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**Humber and North Yorkshire**

**System Choice on Discharge Policy**

**December 2023**

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**AMENDMENTS**

Amendments to the policy may be issued from time to time. A new amendment history will be issued with each change.

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# Introduction

Patient choice is often cited as a reason for delayed discharge. This policy aims to support patient discharge to a setting which meets patient's individual needs and their preferred choice **amongst available options** but also recognises that to remain in the acute hospital setting should not be one of the choice options.

Hospital admission and stays can be a challenging time for patients and families, and they can often find it difficult to make decisions and/or make the practical arrangements for leaving hospital. This could be due to:

* + - A lack of knowledge about the options and how services and systems work.
    - Concerns or uncertainty about either the quality or the cost 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.

When a patient no longer requires inpatient medical care or treatment, and care needs can be met more appropriately in other settings then they are deemed to no longer meet the Criteria to Reside - see [appendix 2](#_Appendix_2_–). In some cases, patients who are ready to leave hospital decline to do so or delay in making a decision. This can cause risks to the patient, which are outlined in this policy.

# Purpose

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

It applies to all adult inpatients in Humber and North Yorkshire NHS acute hospital settings and will be utilised during pre-operative assessment, during admission and in discharge planning to ensure that those who are assessed as no longer meeting the criteria to reside can leave hospital in a safe and timely way.

This policy supports existing national [Hospital discharge and community support guidance](https://www.gov.uk/government/publications/hospital-discharge-and-community-support-guidance/hospital-discharge-and-community-support-guidance) and applies equally to the transfer of patients’ care between health and social care settings as well as to care provided in their own home.

This policy sets out a framework to ensure that NHS inpatient beds across Humber and North Yorkshire will be used appropriately and efficiently for those people who require inpatient care, and that a clear process is in place for when patients remain in hospital longer than is clinically required.

Where the patient lacks Mental Capacity to make decisions about discharge from hospital, then, in line with the Mental Capacity Act 2005, the application of the policy should be adapted and an assessment undertaken, as explained in [Appendix 1](#_Appendix_1:_Hospital). Any decisions regarding the transfer of care arrangements will be made in the patients' best interests.

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

# Definition/ Explanation of Terms

See [Appendix 9](#_Appendix_9_-).

# Scope of the Policy

This policy relates to all patients, including those with very complex care needs, who may have been in hospital for many months or years, and people at the end of life.

Funding arrangements - this policy applies equally to people regardless of the funding arrangements and the nature of their ongoing care. Those people 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 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 transfer of care 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.

This policy will only be effective if there are suitable packages of care and support available for individuals out of hospital. Therefore, this policy should be considered alongside community options/ resources as an individual cannot be discharged unless there is a safe option to be discharged to.

# Principles

In addition to the health, social and financial considerations outlined in [Appendix 4,](#_Appendix_3_-) when implementing this policy, the following general principles should be applied:

1. **Putting high quality care at the centre of all work and practices**

We will deliver high quality care and work with the patient, their carer and family to ensure a positive experience of care and an equally positive outcome for the patient by applying the principles of the 6Cs (care, compassion, competence, communication, courage and commitment) outlined in the [Compassion in practice strategy](https://www.england.nhs.uk/wp-content/uploads/2012/12/compassion-in-practice.pdf)

1. **Helping people to stay independent, maximise well-being and improve health outcomes**

People should be supported to be discharged to the right place, at the right time, and with the right support that maximises their independence and leads to the best possible sustainable outcomes. Under the [Discharge to Assess](https://www.nhs.uk/NHSEngland/keogh-review/Documents/quick-guides/Quick-Guide-discharge-to-access.pdf) model there are a number of pathways a patient could take, which are outlined in [Appendix 3](#_Appendix_3:_Pathways).

With the patient's agreement and where appropriate, a **'home first',** strength-based approach should be adopted, with all possible efforts made to support people to return to their homes instead of residential placements and options around home care packages and housing adaptations considered. The use of a [One-Off Personal Health Budget](https://www.england.nhs.uk/wp-content/uploads/2021/12/C1489-One-off-personal-health-budgets-within-hospital-discharge-pathway-version-2.1-September-2022.pdf) for Discharge to Assess should be considered where

* Payment for a good or service would enable early and safe discharge.
* The good or service cannot be provided via existing commissioned services or cannot be provided in a timely manner.
* The good or service cannot be provided through unpaid care or the voluntary sector or cannot be provided by them without this additional support

Goods and services can include payment of travel costs for informal care, culturally appropriate support where not routinely commissioned and/or to adjust people’s living environment that support them to return home safely.

