GMCA GREATER MANCHESTER COMBINED AUTHORITY

NHS in Greater Manchester

Policy for Patient Choice across Greater Manchester

(In relation to ongoing care upon discharge from hospital)

Final – August 2017

Ratified by Greater Manchester Health and Social Care Partnership, Strategic Partnership Board on the 28th of July 2017.

Contents

1. Background

1.1. Patients exercising 'patient choice' is a contributory factor in delayed transfers of care across Greater Manchester with around one in ten delayed patients being due to patients not wishing to leave the hospital when identified as ready for discharge.

1.2. Best practice in discharge planning can avoid many of the issues that lead to patient choice issues, involving the patient, family and carers early in the process and actively managing expectations from the outset can all contribute to a positive patient experience.

2. Purpose of the Policy

2.1. It is essential that people access alternative care and support services in a timely way to ensure that the NHS can make hospital services available for people that need them.

2.2. The consequences of a patient who is ready for discharge remaining in a hospital bed longer than necessary include:

- Exposure to an unnecessary risk of hospital acquired infection
- Physical and mental decline and loss of mobility / muscle use;
- Frustration and distress to the patient and relatives due to uncertainty during any wait for a preferred choice to become available;
- Increased patient dependence, and greater demand for social care and support in the community, as the hospital environment is not designed to meet the needs of people who are medically fit for discharge;
- Severely ill patients being unable to access services due to beds being occupied by patients who are medically fit for discharge creating pressures on the whole system

2.3. The need to decide to accept care or support at home, to move to an alternative care environment or to live in a nursing or residential home is a major decision that is often made at an very challenging time.

2.4. Personal circumstances can change significantly once a person is admitted to hospital, including adjustment to disability, increasing dependence and potential erosion to social networks.

2.5. On occasion, individuals decline the options that are available and to continue to remain in hospital longer than is necessary. This may be due to a variety of reasons such as:

- A lack of knowledge about the options and how services and systems work

- Their first choice of nursing or residential care home or community carer is not available
    - Anxiety at facing the major life transition of moving from hospital to a care home for the first time, possibly for the rest of their life.
    - Concerns about either the quality or cost of the care provision
    - Reluctance to transfer to another hospital that is not local to their home because loved ones might find it difficult to visit.
    - Unwillingness to move into interim accommodation and then move again later.
    - There is uncertainty or conflict about who will cover costs of care
    - 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
    - Unrealistic expectations about their ability to cope and worry about expectations of what family and carers can and will do to support them
    - Mental capacity issues
    - Ethnic of religious beliefs that limits providing a certain type of service

2.6. It is important that the multi-disciplinary team is sensitive to the above issues when discussing discharge options, however patients must also be made aware of the potential issues of remaining in a hospital bed and staff must ensure that barriers to discharge are removed as early as possible in the care pathway.

2.7. Patient participation, engagement and communication are essential to the process for managing choice on hospital discharge

2.8. This policy has been designed to support 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.

2.9. It applies to all adult inpatients in Greater Manchester NHS settings, including acute and non-acute. It should be applied 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.

2.10. 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. Where the patient lacks capacity to make decisions about discharge from hospital, then the application of the policy should be adapted as explained in Appendix 1, following the Mental Capacity Act 2005.

2.11. This policy seeks to ensure that choice is managed sensitively and consistently through the discharge planning process, and people are provided with effective information and are supported to make a choice.

2.12. This policy is designed to offer guidance support and to provide a framework with which to work with individuals and representatives to manage the challenges of patient choice.

2.13. Both the policy and the process of managing choice on discharge apply equally to all patients, whether or not they need ongoing NHS or social care and whoever may be funding any such care.

2.14. For patients who are at the end of life and whose choice it is to die in hospital this decision should be respected.

2.15. Patients do not have the legal right to remain in hospital longer than is clinically indicated. A summary of legal responsibilities and rights, along with associated case law is contained as Appendix 2 of this document.

