangements for their ongoing care and support.

4.36 Choice Letter F2 should be issued: for NHS provided 'Discharge to Assess' services this will be by the service; for independently provided 'Discharge to Assess' services this will be by the CCG. If the person has arrangements in place then the transfer should proceed according to their preference. If the person still has not made arrangements then the case should be referred to senior management – go to 4.37.

4.37 A senior manager (Home First services: provider executive; Community Hospital: provider executive; CCG beds: CCG executive) should meet with the individual (and their representatives if appropriate). They should discuss the transfer arrangements and consider any concerns about the offer of care and support. If they deem the offer reasonable in the context of usual practice local availability of services then they should confirm this verbally and follow it up in writing – go to 4.38 If they deemed that the concerns are legitimate then they should ask for alternative care and support to be sourced – go to 4.17.

4.38 Choice Letter G1 or G2 should be issued: for NHS provided 'Discharge to Assess' services this will be by the service; for independently provided 'Discharge to Assess' services this will be by the CCG. A senior manager should contact the individual (and their representatives if appropriate) daily to discuss progress. This should also be set out weekly in writing. They should also discuss professionals involved in their care the possibility of discontinuing services.

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.

Appendix 1: Glossary

Advocate	A person representing the best interests of the Patient
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
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'.
D2A	Discharge to Assess – Where people who are clinically optimised and do not require an acute hospital bed, but may still require care services they are provided with short term, funded support to be discharged to their own home (where appropriate) or another community setting. Assessment for longer- term care and support needs is then undertaken in the most appropriate setting and at the right time for the person.
Delayed Transfer of Care (DTOC)	When a patient is ready to move on to the next stage of care but is prevented from doing so for one or more reasons. Timely transfer and discharge arrangements are important in ensuring that the NHS effectively manages emergency pressures. The arrangements for transfer to a more appropriate care setting (either within the NHS or discharge from NHS care) will vary according to the needs of each patient but can be complex and sometimes lead to delays.
Deprivation of Liberty (DOLs)	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.
Discharge Process	Planning the patient's move from hospital whether to home or another care setting
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	Who will represent patients assessed as lacking

Mental Capacity Advocate (IMCA)	capacity under the Mental Capacity Act 2005 to make important decisions, such as change of accommodation, and who have no family or 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.
Local Health Economy (LHE)	All health and social care organisations involved in a patients care.
MDT	Multi-disciplinary team of health and social care professionals involved in the care and assessment of patients.
Medically Stable	This means that it is safe to discharge the patient who no longer requires inpatient care or treatment at that hospital and/or is ready for safe transfer to another location.
Medically Fit for Discharge	This means that further inpatient medical care or treatment is no longer necessary, appropriate or offered at that hospital and it is safe to discharge the patient to another location. Any further care needs can more appropriately be met in other settings, without the need for an inpatient hospital bed.
Mental capacity	Being able to make a specific decision at a specific time (see Appendix 2).
Patient	In this Policy, the Patient is an individual aged 18 and over who is receiving treatment in hospital.
Reablement	Reablement helps people adapt to a recent illness or disability by learning or relearning the skills necessary for independent daily living at home. I**t** encourages patients to develop the confidence and skills to carry out these activities themselves and continue to live at home. Reablement services may be provided by the Local Authority for up to six weeks; however hospital discharge related reablement is the responsibility of Midland Partnership Foundation Trust.
Ready to Transfer	A patient is ready for transfer when: i. A clinical decision has been made that patient is ready for transfer AND ii. A multi-disciplinary team decision has been made that patient is ready for transfer AND

	iii. The patient is safe to discharge/transfer.
Representative	A person nominated by the patient to be involved in discharge planning or a family member, carer, person granted with a lasting power of attorney, court deputy, friend or other advocate that the patient has asked to be involved. It is good practice, unless there are clear reasons for not doing so, to work with the carers, family and friends of an individual to help them to get the care and support they need. Sharing information with these people should always be with the consent of the individual. If the person lacks the mental capacity to make a decision about sharing information with key people, then the Mental Capacity Act should be followed to ensure each decision to share information is in the person's best interests. Decisions and reasoning should always be recorded.
Self-Funder	A person who financially meets the full cost of their own 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
Social Care Assessment	The assessment of an individual's social care needs that all adult patients are entitled to, regardless of financial status. Social care will help identify suitable care and assist with discharge from hospital if asked.
Social Care professional	Social worker or care manager allocated by Adult Services

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 a 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 ready for transfer 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, any more 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's 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.