Carers must be involved in the discharge planning and, in line with the Care Act 2014, offered the information, training and support they need to provide care following discharge, including a carer’s assessment.

1. **Providing high quality information**

Involving patients and carers (including young carers) in discharge planning is central to the process for managing choice on hospital discharge and starts at the earliest opportunity.

Discharge planning starts at hospital admission or pre-admission for elective care with an expected date of discharge agreed at the earliest opportunity. All communication will clearly set out the process that the hospital follows to work towards the patient’s safe and timely transfer of care when their need for inpatient treatment ends. It should be made clear that they will receive advice, information and support in making a decision, but that ultimately a decision has to be reached in a reasonable timescale.

People should be provided with advice, information and support in a form that is accessible to them, as early as possible before or on admission and throughout their stay, to enable effective participation in the discharge process and in making an informed choice. In the context of a discharge decision, the information relevant to the decision will include an understanding of the process of the assessment of needs, offers of care and the options available.

The individual is kept informed, verbally and in writing of all reviews and assessments that have taken place and the rationale for decisions.

Standard leaflets and letter templates can be found in [Appendix 6](#_ppendix_6:_National) and [Appendix 7](#_Appendix_7_-), covering various scenarios, which NHS providers can build into their discharge arrangements.

1. **Supporting people to make decisions**

A good discharge is as important as the treatment received whilst in hospital and every opportunity must be used to manage discharge effectively.

Patients should be involved in all decisions about their care, as per the NHS Constitution, and should be provided with high quality support and information to participate, where possible.

Many patients will want to involve others to support them, such as family or friends, carers or nominated representative. We will not make any decision without individuals, and/or where appropriate their representatives with the patients consent, being involved. An advocate or Independent Mental Capacity Advocate will be appointed for patients when they lack capacity and are 16 years or older with no one independent of services, such as a family member or friend who is “appropriate to consult” - see [Appendix 1](#_Appendix_1:_Hospital).

Every attempt will be made to meet the needs of every patient, although it may not always be possible for them to be fully met. The reasons for this will be explained clearly at the time.

If a patient’s preferred care placement or care package on transfer of care is not available when they no longer meet the Criteria to Reside, 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.

Patients should not be expected to make decisions about their long-term future while in hospital. Assessment and planning for long term care occurs after discharge from hospital. This is the opportunity for the patient to express their needs in detail.

The use of the Discharge Medicines Service (DMS), an essential service commissioned by NHS England for all community pharmacies to deliver, is another avenue that needs to be considered when discharging patients. The service is designed to support patients by ensuring better communication of changes to their medication when they leave hospital and to reduce incidences of avoidable harm caused by medicines. By referring patients to community pharmacy on discharge with information about medication changes made in hospital, community pharmacy can support patients to improve outcomes, prevent harm and reduce readmissions. A toolkit for implementation of DMS can be found [here](https://www.england.nhs.uk/publication/nhs-discharge-medicines-service-essential-service-toolkit-for-pharmacy-staff-in-community-primary-and-secondary-care/).

1. **Adhering to legal frameworks**

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 transfer of care process must not put the patient or their carers at risk of harm or breach their right to respect for private life. Neither should it create a situation whereby the independence of the carer or the sustainability of their caring role is jeopardised.

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

In most circumstances any Package of Care or initial placement is temporary and will take into account a patient’s preferences where possible. NHS organisations should have regard to the NHS Choice Framework (notably section 7) and local authorities should have regard to the Care and Support Statutory Guidance (notably paras. 4.37- 4.50 and 8.36-8.37) as part of their decisions locally.

If a patient is not willing to accept any of the available, appropriate alternatives, then organisations will have a clear escalation process with appropriate safeguards and risk assessments.