3. National Guidance on Choice on Discharge

3.1. LAC (2004)20: Guidance on Choice of Residential Accommodation, states that where patients have been assessed as no longer requiring NHS inpatient care, they do not have the right occupy indefinitely an NHS bed. If an individual continues to unreasonably refuse the interim care home or care package, the council is entitled to consider that it has fulfilled its statutory duty to assess and offer services, and may then inform the individual, in writing, they will need to make their own arrangements. The position also applies to the unreasonable refusal of permanent home care, not just the interim care home or care package

3.2. The Choice Directions Guidance, Ready to Go, Department of Health, states that discharge or transfer from hospital is frequently delayed when an individual's preferred accommodation is not available. Where it is entirely reasonable for a person to exercise choice at an extremely difficult and vulnerable time in their lives, the guidance makes it clear that, as long as an interim placement meets the needs of the individual, it is acceptable for a patient to move from an acute hospital to an interim placement until the permanent of alternative choice becomes available. It is important that consistent messages and information are given to patients and carers by all staff about the likely length of stay in hospital, and the need to move on to more appropriate care when they are ready to do so. This will avoid misunderstandings and surprises later in the process.

3.3. Patient Choice, NHS Constitution 2015, clearly places the patient at the heart of the NHS and upholds the views that patients need to be consulted and involved and offered guidance on the choices they can make.

4. Patient Choice in Discharge Planning

4.1. This policy supports existing guidance on effective discharge planning. It should be delivered within the context of an integrated discharge team, supported by strong executive leadership.

4.2. Discharge plans, that consider patient choice, should be developed before a patient becomes medically fit for discharge.

4.3. This policy supports discharge where the SAFER flow bundle is effectively used in inpatient care settings to support the timely discharge of patients.

4.4. Planning for safe, effective, transfer of care, in collaboration with the patient, their representatives and all members of the multi-disciplinary should start on admission, and for elective patients, before admission.

4.5. Patient choice should be considered as soon as possible after admission along with any other barriers to discharge.

4.6. Communication is central to the process of managing patient choice. Patients should be provided with high quality information, advice and support in a form that is accessible to them as early as possible, for elective admissions this should be before their inpatient stay, to enable effective participation in the discharge process and in making an informed choice. Patients and their representatives should be involved in all decisions about their care.

4.7. 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. Carers must be offered the information, training and support they need to provide care following discharge, including a carer's assessment.

4.8. Patients may wish to involve a member of their family, a carer, friends or others in their choice of care and this person should be identified as soon as possible to ensure that they can be involved in discussions and decisions within appropriate timeframes. This person is referred to as their representative within this document.

4.9. 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.

4.10. Through appropriate implementation of this policy, patients and their representatives should fully understand that they cannot continue to occupy an inpatient bed if appropriate options have been provided for their care. If their preferred location or care provider is not available, the patient should be fully aware that they need to accept an alternative as an interim placement.

4.11. The process and timelines contained in this document should be clearly communicated to the patient so that by the time is medically fit for discharge, they are aware of and understand the discharge process and the decisions and actions that they need to undertake and the support that they will receive.

4.12. Where individuals no longer need inpatient care and their first choice of nursing or residential care home or community carer is not available, the hospital will support a timely decision to be made regarding an interim care location.

4.1. The process of offering choice of care provider and/or discharge destination will be followed in a fair and consistent way and there should be an audit trail of choices offered to people.

4.14. 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 always be explored first through a discharge to assess model, where this is appropriate for their needs.

4.15. Where 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. A discharge to assess model should always be considered for patients.

4.16. Where a discharge to assess model is in place, patients should be assessed for this provision as soon as possible during the patient pathway to enable decisions about longer-term care to be made in the most appropriate care setting.

4.17. If a patient is not willing to accept any of the available, appropriate alternatives, them, it may be that they are discharged, after having had appropriate warning of the risks and consequences of doing so. This option will only be pursued following the offer and rejection of available, appropriate options of care and appropriate safeguards and risk assessments.

4.18. The discharge plan should be developed to include patient choice where possible, and recognise the patient's autonomy to choose from available options.

