Patient Choice Policy

Department / Service:	Clinical Site Management
Accountable Director:	Paul Brennan
Approved by:	Trust Management Executive
Date of approval:	24th March 2021
First Revision Due: **This is the most current document and should be used until a revised version is in place**	16th July 2026
Target Organisation(s)	Worcestershire Acute Hospitals NHS Trust
Target Departments	
Target staff categories	Medical, Nursing and Clinical Support Services

Policy Overview:
This policy supports the timely and effective discharge/transfer of patients from Worcestershire Acute Hospitals NHS Trust inpatient settings, to a setting which meets the needs and is the preferred choice of each individual patient, from amongst available options. It applies to all adult inpatients to ensure that those who are assessed as medically fit, with no reason to reside are enabled to leave hospital in a safe and timely way.

Key Amendments to this Document

Date	Amendment	Approved by:
5th August 2025	Document extended for 6 months whilst discharge process is redesigned	Jo Whitehouse, Associate director of Patient flow
16th January 2026	Document extended for 6 months to allow time for review and update	Jo Whitehouse

Contents page:

1. Introduction

The term 'patient' is used throughout this policy to refer to the individual receiving treatment and care.

This policy reflects published guidance on effective discharge planning. It aims to support a reduction in the time people spend in hospital, when they are ready to leave and no longer need acute care, but are delayed whilst making decisions about or making arrangements for their ongoing care.

- 'Transition between inpatient hospital settings and community or care home settings for adults with social care needs' - (NICE 2015)
- Hospital Discharge Guidance - (NHSI/E 2020)
- SAFER Principles (NHS Improvement 2011)

The consequences of a patient who is ready for discharge remaining in a hospital bed might include:

- Exposure to an unnecessary risk of hospital acquired infection
- Physical decline and loss of mobility / muscle use described as Hospital Acquired Functional Decline (HAFD)
- Poor patient and carers/relatives experience borne of frustration and distress from the uncertainty during any wait for a preferred choice to become available
- Increased patient dependence, as the hospital environment is not designed to meet the needs of people who are medically fit for discharge with no clear reason to reside
- Severely ill patients being unable to access services due to beds being occupied by patients who are medically fit for discharge. *(Hassan. M et al 2010; Kortebein. P et al 2008; Monk. A et al 2006)*

Patients and families can find it difficult to make decisions and/or make the practical arrangements for a range of reasons, such as:

- A lack of knowledge about the options and how services and systems work;
- Concerns about either the quality or the cost of care;
- Feeling that they have insufficient information and support;
- There is uncertainty or conflict about who will cover costs of care;
- Concerns about moving into interim accommodation and then moving again at a later stage
- The choices available do not meet the patient's preferences
- Concerns that their existing home is unsuitable, cold or needs work done to ensure a safe environment for discharge
- Worry about expectations of what family and carers can and will do to support them.

2. Scope of this document

This document applies to all adult inpatients. Discussion and information regarding choices after discharge should be brought to the attention of patients and discussed with them promptly upon admission to hospital. It will ensure that those who are assessed as medically fit with no reason to reside, leave hospital in a safe and timely way.

This policy includes patients who may have been in hospital for many weeks, or months, and those at the end of life.

3. Policy Detail

The purpose of this policy is to ensure that choice is managed sensitively and consistently throughout the discharge planning process, and patients are provided with information and support to make an informed choice.

This policy sets out a framework to ensure that inpatient beds are utilised appropriately for those that require an acute inpatient stay. It sets out to ensure that a clear process is in place when patients remain in hospital longer than is clinically required.

Where a patient lacks capacity to make decisions about discharge from hospital, then the application of the policy should be adapted in accordance with the Mental Capacity Act 2005.

When implemented consistently, this policy should reduce the number and length of delayed discharges and actual length of stay of patients. The result of effective implementation of this Policy will result in patients being successfully transferred to services or support arrangements where their needs for health and care support can be met. Ultimately it aims to improve outcomes and experiences for patients.

3.1 Principles

3.1.1 Supporting patients to make decisions

- Patients are expected to make decisions about their discharge destination while in hospital with a view to returning home or to their usual place of residence.

- Where appropriate, all possible efforts should be made to support patients to return directly to their home or usual place of residence with provision of reablement and domiciliary care support, housing adaptations and equipment needs considered and met.