A summary of legal responsibilities and rights are outlined in [Appendix 4.](#_Appendix_3_-)

# Duties/ Accountabilities and Responsibilities

This policy is a system wide policy and requires the cooperation from all partners in Humber and North Yorkshire in line with Section 82 NHS Act 2006 and the Care Act 2014.

There is a commitment across the system to build capacity in out of hospital services to support delivery of this policy and the model supporting the implementation is multi-agency/ disciplinary with joint responsibilities relating to safeguarding and mental capacity/ mental health needs.

The system has appointed executives from NHS organisations and Local Authorities to take responsibility for strategic oversight of the discharge process and provision of appropriate onward health services and care services. They are supported by:

**Community Health and Care Collaborative**

The Collaborative will be responsible for the current system wide strategic transformation programme of work which specifically focus on the National, Regional and ICB priorities, which includes Admission avoidance – 2 Hour Urgent Care Response & Virtual Wards and Discharge – Discharge 2 Assess system improvement plan.

**Transfer of Care Network**

The Network provides a forum for wider assurance on the progress around admission avoidance and wider transfer of care agenda ensuring clear plans, oversight and reporting and a system wide approach to the management of risk to strengthen relationships and ownership.

**Single Coordinator or equivalent**

Acts on behalf of the system to secure safe and timely discharge on the appropriate pathway for all individuals. They will develop a shared system view of discharge, hold all parts of the system to account and drive the actions that should be taken as a system to address shared challenges. The single coordinator is accountable to the executive leads across health and social care and their work is aligned to the Transfer of Care Network.

**Transfer of Care Hub**

Every local health and social care system based around an acute hospital footprint will work towards developing a transfer of care hub whereby (physically and/ or virtually) all relevant services across sectors (such as health, social care, housing and voluntary sector) are linked together. The transfer of care hub will coordinate care for people who require formal care and support after discharge from hospital, and any support for unpaid carers.

Hubs are multi-disciplinary team of social care professionals, nurses dedicated to ensuring people are discharged from hospital on the right pathways, with the right discharge information, and that they get the right onward care and support (if needed).

Case managers in transfer of care hubs will agree a prescription of need for both Health and Social Care and advise the multi- disciplinary/ ward teams of the ongoing patients discharge needs and subsequent plans. They will ensure that the appropriate assessments are undertaken in the agreed required timescales and communicated effectively with the ward nursing teams to ensure they are kept up to date with current discharge arrangements. The case manager can be from any discipline (such as social care, primary care or therapies) depending on the needs of the individual being supported.

**Chief Executive/ Operating Officers**

It is the responsibility of the CEO/ COO to ensure that there are adequate policies; procedures and systems in place and communicated to manage discharge safely and effectively across the Trust. They will usually be supported by:

* **Medical staff** - who have responsibility for planning the patients’ treatment and managing the setting and management of expected date of discharge as well as assessing through a MDT whether the patient is medically optimised.
* **Head of Nursing** who will ensure that Senior Nurses are adequately trained and supported in discharge and are aware of this policy and how to implement it should the need arise.
* **Multi-disciplinary Team (MDT) -** work with patient, carer, advocate, or relevant community-based professionals to describe the needs that require support after discharge before an assessment of their long-term needs. This could determine whether the person’s home is suitable for their needs upon discharge. Multidisciplinary teams may include social workers, clinicians, therapists, mental health practitioners, pharmacists, care workers, dietitians, housing representatives and volunteers. These teams should be aware of carers’ rights, and ensure carers are willing and able to care and that they have sufficient support to care safely. This helps to facilitate an integrated transition from hospital to the person’s usual place of residence. Safety should be ensured from the day of discharge. They should refer those requiring support to the transfer of care hub. The MDT staff should be experienced in supporting people to make informed choices, weighing up the risks and benefits of options. They should be knowledgeable about carers’ rights and understand the full options available to people in community settings to offer people the best choice and understanding of their recovery pathway.

**Social workers**

Social Workershave a vital role as members of a multi-disciplinary team, ensuring a person-centred and strengths-based approach is adopted during pre-admission, hospital stays and planned safe discharge. Their role in assessment settings is essential for people whose social circumstances are complex and they can arrange to see the patients in their own homes or other residential settings on discharge.