4.19. Where available, patients should be offered a range of options and multi-disciplinary team should provide support to facilitate safe and timely transfer.

4.20. 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. This decision should be made by the multi-disciplinary team caring for the patient.

5. The Patient Choice Process

5.1. All actions taken to discharge a patient and discussions held with patients and their representatives regarding choice should be clearly documented in the patient's notes to ensure that there is an audit trail.

5.2. The discharge planning process should be led by a named health or social care professional, working as part of an integrated discharge team as part of the broader multi-disciplinary ward team; this will usually be the patient discharge coordinator.

5.3. The patient discharge coordinator should be responsible for ensuring that the process is appropriately followed and where issues or potential issues with discharge according to the policy are identified, and where appropriate escalated to a senior member of the team.

5.4. Stage One – Information provided within the first 48 hours

5.4.1. Information regarding discharge should be provided at the start of the patient stay, usually within the first 48 hours, or for elective admissions in advance of the admission to the patient, and where appropriate their identified representative. Information should be provided both verbally and in writing to the patient and to the representative where appropriate. Patients should be provided with the following key information at the stage:

- Factsheet A (Appendix 3) should be provided to the patient and where appropriate, their representative. Its contents should also be discussed verbally with the patient to ensure that it has been appropriately communicated.
- The Estimated Date of Discharge should be communicated to the patient and their identified representatives.

5.4.2. If the patient wants a representative, such as a family member, carer or friend, to be involved in their decisions, the discharge coordinator should identify these people at the start of the process, appropriate consent should be received and all information

should be provided to them in the most appropriate manner. Early involvement and engagement of such representatives can significantly reduce the length of time it takes to discharge a patient.

5.4.3. If additional support is available to patients regarding discharge from the voluntary or third sector, these organisations should be signposted to patients at this stage and patients should be supported to access these services.

5.5. Stage Two – Assessing Future Care Needs

5.5.1. The likelihood of the patient and any carers needing health care, social care, housing or other support after discharge should be considered as soon after admission as possible.

5.5.2. If the patient is likely to have ongoing needs after discharge, the discharge coordinator should obtain consent from the patient and ensure timely referral to these other services for assessment. This should be from a holistic and patient-centred perspective of a person's needs and the care and support options may include, for example:

- Discharge to assess provision;
- 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.

5.5.3. Where there is a trusted assessment model in place for the service provision, a referral should be made to this service to prevent the patient requiring multiple assessments and to reduce the timeframes waiting for the assessment process to be completed.

5.5.4. 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.

5.5.5. Patients and/or their representative should be actively involved in the assessment process and in the development of care plans to enable full and effective assessments and to support planning.

5.5.6. Patients should be informed of the rights they have to complain about an assessment or decisions about their need for support.

5.6. Stage Three – Provision of Information to Patient about Care Needs

5.6.1. The discharge coordinator should advise verbally and in writing the outcome of the assessment at the earliest opportunity.

5.6.2. This stage should be completed well in advance of the estimated date of discharge in order to reduce delays to transfer and to provide as much time as possible for the patient and/or representative to make appropriate decisions about their future care.

5.6.3. The patient and/or representative should be informed about the care options available to them, including the funding arrangements of these options.

5.6.4. Where residential or nursing care home provision is required, where possible, the patient should be provided with all available and appropriate placements that can meet their needs and are registered with the Care Quality Commission. These choices should initially be within the CCG catchment area, however there may be occasions when a range of options are provided that are outside of this. Information should be provided to the patient and/or representatives about the costs of these placements.

5.6.5. Where it is not possible to provide three available, appropriate placements, due to limitations in the market, the rationale for providing limited options should be provided to the patient and/or representative.

5.6.6. Information should be confirmed by providing the patient and their representative with Letter 1, A, B or C as shown in Appendix 4, the version is dependent upon the patient destination. It is important that patients are talked through with patients in advance of their provision.

5.6.7. The patient and/or their representative has the right to look at alternatives that fall within the criteria that are set by the local authority based on their individual needs and the option to top up, or the criteria set by the NHS; however timeframes for decisions should be adhered to.