- Patients should be provided with high quality information, advice and support in a form that is accessible to them, as early as possible prior to or promptly following admission. This enables effective participation in the discharge process and making an informed choice.

- Patients should be involved in all decisions about their care in line with the NHS Constitution. 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.

- Where it is identified that the patient requires a needs assessment under the Care Act 2014 but would have substantial difficulty in engaging in the assessment and care planning process, due diligence should be followed. For those with long term needs to be assessed,

under the Care Act, the local authority must consider whether there is anyone appropriate who can support the individual to be fully involved. If there is not then the local authority must arrange for an independent Care Act advocate.

- Many patients will want to involve others to support them, such as family or friends, carers or others. Where the patient has capacity to make their own decisions about confidentiality and information sharing, confidential information about the patient should only be shared with others with the patient's consent.

- Where the patient has been assessed as lacking capacity in this respect, information may be shared in his or her best interests in accordance with requirements set out in the Mental Capacity Act 2005.

- Patients have a choice about whether or not to provide care for adults and must be informed about the options available when establishing whether they are willing and able to provide care. Where someone is providing care or considering providing care post-discharge, unpaid as a Carer, they must be informed about their rights and sources of support as a Carer.

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

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

- If a patient is not willing to accept any of the available appropriate provision, then it may be the case that they are discharged from hospital, after having had appropriate information regarding the risks and consequences of doing so. This course of action will only be taken following the offer and rejection of available appropriate options of care and appropriate safeguards and risk assessments.

3.1.2 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 aged 16 years 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 considered to be unwise;
- When the patient is assessed to lack capacity staff must act in their best interests;
- Before taking any action or decision on their behalf staff 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 treatment, may lack capacity to make decisions about 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 sections.

  If a patient is assessed to lack capacity this means that staff have tested whether a patient is able to:

- 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 patient being given good quality information to consider.

- 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 neither is it an option for a patient who lacks capacity for the discharge decision to remain in hospital.

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

- 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). They may only make the decision from the available options. If neither of these is appointed then it will be the health or care professional who needs to make the best interests decision in question having consulted with all stakeholders with an interest in the Patient's welfare.. 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 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 a maximum of six weeks 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, at risk of being deprived of liberty (Article 5, European Convention of Human Rights), currently as interpreted by the Supreme Court ruling in the case of P v Cheshire West and Chester Council and P and Q v Surrey County Council [2014] UKSC 19 to mean that the patient lacks capacity to consent to the accommodation or care plan and is "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 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.

3.1.3 Timely discharge from in-patient care

- When a patient is medically fit for discharge, they should not remain in hospital due to the negative impact this can have on their health outcomes.

- Patients do not have the right to remain in hospital longer than required.

- 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 breach their rights with respect to a private life. It should not create a situation whereby the independence of the carer or the sustainability of their caring role is jeopardised.

- Planning for effective transfer of care, in collaboration with the patient and/or representatives and all multi-disciplinary team (MDT) members, should be commenced at or prior to admission, or as soon as possible after an emergency admission. The SAFER patient flow bundle should be applied to support timely discharge.

- The process and timelines within this policy should be clearly communicated to the patient so that by the time a patient is medically fit for discharge they are aware of and understand the discharge process, the decisions and actions that they may need to undertake and the support they will receive.

- If a patient's preferred care placement or package on discharge is not available when they become medically fit for discharge, an available alternative which is appropriate to their health and care needs will be offered on an interim basis, whilst they await availability of their preferred choice.

3.1.4 Funding Arrangements

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

- Those self-funding their own care will be offered the same level of advice, guidance and assistance regarding choice as those fully or partly funded by their local authority or NHS

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

- 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. However, if (and only if) the individual has a 'rapidly deteriorating condition which may be entering a terminal phase' the NHS CHC Fast Track Pathway should be considered.