**Community health service providers including General Practice**

Providers will work closely with other system partners to facilitate timely discharge of people through the transfer of care hub/ multi-disciplinary teams to assess and arrange packages of support and ensure provision of equipment.

# Managing Choice

Both the providers of NHS care and Local Authorities are responsible for ensuring that appropriate health and care provision is available for their population, which will support the discussions around choice.

Patients and families can find it difficult to make decisions about their discharge destination or care provider and/or make the practical arrangements for a range of reasons and it is important these concerns are respected, and they are supported to move forwards.

Communication is central to managing choice on hospital discharge and must be tailored and accessible for the individual. Regular communication across the system (through posters, leaflets etc.) will reinforce the message that once patients are clinically ready to leave acute care, they cannot continue to occupy an inpatient bed.

Interactions with patients and or representatives will need to acknowledge and offer support with any concerns, whilst reinforcing the message that everyone will work towards the patient’s discharge from hospital.

At the time of admission, all patients must understand that if they no longer meet the criteria to reside, they cannot continue to occupy an inpatient bed and that patients do not have the right to remain in hospital longer than is required as this may result in:

* Exposure to an unnecessary risk of hospital acquired infection.
* Frustration and distress to the patient and relatives due to uncertainty and waiting times for a preferred choice to become available.
* Increased patient dependence and reduced strength and mobility as the hospital environment is not designed to meet the needs of people who are ready for transfer of care.
* Severely ill patients being unable to access services due to beds being occupied by patients who no longer meet the Criteria to Reside.

# Reablement and Rehabilitation

Patients, who require on-going reablement or rehabilitation, will be offered support in the first available setting which meets their needs. It is not appropriate to give choice of any other setting as this offer is made based on the availability of the setting which best matches their needs. However, it should be made clear to the patient that the setting of their rehabilitation may change as their needs become clearer.

Whilst it is recognised that it is beneficial for the patient to participate in rehabilitation at home or as close to home as possible, at times it may not be possible. At that point, the setting for reablement or rehabilitation offered will be based on where the needs of the patient can be best met.

Periods of reablement or rehabilitation offered will be in line with needs; it is not appropriate to discuss timescale with patients as their needs will change in line with their response to interventions.

It is not appropriate for people/ patients to prolong their stay in hospital to receive rehabilitation or reablement once they no longer have the criteria to reside.

If the residential reablement/rehabilitation care setting does not have availability an interim alternative residential care setting will be offered.

# Palliative and end of life care

Palliative and end of life care needs should be anticipated and met as part of an individual’s discharge and advanced care planning journey and that includes the offer of a [Personal Health Budget](https://www.england.nhs.uk/wp-content/uploads/2014/09/guidance-on-the-legal-rights-to-personal-health-budgets.pdf) for people identified as fast track through [Continuing Healthcare](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1170290/National-Framework-for-NHS-Continuing-Healthcare-and-NHS-funded-Nursing-Care_July-2022-revised_corrected-July-2023.pdf).

Health and social care partners should work together to provide appropriate rehabilitation and reablement support from palliative and end of life specialist services and voluntary organisations. This may include support to maximise the individual’s independence or meet other personal goals.

# Community Beds

This policy will be utilised by the Intermediate Care and Step-Down beds, however the letters and staff involved will be altered accordingly.

# Out of Area

This policy will be utilised for facilitating the transfer of care of out of area patients where there is agreement and support off out of area partners.

If there is a delay in the availability of a package of care or placement, alternative transfer of care options will be considered on an individual case by case basis, taking into consideration the different commissioning and cost to the patient of such alternatives. Relevant partner organisations will then continue to work with these individuals and placements to repatriate the individual where appropriate.

# 12. Mental Capacity

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

Mental Capacity assessment is not required if the person is returning to their usual place of residence and there is no dispute in that expectation. A capacity assessment is required whenever capacity is in question and best interest decision made to legally demonstrate returning to usual place is in best interests.

Where there is a Lasting Power of Attorney for Health and Welfare or a Court Appointed Deputy, they are the decision-maker.

[Appendix 1](#_Appendix_1:_Hospital) sets out in detail how the application of this policy should be adapted for cases where the patient may lack Mental Capacity to make the relevant decisions at the appropriate time.