5.6.8. Whilst it is recognised that patients and/or their representatives may want to choose a residential or nursing care home other than those that have been identified, it is important that the risks of this approach are highlighted to the patient and/or representative.

5.6.9. Self-funding patients have the right to look at alternative placements; however, the limitations of the market should be explained and it should be advised at this stage that for those residential care homes with waiting lists, a patient does not have the right to wait in hospital until the placements becomes available. Furthermore, the patient and/or representative should be advised that an interim arrangement may be offered until the meantime and whilst this will be funded by [funding

arrangements to be agreed], this funding will be available for a maximum of three weeks.

5.6.10. At this stage, if the patient is interested in taking up the offer of personal budgets (social care), personal health budgets (NHS) or integrated personal budgets, the discharge coordinator should advise them where to get information, who to contact locally and refer them to the lead.

5.6.11. Patients 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 the formal complaints procedure, all 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.

5.7. Step Four – Choosing a Placement within 7 days

5.7.1. Once all information is provided to the patient, including the provision of Letter 1 (Appendix 4), the patient and/ or their representative should make a decision about discharge within seven consecutive days of the date of this letter or a longer timeframe that is in advance of the date of discharge.

5.7.2. The discharge coordinator will advise the patient that the hospital will expect discharge to be achieved within the agreed timescale.

5.7.3. The discharge coordinator will proactively support the patient during this process and will provide advice and support regardless of how the placement is to be funded. Regular communication will be maintained through this period.

5.7.4. In some circumstances, it is recognised that more than seven days are required in order for people to make decisions. This may be the case for out of area patients and/or whose representatives have to travel further distances in order to make arrangements. However, a deadline should still be defined for achieving a decision regarding discharge which takes in to consideration the specific circumstances.

5.8. Step Five – Where a decision has not been made or an offer has been refused

5.8.1. Where a decision has not been made within seven days, and additional time has not been agreed for this decision, an interim package of care or placement should be offered to a patient.

5.8.2. Patients do not have the right to wait in hospital for their preferred option to become available.

5.8.3. Members of the multi –disciplinary team will liaise within two working days of the date the decision was anticipated. The multi-disciplinary team will discuss and seek to agree the recommended interim package or placement with the patient.

5.8.4. The multi-disciplinary team should advise the patient that an interim arrangement is available which meets their assessed needs. This should be confirmed by the provision of letter 2, Appendix 5, (version dependent on funding arrangements). It is important that this letter is addressed to the patient, is personalised to reflect their circumstances and that the process is also discussed with the patient.

5.8.5. The interim package/placement will allow further time for those choices to be resolved outside of hospital. This interim option would normally be one of the initial packages/placements offered if still available.

5.8.6. Discussions regarding permanent options should be continued during the interim placements, with the discharge coordinator providing that liaison.

5.9. Step Six – Formal Escalation

5.9.1. If no agreement has been reached regarding discharge arrangements after the first five steps, and transfer arrangements are challenged by the patient, the issue should be escalation to a local director or identified senior manager.

5.9.2. A formal meeting should be arranged with the patient and their representative to enable all parties to discuss concerns and seek to agree transfer to the most appropriate care provider, at least as an interim option

5.9.3. The discharge coordinator should send Letter 3 following the formal meeting, summarising the discussion, including discussions about risks, and next steps.

5.9.4. If it has not been possible to arrange a formal meeting, or the patient did not engage in the formal meeting, Letter 3, appendix 6 should be sent to the patient and their representative including the details of the arranged meeting.

5.9.5. If the patient declines the available support and care, including interim arrangements, the hospital has the right to discharge the patient. This step should not be taken without considering the risks of discharge and where appropriate, the hospital should consult their local legal advisors regarding legal proceedings

6. Overview of Process

6.1. A flow diagram of the process is available in Appendix 7 of this document.

7. Funding Arrangements

7.1. This policy applies equally to people regardless of the funding arrangements and the nature of their ongoing care.

7.2. Those self-funding care will be offered the same level of advice, guidance and assistance regarding choice as those fully or partly funded by the Local Authority or NHS, although it is recognised that some of the content of that care may be different.