Organisation	Responsibility or right in relation to choice at discharge	Relevant legislation / case law
Hospital (NHS Trust)	No clinician or Trust is obliged to offer anything which is not clinically indicated. This includes provision of an acute inpatient bed. 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 ready for transfer In some cases, where the patient's refusal to leave hospital when ready for transfer constitutes a nuisance or disturbance, an offence may be committed and there is a power to remove the patient Alternatively, other remedies may be available to Trusts under property law 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	R (Burke) v GMC [2005] EWCA Civ 1003; Aintree University Hospitals NHS FT v James [2013] UKSC 67 NHS Act 2006 (as amended) s26, 63 Criminal Justice and Immigration Act 2008, ss119-121 [and see NHS Protect guidance] Barnet PCT v X [2006] EWHC 787 Care Act 2014, Schedule 3, Care and Support (Discharge of Hospital Patients) Regulations 2012, and Delayed Discharge (Continuing Healthcare) Directions 2013 MCA Schedule A1, paras 1-3 , 24 and 76

	local authority where discharge is delayed as a result of failure to meet needs Responsibility to seek authorisation for any deprivation of liberty occurring in the hospital	
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 Responsibility to assess a carer's needs for support and choice about caring 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 Responsibility to provide information and support on choices Responsibility to offer choices / involve the patient in preparation of a care and support plan 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 Responsibility to authorise deprivation of liberty in care homes and hospitals	Care Act 2014 s9 Care Act 2014 s10 Care Act 2014 s30, Care and Support and After-care (Choice of Accommodation) Regulations 2014 Care Act 2014 s4 Care Act 2014 s25 Care Act 2014, s67 MCA Schedule A1 paras 21, 50
Clinical Commissioning Group [and NHS England]	Responsibility to ensure an assessment for eligibility for NHS funded Continuing Healthcare where it appears	NHS Commissioning Board and Clinical Commissioning Groups (Responsibilities and

	that there may be a need for such care. [This is the responsibility for NHS England for military personnel and prisoners]	Standing Rules) Regulations 2012, reg 21
Patient	Right to assessment for care and support by local authority and for NHS Continuing Healthcare as appropriate No right to insist on particular treatment which is not clinically indicated, including provision of an acute inpatient bed when medically fit for discharge Right to be involved in decision making about care 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 ready for transfer while preferred choice is awaited) Right to respect for family life and to not be treated in an 'inhuman or degrading' way	Care Act 2014, s9 and NHS Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) Regulations 2012, reg 21 Barnet PCT v X [2006] EWHC 787; R (Burke) v GMC [2005] EWCA Civ 1003 NHS Constitution Care Act 2014 s30, Care and Support and After-care (Choice of Accommodation) Regulations 2014 Human Rights Act 1998 s6 in relation to Articles 3 and 8 of the European Convention of Human Rights
Carer	Right to carer's assessment / support and choice about caring i.e. willingness to provide care	Care Act 2014 s10

Appendix 4: Supporting Template and Factsheet and Letters

Factsheet A: The Assessment and Discharge Process

Planning your discharge from hospital

We want to help you leave hospital as soon as you are ready. If you stay in hospital too long there is a risk that your health will get worse.

We will involve you in decisions about your treatment and discharge, and give you the information and support you need to make the best decisions. If you are deemed unable to make decisions about your care we will talk to your family or identified carers or will refer you for an Independent Mental Capacity Advocate to support any decision making.

Your health and care professionals will start planning your discharge from hospital as soon as possible during your stay.

You will be given an 'Expected Date of Discharge' which is the day when we expect you to return home, and you will be told if this changes.

You will only stay in the hospital whilst you need medical treatment. Once you are fit enough to leave, the aim will be to discharge you straight away.