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 transfer of care process must not put the patient or their carers at risk of harm or that could breach their right to respect for private life. Neither should it create a situation whereby the independence of the carer or the sustainability of their caring role is jeopardised.

Where the patient lacks capacity to make decisions about transfers of care, the implementation of this policy will initially be applied by involving the patient's representative who has legal Lasting Power of Attorney for both welfare and finance to be able to make decisions regarding their health and welfare. Where there is any doubt, advice must be gained.

# 13. Overview of Process for Timely discharge from acute care

Once a patient no longer meets the criteria to reside timely discharge enables them to maximise their opportunity for recovery and/or rehabilitation. Remaining in hospital can have a negative impact on their health outcomes.

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

Planning for effective transfer of care, in collaboration with the patient and/or representatives and all Multi-Disciplinary Team (MDT) members, should be commenced at or before admission, or as soon as possible after an emergency admission. The principles of [The SAFER patient flow bundle](https://fabnhsstuff.net/fab-stuff/the-safer-patient-flow-bundle)  should be applied to support timely discharge.



Pre-Admission

Post discharge

The process and timelines within this policy should be clearly communicated to the patient so that by the time a patient no longer meets the criteria to reside 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.

When a patient’s needs have changed during the admission the patient will be provided with an initial care package or placement once they cease to meet the criteria to reside. The opportunity to participate in a full assessment of their long-term needs, if required, will take place once they have had a chance to recover from their acute or community hospital admission, usually within a week or two, and had time to consider how they would like their longer term needs to be met. This will be incorporated into their longer-term care plan, individual choices will be respected and met, where this is financially and logistically possible.

Each sub system within the ICB will have a Single Coordinator for Discharge and/ or an agreed approach to support the process and a suite of factsheets and letters have been designed to standardise the process where possible - see [Appendix 6](#_Appendix_6_-) and [Appendix 7](#_Appendix_7_-).

As a minimum the following process should be taken:

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| **Step 1 - Providing standard information** | * Identify discharge coordinator, and other people who have the patient's consent to be involved in discussions and decisions, e.g., carers, relatives * Discharge expectations discussed and patients made aware of policy * Determine whether the patient has mental capacity and if not, put in place appropriate measures * DoLs - patients should have independent advocate to participate in decisions if there is no appropriate family/friend/carer with whom to consult * Patient/ Carers/ advocates provided with initial factsheet in [Appendix 6](#_Appendix_5_-) * Patient given Expected/ predicted date of discharge |
| **Step 2 - Assessing need** | * Early identification of complexities likely to delay discharge * Risk stratification using objective and subjective data to assign risk levels to patients * Share information identified with the transfer of care hub/ community services * Ensure all necessary referrals are made to required health and care services * Follow appropriate national/ [NICE assessment guidance](https://www.nice.org.uk/guidance/qs136/chapter/Quality-statement-4-Discharge-plans) |
| **Step 3 - Preparing for discharge** | * Completed well before Expected/ predicted date of discharge * Transfer of care hub will decide whether patient can be managed at home * Explain options, process and timeline to patient * Issue initial discharge letter A and relevant leaflet to support decisions, offer DMS where appropriate - see [Appendix 7](#_Appendix_7_-) * Describe care needs * Direct patient to advocacy services if appropriate * Ensure all arrangements are in place ready for discharge e.g., medications, transport, and equipment * Discharge plans will be discussed regularly |
| **Step 4 - Packages and Placements** | * When required care packages or placements offered to facilitate discharge; issue relevant letter (B-B6) in [Appendix 7](#_Appendix_7_-) tailored to individual need * Interim package of care or placement may be offered if available options have been declined, or where specific package, placement, or adaptation is not yet available. * Where patient declines the agreed discharge plan the patient or advocate has 24hours to identify an alternative * If 24hours elapses with no alternative identified, then the discharge plan will be escalated as per the escalation process. |
| **Step 5 - Facilitated discharge** | * Each organisation enacts their facilitated discharge policy when required |
| **Step 6 - Escalation process** | * Each organisation enacts their facilitated discharge policy when required - see guideline in Section 14 |
| **Step 7 - Post discharge** | * Contact details provided at point of discharge and patient advised to make contact if they are concerned about anything. |

Discharge starts at admission and discharge planning will be discussed regularly during assessment and on-going treatment. All required treatment will be reviewed to ensure it is essential within an acute environment. Where not essential, further tests and treatment will be planned as an outpatient or transferred to the GP to complete. All patients will receive the relevant Discharge Choice letter and leaflet.