7.3. A full assessment for NHS CHC should only be undertaken where the longer term needs of the individual are clear. In the majority of cases, these assessments should be conducted outside of hospital within a reasonable time frame and should not be a reason for delaying discharge to care outside of hospital.

7.4. Where the individual has a 'rapidly deteriorating condition which may be entering a terminal phase' the NHS CHC Fast Track Pathway should be considered.

7.5. For self-funding patients where it has not been possible to transfer a patient to their choice of care home, interim placements will be funded by [funding to be agreed] for the first three weeks. It is anticipated that the transfer to the permanent placement will be facilitated within this timescale, and the funding made by the self-funding patient.

8. Consultation and Approval Process

8.1. This policy has been adapted from a national policy on patient choice that has been implemented nationally by a number of NHS organisations.

8.2 The health and social care community across Greater Manchester has been consulted on its revised content. It has been formally signed off by the Greater Manchester Strategic Partnership Board on [insert date].

9. Review and Monitoring

9.1. This policy will be reviewed within 12 months of its launch across Greater Manchester by Greater Manchester Health and Social Care Partnership.

9.2. Local monitoring of its implementation should take place by each hospital through a local audit of the following:

- 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.

APPENDIX 1

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 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 interests 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.]

Ratified by Greater Manchester Health and Social Care Partnership, Strategic Partnership Board on the 28th of July 2017.

APPENDIX 2

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)	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 medically fit for discharge 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 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 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	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	Responsibility to assess a patient's needs for care and support where it appears to the local authority that the patient may	Care Act 2014 s9

	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 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 that there may be a need for such care. [This is the responsibility for NHS England for military personnel and prisoners]	NHS Commissioning Board and Clinical Commissioning Groups (Responsibilities and 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 medically	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)

	fit for discharge while preferred choice is awaited) Right to respect for family life and to not be treated in an 'inhuman or degrading' way	Regulations 2014 Human Rights Act 1998 s6 in relation to Articles 3 and 8 of the European Convention of Human Rights

APPENDIX 3

FACTSHEET A FOR PATIENTS

Date:

Dear <Name>

Plans for your discharge after your hospital stay.

We want to give you the support you need to get home as quickly as possible. Most patients can be discharged back to their own home as soon as they are well enough. However, some patients require some form of additional care after their hospital stay, such as intermediate care, care provided in your own home or in supported accommodation options and longer-term care such as residential or nursing home care.

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

We will tell you when your treatment is due to end and when you would be considered well enough to leave hospital - we will 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 to support you throughout your time in hospital and make sure that things happen when they are supposed to.

We will tell you have 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 permissions, we will request assessment to find out what needs you have and the services you might need to be safely discharged from hospital. The assessment could be for social care, home assessment for any adaptations, eligibility for NHS continuing healthcare, etc.

It may 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. Speak with your named member of staff to find out what the time limits are for free care and what this might mean for you.

Once you have received information about the discharges choices that are available for you, **we require you to make a decision within 7 days.** You may wish to arrange for yourself or a family member to meet with care providers during this time. We will do our best to help make this possible for you and you will be able to speak to *[insert local support arrangements]* about these choices.

If your preferred choice is not available when you are ready for discharge, an alternative option will be arranged for you temporarily.

It is not possible for you to wait in this hospital once you no longer need hospital care.

Your anticipated date of discharge will be communicated to you as soon as it is known so that the hospital can work with you to make appropriate arrangements for your discharge.

Most patients can be discharged back to their own home as soon as they are well enough. However, some patients require some form of care after their hospital stay such as intermediate care, care provided in their own home or longer-term care such as a residential or nursing home. Your care after your hospital stay will be considered by the team involved in your care and the options for your care will be discussed with you during your stay.

If your choice of care provision is not available at the time of your discharge, an interim arrangement which is appropriate for your needs will be offered to ensure that you are in the best setting for your care needs. It will not be possible for you to wait in hospital.