Your health and care professionals will talk to you about what you can do for yourself and what help you can get from family, friends and neighbours after you leave hospital.

- The vast majority of people who are discharged from hospital can return home with no ongoing support, or just follow up from their GP if necessary.
- People who do need a bit of extra help whilst they recover can usually get this from family, friends, and their community.
- Only a small number of people need ongoing support from the NHS or social services.

Support after hospital discharge: 'Home First'

- 'Home First' services are for people recovering from an illness or operation who need therapy and/or support whilst they regain independence.
- 'Home First' services are provided by trained staff who work alongside nurses, social workers and therapists.
- The services usually operate from early till late, 7 days a week, all year round.

If you need ongoing therapy and support to aid your recovery we will try and get you home with one of our 'Home First' services where possible, subject to availability.

'Home First' services will look after you for a few weeks.

They will try and get you back to full independence so that you can look after yourself.

If you need ongoing care and support at home after 'Home First' we will arrange an assessment of your needs. This may also happen in hospital if 'Home First' services are not appropriate for you or not available.

The assessment will determine the most suitable way to support you and whether you are eligible for funding from the NHS or social services.

If you are eligible for funding from social services you can either arrange your own care or ask social services to arrange it for you.

It is likely that you will be asked to contribute towards the cost of your care and support, depending on your financial circumstances.

- If you ask social services to arrange your ongoing care and support then we will find the most suitable service that meets your needs.
- We will try to find a service that meets your personal preferences but this may not always be possible - for example we may not be able to arrange visits at the exact time that you want.
- Any company that we ask to provide your care and support will be regulated by the Care Quality Commission.
- You will not usually get a choice of which company provides your services.

Support after hospital discharge: beds

We will transfer you to a community bed depending on what is most appropriate for you and the vacancies available at the time you need to leave hospital. You will be told what type of bed you are being transferred to. These could be:

1. **A community hospital bed**. This will be for a few weeks whilst you recover. These are free under the NHS.
2. **An NHS funded temporary care home bed**. This will be for a few weeks whilst you recover. These are free under the NHS.
3. **A social services funded temporary care home bed**. This will be for a few weeks whilst you recover. You may be asked to contribute to the cost of your care, depending on your financial circumstances.
4. **A social services funded care home bed for ongoing care and support**. This will become your permanent residence. You may be asked to contribute to the cost of your care, depending on your financial circumstances.

If you need ongoing therapy and/or support and are unable to return home straight away then we will arrange for you to be transferred to a community bed for a few weeks.

If possible we will try and get you back to full independence so that you can return home after a short stay.

We will try to offer you a choice of bed, however this may not be possible.

We will try and find a bed close to where you live, however this may not be possible and you may have to travel.

We may ask you to accept the first bed that becomes available and to make a decision quickly so that we can avoid delaying your discharge.

If you are funding your own care home placement on leaving hospital then we may ask that you make a decision quickly about which home you are going to so that we can avoid delaying your discharge.

If you are in a community hospital or a temporary care home bed and need ongoing care and support beyond a few weeks then we will arrange an assessment.

The assessment will determine the right kind of care home for you and whether you are eligible for any ongoing funding from the NHS or social services.

If you are eligible for funding from social services it is likely that you will be asked to contribute towards the cost of your care and support, depending on your financial circumstances.

- We will try to offer you a choice of bed, however this may not be possible.
- We will try and find a bed close to your home, however this may not be possible and you may have to travel.
- If you want to choose a different placement and this is more expensive we will ask you to pay the difference. This is in addition to your contribution to the cost of your care.

Delayed discharges

Once you are well enough to leave hospital then if appropriate care and support has been identified for you or if you are making your own arrangements for care and support you will not be able to remain in hospital whilst you make a decision. Staying in hospital will create a risk to your health and independence and prevents the NHS from looking after people who are seriously ill.

If you do not accept the care and support that has been identified for you or you are unable to make your own arrangements within a reasonable period then it may be necessary to discharge you without care.