3.1.5. Overview of process

See Table below

Step 1 - Providing standard information and support	• Start discussions about discharge with patient before or as soon as possible after admission • Determine whether the patient has mental capacity and if not, put in place appropriate measures • Identify 'discharge coordinator,' and other people who have the patient's consent to be involved in discussions and decisions, e.g. carers, relatives • Provide Factsheet A • Refer to support services and advocacy, as required
Step 2 - Assessing need	• Refer patient and any carers to required health and care services when they are ready to have their needs assessed for discharge • Ensure assessments to clarify care needs and carers' needs are completed [note: NHS CHC assessments should be conducted outside of hospital in the main]
Step 3 - Preparing for discharge	• Discuss available and appropriate options with patient • Refer to support services and/or advocacy, as required • Explain the decision-making process, including how to appeal any decisions, to the patient and advise that the hospital will expect discharge within the seven day window • Provide Letter B and tailored information on options which are suitable to meet assessed needs and available funding
Step 4 - Seven day window	• Initiates upon provision of Letter B and information on choices to patient, in advance of the estimated discharge date • Allow up to seven consecutive days for the patient to consider their available options • Support the patient to make a decision, respond to concerns and offer advice, support and encouragement
Step 5 - Interim placements and packages	• If decision and/or discharge has not been achieved with seven consecutive days, MDT to liaise with patient and arrange the offer of an interm placement or package which meets assessed needs • Advise the patient that an interim arrangement for a given length of time is offered with a proposed date for discharge. Details should be provided of how interim funding arrangements relate to funding of subsequent care. • Give appropriate version of Letter C and offer further support
Step 6 - Escalation	• 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 • Letter D to be sent following formal meeting or if patient does not engage in formal meeting [note: this applies where reasonable options have been rejected and there are no ground to challenge] • Consult local legal advisors, if neccessary

3.1.6 Overview of steps to discharge/transfer:

Step 1 – Providing standard information and support

On admission, a member of the nursing team or discharge coordinator will explain the discharge planning process to the patient. They will ensure that the patient is aware of the principles of this policy and of the circumstances in which an interim placement or package might be necessary. All communication will clearly set out the process that the hospital will follow in order to work towards the patient's safe and timely discharge when their need for inpatient treatment ends. It should be made clear that they will receive advice and support in making a decision.

Factsheet A should be given to and discussed with the patient.

All patients will be given an Estimated Date of Discharge (EDD) as soon as possible after admission. Regular review and discussion about the EDD as part of 'board rounds' will ensure all parties understand when support will be required to facilitate discharge.

Patients should be involved in all decisions about their care and supported to do so, where necessary.

At this point, it should be clearly identified who else the patient wishes to be informed and/or involved in the discussions and decisions regarding discharge and appropriate consent received (if the patient lacks capacity then other legal basis needs to be established). This can include, but is not limited to, any formal or informal carers, friends and family members.

Steps will be taken by ward staff to ensure that any carer(s) of the patient are identified and supported through the discharge process. This includes providing information on Carer's Assessments and support services and/or referrals to the relevant support services. Ensuring the carer has adequate support in place will reduce the risk of unnecessary readmission of the patient.

The likelihood of the patient and any carers needing health (including mental health) care, social care, housing, or other support after discharge will be considered as soon after admission as possible.

If the patient is likely to have ongoing health, housing or social care needs after discharge, ward staff will ensure timely referral to these other services for assessment. This should be from a holistic and patient-centred perspective of a person's needs. Care and support options may include, for example:

- Intermediate care (or step down care), either bed based or community based;
- Social care assessment;
- Community nursing services, including community matrons;
- Reablement;
- Short-term placement in a care home;
- Care at home support package;
- Financial assessment and benefits advice;
- Eligibility for NHS Continuing Healthcare or Funded Nursing Care;
- Home assessment for aids, adaptations and / or assistive technology;

- Other local health, social or voluntary service.

Step 2 – Assessing need

It should be made clear to the patients (and their carers, where appropriate) what the initial assessment in hospital is for, and what further assessments they can expect following discharge/transferred.
Any carers of the patient should be advised of their rights to have a carers' assessment, with appropriate information and support, and referral to relevant support services: this is not as an inpatient.
Patients should be actively involved in the assessment process and in the development of care plans to enable full and effective assessments and support planning.

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

Step 3 – Preparing for discharge

Letter B (version dependent upon destination) will be prepared and given to the patient by the team member coordinating the patients discharge. The process will be explained to the patient ensuring they are aware of all timelines and steps.

Tailored information should be provided to the patient about the care options available to them, including details of costs. The conditions of funding for interim, intermediate and reablement placements/services (and the 12 week property disregard of fees in circumstances when the patient transfers directly to a care home) should be made clear.