When it is agreed by the patient’s MDT that they no longer meet the **Criteria to Reside** - see [appendix 2](#_Appendix_2_–), all plans will be made to manage their transition home safely. If their discharge occurs within the expected timescales, the discharge process is complete.

An interim package of care or placement will be offered to a patient where a decision has not been made within seven days of completion of step 3, available options have been declined, or where a decision has been made but the specific package, placement, or adaptation is not yet available. Patients do not have the right to remain in hospital to wait for their preferred option to become available.

The interim package or placement is distinct from intermediate care or reablement.

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

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 with letter B4-6 (version dependent upon funding arrangements). The interim package / placement will allow further time for the choice of package / placement to be resolved outside of hospital and funding arrangements will be agreed locally. Please note that self-funders will be required to fund their care in the interim package / placement beyond the agreed period if a permanent decision has not yet been made or if the chosen package / placement is not yet available. The exception to this is where the 12-week property disregard applies.

If all steps have been taken to manage someone’s discharge safely and they do not wish to accept those plans, the System Choice Escalation Process must be initiated - see Section 14.

The initiation of the Choice Escalation Process includes a review to confirm that the required steps to plan a safe discharge have occurred. This should be documented and kept in patient medical records noting the date and time of the audit:

1. Ensure that the MDT agrees that the patient no longer meets the Criteria to Reside, and the doctors have documented this in the Patient’s Medical Record.

2. Check that all procedures and services are in place for a safe discharge, whether these are the ideal patient choice or not. This should include all support services.

3. Check with that all equipment necessary for the patient to be safely discharged has been delivered and installed if required.

4. Ensure the patient is aware of their EDD and that the ‘Discharge Choice Information Leaflets have been given to the patient - sess [Appendix 7](#_Appendix_7_-) for relevant letter. Patient carers/ representatives should also have this information if appropriate.

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 not to be treated in an inhuman or degrading way.
* the right to respect for private and family life, home and correspondence.
* the right to life.
* the right to freedom of religion and belief.
* freedom from torture, inhuman or degrading treatment.
* right to liberty and security.
* freedom of expression.
* protection from discrimination in respect for these rights and freedoms.

Any communication with the patient/representative regarding their discharge will be documented in the clinical record. At all stages the patient will be provided with information and contact details of the Patient Advisory and Liaison Service (PALS) and patients should be informed of their rights to complain. 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.

The patients also have the right to have a seamless transition from hospital-based care to care provided within the Continuing Healthcare framework and under the Care Act 2014. Therefore, it is crucial for the hospital to ensure that the proposed transfer is appropriate and in line with human rights legislation and other legislation.

# 14. Choice Escalation Process Summary

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| Organisations will have clearly communicated escalation process. If a patient is not willing to accept any of the available, appropriate alternatives it may be that they are discharged, after having had appropriate warning of the risks and consequences of doing so. This option would only be pursued following the offer and rejection of available, appropriate options of care and appropriate safeguards and risk assessments. If this is the case there must be sufficient rationale and a contemporaneous record of the options, discussion, and decision.  Organisations will follow a 4-stage process described below:  **Stage 1 - Discharge Plan not agreed within timescale**  **Stage 2 - Choice Escalation Process - Informal Discussion**  **Stage 3 - Formal Discussion**  **Stage 4 - Establish most suitable option for the patient**  Further detail is outlined in the flowchart below: |
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# 15. Consultation

This policy was based on national guidance which was developed by a collaboration of partners with input from people working across the system, both locally and nationally.

Organisations from across the Humber and North Yorkshire Health and Care Partnership have been involved in the development of the local policy, which will be signed off by through Integrated Care Board governance arrangements.

# 16. Training

Staff with responsibility for arranging the discharge of patients from hospital will receive training and guidance on how and when to implement this policy and its processes.