University Hospitals of Derby and Burton
NHS Foundation Trust

CHOICE LETTERS CONTENT

Choice Letter B1

Issued by: Acute Trust Discharge Co-ordinator

Proposed discharge: interim – 'Home First'
Issue date: as soon as person indicates that they are unwilling to transfer to the support offered

<Date>

Dear ***<Name>***

Discharge home with therapy and support

You are or will soon be ready to be discharged from the acute hospital. Your expected date of discharge is ***<date>.***

You have been offered rehabilitation and support at home from one of our 'Home First' services whilst you recover. You will be looked after by the 'Home First' service for a few weeks until you have recovered your independence or an assessment of your ongoing needs has been completed, and a plan for your ongoing care is in place. The assessment will determine the best way to support you in the longer term and whether you are eligible for funding from the NHS or social services.

It is very important that we can discharge you from the acute hospital. Staying here is a risk to your own health and stops us from being able to treat other seriously ill people.

Please confirm in the next 3 days that you will accept the offer of rehabilitation and support at home from the 'Home First' service.

Please do not hesitate to ask a member of the team looking after you, if you have any questions or if you would like a copy of this letter to be given to someone else.

If you wish to make a complaint or appeal against any part of the discharge process then contact at any point **[*insert details of local complaints and appeals procedures*].**

Yours sincerely,
(Insert signature)

University Hospitals of Derby and Burton
NHS Foundation Trust

Choice Letter B2

Issued by: Acute Trust Discharge Co-ordinator
Proposed discharge: interim – NHS funded community bed
Issue date: as soon as person indicates that they are unwilling to transfer to the bed offered

<Date>

Dear ***<Name>***

Discharge to a temporary community bed

You are or will soon be ready to be discharged from the acute hospital. Your expected date of discharge is ***<date>.***

You have been offered care after discharge in one of our community beds at <***name of community hospital or care home>***. You will be looked after here for a few weeks until you have recovered your independence or an assessment of your ongoing needs has been completed, and a plan for your ongoing care is in place. The assessment will determine the best way to support you in the longer term and whether you are eligible for funding from the NHS or social services.

It is very important that we can discharge you from the acute hospital. Staying here is a risk to your own health and stops us from being able to treat other seriously ill people.

Please confirm in the next 3 days that you will accept the offer of care at ***<name of community hospital or care home>.***

Please do not hesitate to ask a member of the team looking after you, if you have any questions or if you would like a copy of this letter to be given to someone else.

If you wish to make a complaint or appeal against any part of the discharge process then contact at any point ***[insert details of local complaints and appeals procedures].***

Yours sincerely

[*Insert signature*]

University Hospitals of Derby and Burton NHS Foundation Trust

Choice Letter B3

Issued by: Acute Trust Discharge Co-ordinator
Proposed discharge: local authority or NHS CHC funded ongoing care and support – home Issue date: as soon as person indicates that they are unwilling to transfer to the support offered

<Date>

Dear ***<Name>***

Discharge home with support

You are or will soon be ready to be discharged from the acute hospital. Your expected date of discharge is ***<date>.***

You have been assessed as requiring ongoing support at home after you leave hospital and you have been offered support from a home care agency. They will meet the needs identified in your assessment. Your needs will be reviewed in a few weeks to see whether you still need the support. You may need to make a contribution to the cost of your care.

It is very important that we can discharge you from the acute hospital. Staying here is a risk to your own health and stops us from being able to treat other seriously ill people.

Please confirm in the next 3 days that you will accept the offer of support at home. If you would like to make alternative arrangements for your ongoing support you are free to do so and will need to confirm these within 3 days. If the cost is greater than the home care agency offered you or someone else will need to pay the difference as a 'top-up'. We can provide you with details about suitable home care agencies on request.

Please do not hesitate to ask a member of the team looking after you, if you have any questions or if you would like a copy of this letter to be given to someone else.