The patient will be referred to the relevant team in order to receive advice and support in making an informed choice and to develop a person centred care and support plan which focuses on the individual's needs and preferences. This should include a discussion of the option of a personal budget.

The patient should be directed to 'On-side' for advice and information regarding advocacy, if required.

If the patient is assessed to have care needs after discharge, the discharge coordinator will advise the patient at the earliest appropriate opportunity about currently available care providers that can meet their needs and are registered with the Care Quality Commission (CQC). In some cases it is possible that there may be only one appropriate option, and the rationale for this must be explained.

If it is known that the placement/package is to be funded or provided by the NHS, the local Continuing Health Care team will advise the patient of their right to look at alternatives that fall within the criteria set by the CCG, based on their individual needs.

If it is known that the placement/package is to be funded by Social Services, Worcestershire County Council will advise the patient of their right to look at alternatives that fall within the criteria set by the local authority, based on their individual needs , and the option to top-up. Particular consideration should be given to the timings within this policy to prevent breaches of local authority duties relating to discharge.

If the patient is interested in taking up the offer of a personal budget (social care), personal health budget (NHS) or integrated personal budget, the relevant team will advise them where to get information, who to contact locally and refer them to the lead locally.

Self-funders should be provided with the same level of information, advice and support as people whose care is being funded by the NHS or the local authority.

The discharge coordinator should discuss discharge plans with the patient regularly, in some cases this may be as often as daily. The discharge coordinator will endeavour to meet the patient's wishes regarding specific concerns about the appropriateness of a temporary arrangement, if concerns are brought to their attention.

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 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.

Step 4 – Seven day window

Once step 3 is completed by providing appropriate information on packages of care or placements, resolving any disputes and giving appropriate letters to the patient, the expectation is that the patient makes a decision about discharge within 24 hours, and either discharge has happened or arrangements are in place to do so.

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 24 hours, a longer period may be agreed for an individual.

Patients do not have the right to remain in hospital longer than required. However, they do have the right to respect for private life and to be treated fairly. Therefore, it is crucial for the hospital to ensure that the proposed transfer is appropriate and in line with human rights legislation.

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

The discharge coordinator and relevant team will proactively support the patient during this process and will offer advice and support regardless of how the placement is to be funded. Regular communication will be maintained throughout this period by the discharge coordinator and the support service.

Implementation of this policy does not impact on the measurement of the'right to reside' indicators, which should continue to be reported against the guidance laid out by NHSEngland/Improvement.

Step 5 – Interim packages and placements

An interim package of care or placement will be offered to a patient in the following circumstances: where a decision has not been made within 24 hours of completion of step 3, in

the event that available options have been declined, or where a decision has been made but the specific package, placement, or adaptation is not yet available. The basis for offer of an interim arrangement is because patients do not have the right to remain in hospital to wait for their preferred option to become available.

Where a decision and/or discharge are not achieved within 24 hours of completion of step 3, members of the MDT will liaise within two working days. The MDT will discuss and seek to agree the recommended interim package or placement with the patient. Consideration of interim arrangements must be accompanied by a risk assessment, including impact on any carers.

The MDT may then advise the patient that an interim package or placement, which meets their assessed needs, is being offered, the reasons why the offer is appropriate, and a proposed date for transfer.

The interim package or placement will be confirmed in a letter (Letter C, version dependent upon funding arrangements). Letter C will be prepared and given to the patient by a hospital representative. It is important that the letter is addressed to the patient, is personalised to reflect their circumstances and that the process is also discussed with the patient.

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

Interim placements will be funded according to the assessed funding status of the individual patient and their needs. It will be clearly communicated to the patient from the outset.

Discussions regarding permanent options will continue throughout the interim placement with a designated person from the relevant organisation.

Self-funders will be required to fund their care in the interim package/placement beyond a maximum period of six weeks, if a permanent decision has not been made or if the chosen package/placement is not yet available. The exception to this is where the 12 week property disregard applies.

Where the need for a NHS CHC assessment has been identified on hospital discharge the individual should not be charged for their care during the period it takes to complete the NHS CHC assessment.

The relevant statutory organisation is responsible for funding the interim placement beyond the maximum six week period if the ongoing placement/package is not yet available.