The training will be provided by an appointed lead within each organisation.

# 17. Monitoring Compliance

To ensure effective implementation and assess policy effectiveness each Trust will align their policies to the System Choice on Discharge Policy and effectively communicate across the organisation - see [Appendix 8](#_Appendix_8_-)**.**

Monitoring in each hospital will be undertaken on a regular basis, facilitated by the System Single Coordinator for discharge/ transfer of care hub covering each locality. Monitoring of the policy will include (but not limited to):

* Feedback on staff training relevant to the policy.
* Barriers to discharge
* Patient and/or representative feedback and complaints.
* Number of people with No Criteria to Reside.
* Length of Delayed Transfers of Care.

System Single Coordinators for Discharge across the ICB will report relevant metrics to the Transfer of Care Network which will facilitate a response to issues and develop systems and processes to unblock barriers to discharge.

# 18. Arrangements for Review

This policy will be reviewed at least every 3 years unless there are substantial changes required by the Transfer of Care Network or similar body.

# 19. References

* Template Policy: Supporting Patient's Choices to Avoid Long Hospital Stays - 2016
* Compassion in Practice, Nursing, Midwifery and Care Staff Our Vision and Strategy
* Quick Guide: Discharge to Assess
* Guidance: Hospital discharge and community support guidance
* ECIP Quick Guide - The SAFER patient flow bundle
* Hospital Discharge and Community Support Guidance - 2022
* Choice Policy: A joint policy between Ealing Council – Adults Services, London North West Healthcare NHS Trust and NHS Ealing Clinical Commissioning Group
* Hospital Choice Policy - Medway
* Mental Capacity Act 2005
* Care Act 2014
* NHS Choice Framework
* Care and Support Statutory Guidance
* Transition between inpatient hospital settings and community or care home settings for adults with social care needs - NICE Quality standard [QS136]
* NHSE One-off personal health budgets within hospital discharge pathway

# 20. Appendices

[Appendix 1 - Hospital Discharge and Mental Health Considerations](#_Appendix_1:_Hospital)

[Appendix 2 - Criteria to reside – maintaining good decision-making in acute settings](#_Appendix_2_-)

[Appendix 3 - Pathways for the Discharge to Assess Model](#_Appendix_3:_Pathways)

[Appendix 4 - The principles guiding discharge arrangements](#_Appendix_4:_The)

[Appendix 5 - Summary of Legal Rights and Responsibilities](#_Appendix_5:_Summary)

[Appendix 6 - National Choice Leaflets](#_Appendix_6:_National)

[Appendix 7 - Sample Choice Letters](#_Appendix_7_-)

[Appendix 8: Choice on Discharge Policy Implementation Checklist](#_Appendix_8:_Choice)

[Appendix 9 - Definition/ Explanation of Terms](#_Appendix_9_-)

# 21. Impact Assessments

## 21.1 Equality

NHS Humber and North Yorkshire ICB is committed to creating an environment where everyone is treated equitably and the potential for discrimination is identified and mitigated. It aims to design and implement services, policies and measures that meet the diverse needs of our service, population and workforce, ensuring that none are placed at a disadvantage over others. Promoting equality and addressing health inequalities are at the heart of our values. Therefore, in developing this policy due regard has been given to:

* The need to eliminate discrimination, harassment, and victimisation, to advance equality of opportunity, and to foster good relations between people who share a relevant protected characteristic (as cited under the equality act 2010) and those who do not share it; and
* The need to reduce inequalities between patients in access to, and outcomes from healthcare services and to ensure services are provided in an integrated way where this might reduce health inequalities
* The value of a strength-based approach to delivering health and care. Valuing patients as partners in this process who each bring their individual strengths to their discharge from hospital.

Potential adverse impact on any protected group identified through the EIA will be monitored as part of the routine work to monitor compliance with the policy.

## 21.2 Bribery Act 2010

Due consideration has been given to the Bribery Act 2010 in the development (or review, as appropriate) of this policy document. The ICB follows good NHS business practice as outlined in the Business Conduct Policy and the Conflicts of Interest Policy and has robust controls in place to prevent fraud, bribery and corruption. Under the Bribery Act 2010 there are four criminal offences:

• Bribing or offering to bribe another person (Section 1)

• Requesting, agreeing to receive, or accepting a bribe (Section 2).