If you wish to make a complaint or appeal against any part of the discharge process then contact at any point ***[insert details of local complaints and appeals procedures].***

Yours sincerely,

[*Insert signature]*

University Hospitals of Derby and Burton
NHS Foundation Trust

Choice Letter B4

Issued by: Acute Trust Discharge Co-ordinator
Proposed discharge: local authority or NHS CHC funded ongoing care and support – bed Issue date: as soon as person indicates that they are unwilling to transfer to the bed offered

<Date>

Dear ***<Name>***

Discharge to a care home

You are or will soon be ready to be discharged from the acute hospital. Your expected date of discharge is ***<date>.***

You have been assessed as requiring ongoing care in a care home after you leave hospital and you have been offered a place at <***name of care home>.*** They will meet the needs identified in your assessment. Your needs will be reviewed in a few weeks to see whether this remains the best care home for you or whether an alternative care home is more appropriate. You may need to make a contribution to the cost of your care.

It is very important that we can discharge you from the acute hospital. Staying here is a risk to your own health and stops us from being able to treat other seriously ill people.

Please confirm in the next 3 days that you will accept the offer of care at ***<name of care home>.*** If you would like to make alternative arrangements for your ongoing care you are free to do so and will need to confirm these within 3 days. If the cost is greater than the care home offered you or someone else will need to pay the difference as a 'top-up'. This is in addition to the contribution to the cost of your care. We can provide you with details about suitable care homes on request.

Please do not hesitate to ask a member of the team looking after you, if you have any questions or if you would like a copy of this letter to be given to someone else.

If you wish to make a complaint or appeal against any part of the discharge process then contact at any point ***[insert details of local complaints and appeals procedures].***

Yours sincerely,

[Insert signature]

University Hospitals of Derby and Burton
NHS Foundation Trust

Choice Letter B5

Issued by: Acute Trust Discharge
Co-ordinator Proposed discharge:
self-funded ongoing care
Issue date: as soon as the assessment confirms that they requiring ongoing care and support and are a self-funder

<Date>

Dear ***<Name>***

Discharge with ongoing care and support

You are or will soon be ready to be discharged from the acute hospital. Your expected date of discharge is ***<date>.***

You have been assessed as requiring ongoing care and support after you leave hospital and we understand that you will be funding your own care.

It is very important that we can discharge you from the acute hospital. Staying here is a risk to your own health and stops us from being able to treat other seriously ill people.

We would be grateful if you could confirm the arrangements for your ongoing care and support within 3 days. We can provide you with details about suitable care and support providers on request.

Please do not hesitate to ask a member of the team looking after you, if you have any questions or if you would like a copy of this letter to be given to someone else.

If you wish to make a complaint or appeal against any part of the discharge process then contact at any point ***[insert details of local complaints and appeals procedures].***

Yours sincerely,

[Insert signature]

NHS
University Hospitals of Derby and Burton
NHS Foundation Trust

Choice Letter C1

Issued by: Acute Trust Discharge Co-ordinator
Proposed discharge: any care and support arranged by NHS or local authority
Issue date: after Choice Letter B1, B2, B3, B4 if discharge is unresolved

<Date>

Dear ***<Name>***

Discharge from hospital

We wrote to you previously ***<attach letter>*** to let you know that you are ready to be discharged from the acute hospital and that we have arranged care and support for you after discharge. Your expected date of discharge was ***<date>.***

You have not yet confirmed that you will accept the offer of care and support after discharge or that you have made alternative arrangements.

We do not wish to cause you or your family anxiety but you cannot remain in the acute hospital any longer. Staying here is a risk to your own health and stops us from being able to treat other seriously ill people.

Please do not hesitate to ask a member of the team looking after you, if you have any questions or if you would like a copy of this letter to be given to someone else.

If you wish to make a complaint or appeal against any part of the discharge process then contact at any point ***[insert details of local complaints and appeals procedures].***

Yours sincerely

[Insert signature]

NHS
University Hospitals of Derby and Burton
NHS Foundation Trust

Choice Letter C2

Issued by: Acute Trust Discharge Co-ordinator Proposed discharge: self-funders
Issue date: after Choice Letter B5 if discharge is unresolved

<Date>

Dear ***<Name>***

Discharge from hospital

We wrote to you previously ***<attach letter>*** to let you know that you are ready to be discharged from the acute hospital and that you needed to arrange care and support after discharge. Your expected date of discharge was ***<date>.***

You have not yet confirmed that you have arranged care and support.
We do not wish to cause you or your family anxiety but you cannot remain in the acute hospital any longer. Staying here is a risk to your own health and stops us from being able to treat other seriously ill people.