Whilst you will not be asked to leave hospital until you are medically ready, leaving hospital as soon as possible after this will allow you to recuperate and give you more independence than being on the ward.

Hospitals are not places of safety and longer stays in hospital are associated with an increased risk of infection, low mood and reduced motivation. If you remain in hospital longer than is necessary, severely ill patients may be unable to access a bed if beds in the hospital are occupied with patients who are medically fit for discharge.

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 appeal procedures]*

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

With best wishes for a speedy recovery,

[Insert NHS Trust Chief Executive Signature]

APPENDIX 4

LETTER 1 (A).

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 7 days of receiving this letter {or insert a longer timeframe if letter is sent more than 7 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 7 days to make your decision, or need to wait for your preferred care provider.

Additional information to help you with your decision

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 [insert details of local complaints and appeals procedures].

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]

APPENDIX 4

LETTER 1 (B).

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 7 days of receiving this letter {or insert a longer timeframe if letter is sent more than 7 days before the EDD}. We will arrange for temporary accommodation to be made available to you if you need longer than 7 days to make your decision, or need to wait for your preferred choice if it has no current vacancies.
Additional information to help you with your decision

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 [insert details of local complaints and appeals procedures].

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]

APPENDIX 4

LETTER 1 (C).

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 7 days of receiving this letter {or insert a longer timeframe if letter is sent more than 7 days before the EDD}. We will arrange for temporary accommodation to be made available to you if you need longer than 7 days to make your decision, or need to wait for your preferred choice if it has no current vacancies.

Additional information to help you with your decision

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 [insert details of local complaints and appeals procedures].

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]

APPENDIX 5

CHOICE LETTER 2 (a)

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 anxiety, 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 7 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> weeks . 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.

If you would like to make a complaint or appeal against this decision 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

CHOICE LETTER 2 (b)

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 anxiety 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 7 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> weeks . 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 [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

CHOICE LETTER 2 (c)

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 anxiety 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 7 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> weeks . 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.

If you would like to make a complaint or appeal 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 6

CHOICE LETTER 3 (a)

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]

GMCA GREATER MANCHESTER COMBINED AUTHORITY

NHS in Greater Manchester

APPENDIX 7

OVERVIEW OF PATIENT CHOICE PROCESS

Step 1: Providing Information: Start discharge planning before or shortly after admission. Discuss discharge with patient and/or representative. Identify discharge coordinator and other people who have the patient's consent to be involved in discussions and decisions. Ensure patient and/or representative is aware of the Patient Choice Protocol and expectations. Inform patient of estimated date of discharge. Refer to support services and advocacy as required. **Provide patient with Patient Discharge Factsheet.**

Step 2: Assessing Need: Obtain consent from patient to undertake assessment. Make appropriate referral to identified service as soon as patient is ready and ensure patient is involved throughout the process. Discharge coordinator to ensure that assessments are completed in a timely manner.

Step 3: Preparing for Discharge: Provide patient and/or representative with Letter A. Explain the process to them ensuring that it is essential that they choose an available discharge option, either on an interim or permanent basis. Provide the patient and/or representative with up to three available options. Where this is not possible, explain the rationale for providing limited option.

Step 4: Patient Choice (7 Days): The patient and/or representative should be given up to seven consecutive days to make a decision, or in advance of the estimated date of discharge, whichever is the longer period. Advise that the hospital will expect discharge within the agreed timescale. This should be used by families to view placements. In exceptional circumstances, a longer timeframe may be given, however a clear deadline for decision must be given.

Step 5: Interim Placement: If discharge has not been achieved within seven consecutive days, advise the patient and/or their representative that an interim placement or service has been arranged, which meets assessed need and a date for this transfer will be given. Information should be provided regarding funding arrangements. **Provide patient with Letter 2.**

Step 6: Escalation: If no agreement has been reached regarding discharge, and/or transfer arrangements are challenged, senior staff to hold formal meeting with patient to understand and resolve issues and reiterate policy. Consult legal advisors if necessary. **Provide Patient with Letter 3.**