Step 6 – Escalation Process

If no agreement has been reached regarding discharge arrangements after steps 1-5, and transfer arrangements are challenged by the patient, each organisation will apply its appropriate escalation process.

The patient will be provided with details of complaints and appeals procedures throughout the process.

A formal meeting will be held, enabling all parties to discuss concerns and seek to agree transfer to the most appropriate care provider, at least as an interim option. The discharge coordinator will send letter D following the formal meeting, summarising the discussion, including risks, and next steps.

Letter D should also be sent if the patient does not engage in the formal meeting, including details of the reasons why the patient did not engage.

The discharge coordinator will continue to work with the patient throughout this process to try and understand and address barriers to a decision being made.

If the patient declines NHS treatment and a care or support package, they may be discharged from hospital. In those circumstances they will be advised in advance of any further NHS or social care support they may be able to access in the community and of the risks if they refuse such support.

Some cases may justify an adult safeguarding referral, including for cases which may amount to self-neglect.

The discharge coordinator will be supported to consult local legal advisors and escalate as required to ensure discharge from hospital, in order to safeguard the health and wellbeing of the patient and other patients.

5. MENTAL CAPACITY

All patients should be assumed to have mental capacity to make a decision about their ongoing care, including 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.

4. Implementation

4.1 Plan for implementation

- Formal consultation with System partners and approval via the System Discharge Requirements Forum
- Formal approval by TME

4.2 Communication and dissemination

This Policy will be disseminated to in-patient wards via the Clinical Divisional structure. Copies will be shared with the Clinical Site team, Flow Matrons and the Onward Care Team.

5. Monitoring and compliance

Compliance with be monitored via the Clinical Division's Clinical Governance Committees.

6. Policy Review

This policy will be reviewed by the Trust's Director of Capacity & Flow on a 12 monthly basis.

GLOSSARY
Advocacy: a service to help people to be involved in decisions, explore choices and options, defend their rights & responsibilities, and speak out about issues that matter to them.
CHC: NHS Continuing Healthcare is defined as a package of ongoing care for an individual aged 18 or over which is arranged and funded solely by the NHS where the individual has been found to have a 'primary health need'.
Deprivation of liberty: when an individual without mental capacity to consent is under continuous supervision and control and is not free to leave, and this is imputable to the state.
Discharge coordinator: the named individual responsible for coordinating a patient's discharge. This could be a named nurse from the ward, a named social care professional from the local authority, an appropriate person from a voluntary sector organisation contracted to co-ordinate statutory services and act as patient advocate, or a named CHC health professional.
EDD: Estimated or expected date of discharge. This means when the patient is clinically assessed as ready for discharge. The EDD may change several times in response to the patient's specific needs.
Independent Mental Capacity Advocate (IMCA): will represent patients assessed as lacking capacity under the Mental Capacity Act 2005 and have no family or friends to consult, to make important decisions, such as change of accommodation.
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 to people who no longer need to be in hospital but may need extra support to help them recover.
MDT: Multidisciplinary team of health and social care professionals involved in the care and assessment of patients.
Medically fit for discharge: Further inpatient medical care or treatment is no longer necessary, appropriate or offered. Any further care needs can more appropriately be met in other settings, without the need for an acute inpatient hospital bed.
Mental capacity: Being able to make a specific decision at a specific time.
Patient: The individual receiving treatment in hospital.
Reablement: Reablement services help people adapt to a recent illness or disability by learning or relearning the skills necessary for independent daily living at home.
Self-funder: A person who financially meets the full cost of their social care needs (apart from reablement care funded for a maximum of 6 weeks and the 12 week property disregard) 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.

References: Code:

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. 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. 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).	
Discharge Guidance (October 2020) NHSIE	
Nice Guidance	

6.1 Equality requirements

There are no adverse Equality impacts.

6.2 Financial risk assessment

There are no adverse financial impacts.

Contribution List

This key document has been circulated to the following individuals for consultation;

Designation
Worcester County Council
Worcestershire and Herefordshire Health & Care Trust
System Discharge Requirements Forum

This key document has been circulated to the chair(s) of the following committee's / groups for comments;

Committee

6.3 Version Control

This section should contain a list of key amendments made to this document each time it is reviewed.