Please do not hesitate to ask a member of the team looking after you, if you have any questions or if you would like a copy of this letter to be given to someone else.

If you wish to make a complaint or appeal against any part of the discharge process then contact at any point ***[insert details of local complaints and appeals procedures].***

Yours sincerely,

[Insert signature]

University Hospitals of Derby and Burton
NHS Foundation Trust

Choice Letter D1

Issued by Acute Trust Senior Manager
Proposed discharge: any care and support arranged by NHS or local authority Issue date: after Choice Letter C1 if discharge is unresolved

<Date>

Dear ***<Name>***

Discharge from hospital

We wrote to you previously ***<attach letters>*** to let you know that you are ready to be discharged from the acute hospital and that you either need to accept our offer of care and support to enable discharge or make your own arrangements.

We met today to discuss your discharge. We confirmed the following:

- ***<care and support offered to enable discharge>***
- ***<reasons why the person is unwilling to accept the offer of care and support>***
- ***<why the offer is reasonable>***
- ***<risks to them of not accepting the offer>***
- ***<other points>***

We will continue to work with you to try to come to a mutually agreeable solution.

NHS Trusts have statutory rights under the **Criminal Justice and Immigration Act 2008** to remove a person from NHS premises where a person:

1) Is causing a nuisance or disturbance to staff members
2) Is not receiving medical treatment; and
3) Refuses to vacate the premises upon being asked to do so

This also applies to people who have received their medical treatment and no longer require hospital care.

We will consult with our legal advisers about your situation whether it is appropriate for us to invoke our powers under the Act. You may also wish 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].***

Yours sincerely,

[Insert signature]

University Hospitals of Derby and Burton
NHS Foundation Trust

Choice Letter D2

Issued by Acute Trust Senior Manager

Proposed discharge: self-funders
Issue date: after Choice Letter C2 if discharge is unresolved

<Date>

Dear ***<Name>***

Discharge from hospital

We wrote to you previously ***<attach letters>*** to let you know that you are ready to be discharged from the acute hospital and that you need to arrange care and support to enable discharge.

We met today to discuss your discharge. We confirmed the following:

- ***<reasons why the person is unable to arrange care and support>***
- ***<why they need to do so>***
- ***<other points>***

We will continue to work with you to try to come to a mutually agreeable solution.

In addition, NHS Trusts have statutory rights under the **Criminal Justice and Immigration Act 2008** to remove a person from NHS premises where a person:

4) Is causing a nuisance or disturbance to staff members
5) Is not receiving medical treatment; and
6) Refuses to vacate the premises upon being asked to do so

This also applies to people who have received their medical treatment and no longer require hospital care.

We will consult with our legal advisers about your situation whether it is appropriate for us to invoke our powers under the Act. You may also wish 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].***

Yours sincerely,

[Insert signature]

Choice Letter E1
Issued by: NHS 'Discharge to Assess Service' or CCG
Proposed transfer: local authority or NHS CHC funded ongoing care and support – home
Issue date: as soon as person indicates that they are unwilling to transfer to the support offered

<Date>

Dear ***<Name>***

Transfer into home care

You are or will soon be ready to be transferred from 'Home First' services.

You have been assessed as requiring ongoing support at home after you leave hospital and you have been offered support from a home care agency. They will meet the needs identified in your assessment. Your needs will be reviewed in a few weeks to see whether you still need the support. You may need to make a contribution to the cost of your care.

It is very important that we can transfer you out of 'Home First' services. This is so that we can discharge other people from hospital.

Please confirm that you will accept the offer of support at home. If you would like to make alternative arrangements for your ongoing support you are free to do so and will need to confirm these. If the cost is greater than the home care agency offered you or someone else will need to pay the difference as a 'top-up'. This is in addition to the contribution to the cost of your care. We can provide you with details about suitable home care agencies on request.