Date	Amendment	By:
	Creation of initial draft document	

Appendix 1:

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 Mental Capacity Act 2005 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	Care Act 2014 s9

	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 provided specified conditions are met 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 Mental Capacity Act 2005 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	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

	home / shared lives / supported living, where this is to be arranged by the local authority, in some circumstances provided specified conditions are met (but no right to remain in hospital when medically 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	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 2: SUPPORTING TEMPLATE FACTSHEET AND LETTERS

FACTSHEET A: The Assessment and Discharge Process

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

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

What can you expect to happen?

- We will tell you when your treatment is due to end and when you would be considered well enough to leave hospital (this is called an estimated discharge date) – we aim to tell you this within 48 hours of you being admitted and will discuss with you if this changes.
- We will provide you with a named staff member who will support you throughout your time in hospital and make sure that things happen when they are supposed to.
- We will tell you how to access information, advice and support to help you make your discharge decision. This will include helping you to understand your care needs, the process of assessing your needs and the care options available to you
- With your permission, we will request assessment(s) to find out what needs you have and the services you might need to be safely discharged from hospital. The assessments could be for social care, home assessment for any adaptations, eligibility for NHS continuing healthcare, etc.
- It may also be necessary to assess how any ongoing care will be funded, although in most circumstances to avoid any delay this will be carried out after you have been discharged. It is important to note that whilst NHS care is free to everyone, social care is not. Speak with your named staff member to find out what the time limits is for free care and what this might mean for you.
- Once you have received information about the discharge choices that are available to you, we request that you make a decision within 7 days. You may wish to arrange for yourself or a family member to meet with the care providers during this time. We will do our best to help make this possible for you and you will be able to speak about these choices.
- If your preferred choice is not available when you are ready for discharge, an alternative option can be arranged for you temporarily. It is not possible for you to wait in this hospital, once you no longer need hospital care.
- If you wish to make a complaint or appeal against any part of the discharge process then contact at any point [*insert details of local complaints and appeals procedures*].

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

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

With best wishes for a speedy recovery,

[*insert NHS Trust Chief Executive signature*]

CHOICE LETTER B1

Date: ……

Dear <*Name*>

You now need to choose a care package at home

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

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

We request that you make your decision within 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,

Yours sincerely,
[*letter to be signed by the Ward Matron or Named Consultant*]

CHOICE LETTER B2

Date: ……

Dear <Name>

You now need to choose a care home.

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

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

We request that you make this decision within 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 the Ward Matron or Named Consultant]

CHOICE LETTER B3

Date: ……

Dear <Name>

You now need to choose an available housing option.

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

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

We request that you make this decision within 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 the Ward Matron or Named Consultant]

CHOICE LETTER C1

Date: ……

Dear <Name>

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

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

We do not wish to cause you or your family 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[1]. 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 the Ward Matron or Named Consultant]

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

CHOICE LETTER C2

Date: ……

Dear <Name>

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

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

We do not wish to cause you or your family 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[2]. 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 the Ward Matron or Named Consultant]

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

CHOICE LETTER C3

Date: ……

Dear <*Name*>

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

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

- We do not wish to cause you or your family 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[3]. 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* the Ward Matron or Named Consultant]

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

CHOICE LETTER D

Date: ……

Dear <Name>

Confirmation of discharge plans following formal meeting

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

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

At the meeting we discussed the following points:
<insert summary discussion here>.
We discussed the following options to enable the discharge process to proceed:
<insert options provided here>.

Discharge plan discussion
The following discharge plan was agreed:
<insert agreed next steps here>.
OR
We noted the reasons why you are unwilling to engage with this process:
<insert reasons here>.

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

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

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

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

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

Yours sincerely, [letter to be signed by the Ward Matron or Named Consultant]

Supporting Document 1 - Equality Impact Assessment Tool

To be completed by the key document author and attached to key document when submitted to the appropriate committee for consideration and approval.