Please do not hesitate to ask a member of the team looking after you, if you have any questions or if you would like a copy of this letter to be given to someone else.

If you wish to make a complaint or appeal then contact at any ***point [insert details of local complaints and appeals procedures].***

Yours sincerely,

[Insert signature]

University Hospitals of Derby and Burton NHS Foundation Trust

Choice Letter E2

Issued by: NHS 'Discharge to Assess' service or CCG

Proposed transfer: local authority or NHS CHC funded ongoing care

<Date>

Dear ***<Name>***

Transfer to a care home

You are or will soon be ready to be transferred from the temporary community bed. Your expected date of discharge is ***<date>.***

You have been assessed as requiring ongoing care in a care home and it is imperative for yourself or your relative that a choice of home is found within the next 3 days to support their exit from this temporary community bed. Your multi-disciplinary team has helped you identify where vacancies are and which category of home you should be looking at. Your needs will be reviewed in a few weeks to see whether this remains the best care home for you or whether an alternative care home is more appropriate. You may need to make a contribution to the cost of your care.

It is very important that we can discharge you from the temporary community bed. This is so that we can discharge other people from hospital.

If you would like to make alternative arrangements for your ongoing care you are free to do so and will need to confirm these within the next 3 days.

Please do not hesitate to ask a member of the team looking after you, if you have any questions or if you would like a copy of this letter to be given to someone else.

If you wish to make a complaint or appeal then contact at any point **[*insert details of local complaints and appeals procedures*].**

Yours sincerely,

[*Insert signature*]

Choice Letter E3
Issued by: NHS 'Discharge to Assess' service or CCG
Proposed discharge: self-funded ongoing care
Issue date: as soon as the assessment confirms that they requiring ongoing care and support and are a self-funder

<Date>

Dear ***<Name>***

Discharge with ongoing care and support

You are or will soon be ready to be transferred from ***['Home First services / the temporary community bed].***

You have been assessed as requiring ongoing care and support after you leave hospital and we understand that you will be funding your own care.

It is very important that we can discharge you from ***['Home First services / the temporary community bed].*** This is so that we can discharge other people from hospital.

We would be grateful if you could confirm the arrangements for your ongoing care and support.

You have been offered a placement/ package of care that will meet your or your relative's needs. If you wish to make alternative arrangements and the cost is greater than the package or placement offered you will need to pay the difference as a top up. This is in addition to the contribution to the cost of your care.

Please do not hesitate to ask a member of the team looking after you, if you have any questions or if you would like a copy of this letter to be given to someone else.

If you wish to make a complaint or appeal then contact at any point ***[insert details of local complaints and appeals procedures].***

Yours sincerely,

[Insert signature]

NHS
University Hospitals of Derby and Burton
NHS Foundation Trust

Choice Letter F1
Issued by: NHS 'Discharge to Assess' service or CCG
Proposed discharge: any care and support arranged by NHS or local authority Issue date: after Choice Letter E1 or E2 if discharge is unresolved

<Date>

Dear ***<Name>***

Discharge from hospital

We wrote to you previously ***<attach letter>*** to let you know that you have completed your time with 'Discharge to Assess' services and that we have arranged ongoing care and support for you.

You have not yet confirmed that you will accept the offer of care and support or that you have made alternative arrangements.

We do not wish to cause you or your family anxiety but you cannot remain in 'Discharge to Assess' any longer. This is stopping us from being able to discharge other people from hospital.

Please do not hesitate to ask a member of the team looking after you, if you have any questions or if you would like a copy of this letter to be given to someone else.

If you wish to make a complaint or appeal then contact at any point ***[insert details of local complaints and appeals procedures].***

Yours sincerely,

[Insert signature]

University Hospitals of Derby and Burton
NHS Foundation Trust

Choice Letter F2
Issued by: NHS 'Discharge to Assess' service or CCG
Proposed discharge: self-funders
Issue date: after Choice Letter E3 if discharge is unresolved

<Date>

Dear ***<Name>***

Discharge from hospital

We wrote to you previously ***<attach letter>*** to let you know that you have completed your time with 'Discharge to Assess' services and that you needed to arrange ongoing care and support.