		Yes/No	Comments
1.	**Does the Policy/guidance affect one group less or more favourably than another on the basis of:**		
	• Race	No	
	• Ethnic origins (including gypsies and travellers)	No	
	• Nationality	No	
	• Gender	No	
	• Culture	No	
	• Religion or belief	No	
	• Sexual orientation including lesbian, gay and bisexual people	No	
	• Age	No	
2.	**Is there any evidence that some groups are affected differently?**	No	
3.	**If you have identified potential discrimination, are any exceptions valid, legal and/or justifiable?**	No	
4.	**Is the impact of the Policy/guidance likely to be negative?**	No	
5.	**If so can the impact be avoided?**	No	
6.	**What alternatives are there to achieving the Policy/guidance without the impact?**	No	
7.	**Can we reduce the impact by taking different action?**	No	

If you have identified a potential discriminatory impact of this key document, please refer it to Assistant Manager of Human Resources, together with any suggestions as to the action required to avoid/reduce this impact.

For advice in respect of answering the above questions, please contact Assistant Manager of Human Resources.

Supporting Document 2 – Financial Impact Assessment

To be completed by the key document author and attached to key document when submitted to the appropriate committee for consideration and approval.

	Title of document:	Yes/No
1.	Does the implementation of this document require any additional Capital resources	No
2.	Does the implementation of this document require additional revenue	No
3.	Does the implementation of this document require additional manpower	No
4.	Does the implementation of this document release any manpower costs through a change in practice	No
5.	Are there additional staff training costs associated with implementing this document which cannot be delivered through current training programmes or allocated training times for staff	No
	Other comments:	

If the response to any of the above is yes, please complete a business case and which is signed by your Finance Manager and Directorate Manager for consideration by the Accountable Director before progressing to the relevant committee for approval

Supporting Document 3

Guidance Notes from the Local Authority

Guidance for discharge of patients to block beds pending an alternative pathway. Please read in conjunction with the guide below.

https://www.google.com/url?sa=t&rct=j&q=&esrc=s&source=web&cd=&ved=2ahUKEwiw2vbm8KntAhWGN8AKHS13AtgQFjACegQIAhAC&url=https%3A%2F%2Fwww.nhs.uk%2FNHSEngland%2Fkeogh-review%2FDocuments%2Fquick-guides%2FQuick-Guide-supporting-patients-choices.pdf&usg=AOvVaw1k-QPar8vVTSWaZS5lR_w1

Home First

In all circumstances Worcestershire County Council expects a conversation to take place with the patient to ascertain what support is available in an interim period that may enable them to safely return home.

If there is no alternative to an interim placement, consideration should be given to transfer to a block bed (these include residential dementia beds and nursing home beds).

These should be considered in the following circumstances:

Pending reablement (PW1) – If a referral has been made to Pathway 1 for support at home and there is a delay due to available reablement capacity, a person can transfer to a block bed temporarily, free of charge (regardless of their funding status). This can be arranged via Social Care as a short term option.

Pending further assessments - This includes social care assessments, Mental Capacity Assessments and Continuing Health Care consideration and would be classed as a Discharge to Assess placement for up to 6 weeks which is free of charge. These assessments will need to be concluded once a person is at their optimum and have fulfilled any further rehabilitation potential.

Assessments completed - Pending care provider of choice (self-funders) – a person may have made a decision to organise their own care but the provider of choice is not able to meet their needs at the point they are fit for discharge. Block beds can be used in this transitional period (subject to relevant assessments and discussions, including consideration of Mental Capacity)

Once they have been discharged to a block bed, a social worker will discuss the plan of action and timescales and complete a financial declaration for full charge to be paid if the service is required for longer than one week. From week 2 another CPLI will be required to change the service to chargeable. The signed CCN will need to be uploaded before any chargeable CPLI is put through to Brokerage. It is important this conversation is known to the patient as soon as possible to support their decision-making and to ensure all alternative options to meet their needs have been explored. A record of this must be kept.

Assessments completed - Pending care home of choice (self-funders) – a person may have made a decision to organise their own care home placement but the provider of choice is not able to meet their needs at the point they are fit for discharge. Block beds can be used in this transitional period (subject to relevant assessments and discussions, including consideration of Mental

Capacity). Once they have been discharged to a block bed, a social worker will discuss the plan of action and timescales and complete a financial declaration for full charge to be paid if the service is required for longer than one week. From week 2 another CPLI for replacement care will be required to change the service to chargeable. The signed CCN will need to be uploaded before any chargeable CPLI is put through to Brokerage. It is important this conversation is known to the patient as soon as possible to support their decision making and to ensure all alternative options to meet their needs have been explored. A record of this must be kept.