You have not yet confirmed that you have arranged care and support.

We do not wish to cause you or your family anxiety but you cannot remain in 'Discharge to Assess' any longer. This is stopping us from being able to discharge other people from hospital.

Please do not hesitate to ask a member of the team looking after you, if you have any questions or if you would like a copy of this letter to be given to someone else.

If you wish to make a complaint or appeal then contact at any point ***[insert details of local complaints and appeals procedures].***

Yours sincerely,

[*Insert signature*]

University Hospitals of Derby and Burton NHS Foundation Trust

Choice Letter G1
Issued by: NHS 'Discharge to Assess' service or CCG
Proposed discharge: any care and support arranged by NHS or local authority Issue date: after Choice Letter F1 if discharge is unresolved

<Date>

Dear ***<Name>***

Transfer to ongoing care and support

We wrote to you previously ***<attach letters>*** to let you know that you have completed your time with 'Discharge to Assess' services and that you either need to accept our offer of care and support or make your own arrangements.

We met today to discuss your transfer to ongoing care and support. We confirmed the following:

- ***<care and support offered>***
- ***<reasons why the person is unwilling to accept the offer of care and support>***
- ***<why the offer is reasonable>***
- ***<risks to them of not accepting the offer>***
- ***<other points>***

We will continue to work with you to try to come to a mutually agreeable solution. In the meantime we will consult with the professionals involved in your care about to determine whether it is appropriate for us to discontinue your current care and support.

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 wish to make a complaint or appeal then contact at any point ***[insert details of local complaints and appeals procedures].***

Yours sincerely,

[Insert signature]

University Hospitals of Derby and Burton
NHS Foundation Trust

Choice Letter G2
Issued by: NHS 'Discharge to Assess' service or CCG
Proposed discharge: self-funders
Issue date: after Choice Letter F2 if discharge is unresolved

<Date>

Dear ***<Name>***

Transfer to ongoing care and support

We wrote to you previously ***<attach letters>*** to let you know that you have completed your time with 'Discharge to Assess' services and that you need to arrange care and support to enable discharge.

We met today to discuss your discharge. We confirmed the following:

- ***<reasons why the person is unable to arrange care and support>***
- ***<why they need to do so>***
- ***<other points>***

We will continue to work with you to try to come to a mutually agreeable solution. In the meantime we will consult with the professionals involved in your care about to determine whether it is appropriate for us to discontinue your current care and support.

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 wish to make a complaint or appeal then contact at any point ***[insert details of local complaints and appeals procedures].***

Yours sincerely,

[Insert signature]

APPENDIX 5: CHOICE PATHWAY FORM

File in person's notes and copy to receiving services

Affix patient label	Hospital: Ward: Discharge coordinator: Ward lead:

STAGE & ACTION	**Date Discussed**	**Site**	**Initial/sign**
Step 1 – Providing standard information and support • Discuss discharge with person/representative before or as soon as possible after admission • Check if person has mental capacity and if not put appropriate measures in place • Person/representative informed of named discharge coordinator • Locally agreed discharge planning tool or paperwork started Provide **Factsheet A**			
Step 2 – Determination of and discharge from acute hospital • Person referred to team co-ordinating complex discharges for the site to determine the support required to facilitate discharge • If the person indicates that they are unwilling to agree to the transfer then the Discharge Co-ordinator and MDT should issue **Letter B1**, **B2, B3,**			
Step 2a – Escalation at discharge from acute hospital • Follow escalation protocol • Issue **Letters C1 or C2** as required			
Step 3 – Rehabilitation in 'Discharge to Assess' services and assessment and transfer to ongoing care and support • Person referred to team co-ordinating complex discharges for the site to determine the support required to facilitate discharge • If the person indicates that they are unwilling to agree to the transfer then the Discharge to Assess service should issue **Letter E1**, **E2 or E3** as			
Step 3a Escalation at transfer out of 'Discharge to assess' services • Follow escalation protocol • Issue **Letters F1 or F2** as required • Issue **Letters G1 or G2** as required			