• Bribing, or offering to bribe, a foreign public official (Section 6).

• Failing to prevent bribery (Section 7).

## 21.3 General Data Protection Regulations (GDPR)

The ICB is committed to ensuring that all personal information is managed in accordance with current data protection legislation, professional codes of practice and records management and confidentiality guidance. More detailed information can be found in the Data Protection & Confidentiality Policy and related policies and procedures.

## Appendix 1: Hospital Discharge and Mental Capacity Considerations

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

* Presume that adults are mentally capable of making their own decisions.
* Do not determine the person lacks capacity until all practicable steps to support them to make the decision have been taken without success.
* Do not consider someone to lack capacity because they make a decision, others may consider to be unwise.
* When the patient is assessed to lack capacity, we must act in their best interests and have regard to their wishes.
* 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 transfer of care 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. Where a practitioner is wishing to rely upon the statutory presumption of capacity to make a decision this should be documented.

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. Where ultimately the patient is determined to lack capacity their views must still be considered as part of any subsequent best interests decision.

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 transfer of care decision, the information relevant to the decision will include an understanding of their care needs on transfer of care, 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; this is likely to include the decision for the patient to remain in hospital will not be an available option and should not be considered in the capacity assessment or the best interests decision. A patient with capacity cannot insist on staying in hospital after they no longer meet the [Criteria to Reside](#_Appendix_2_–).

Where a patient, despite all reasonable efforts to support them, lacks capacity for transfer of care 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 several different people. The decision maker may be a valid/ registered Lasting Power of Attorney for health and welfare 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 social care professional who needs to make the decision in question. Any decisions regarding the transfer of care arrangements will be made in the patients' best interests. (A Lasting Power of Attorney for property and affairs is not the decision maker in cases relating to health although should be consulted as part of the best interests decision)

“Best interests” is interpreted widely and goes beyond medical risk and benefit to include social, psychological, and emotional factors. Before making a best interest's decision attempts should be made to ascertain the Patient's wishes as far as possible.

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 available and appropriate to consult about their best interests other than a paid professional (MCA s38-39).

If the proposed placement or care package on transfer of care 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. It is preferable that any required authorisation happens prior to the move however this will not always be possible and does not necessarily mean there should be a delay in the discharge where the option to remain in hospital is not an option available to the Court of Protection of the Local Authority to make. It is recommended that in these cases legal advice be sought.

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 in those circumstances can only be authorised by the Court of Protection.

## Appendix 2 - Criteria to reside – maintaining good decision-making

The Transfer of Care Network will lead the work to understand variation and work on standardisation to consistently apply the criteria to reside.

The intention is for every person on every general ward to be reviewed on a twice-daily ward round to determine the following. If the answer to each question is ‘no’, active consideration for discharge to a less acute setting must be made:

* requiring ITU or HDU care?
* requiring oxygen therapy/NIV?
* requiring intravenous fluids?
* NEWS2 greater than 3? (Clinical judgement required in persons with AF and/or chronic respiratory disease)
* diminished level of consciousness where recovery realistic?
* acute functional impairment in excess of home/community care provision?
* last hours of life?
* requiring intravenous medication > b.d. (including analgesia)?
* undergone lower limb surgery within 48 hours?
* undergone thorax-abdominal or pelvic surgery with 72 hours?
* within 24 hours of an invasive procedure? (With attendant risk of acute life- threatening deterioration)

Clinical exceptions will occur but must be warranted and justified. Recording the rationale will assist meaningful, time efficient review.

## Appendix 3: Pathways for the Discharge to Assess Model

Adapted from John Bolton model for persons aged 65 and over, and when used across all 18+ age groups, it is expected that a greater percentage than detailed will be allocated to pathways 0 and 1:

**Pathway 0**

Likely to be minimum of 50% of people discharged:

* simple discharge home
* no new or additional support is required to get the person home or such support constitutes only:
* informal input from support agencies
* a continuation of an existing health or social care support package that remained active while the person was in hospital

**Pathway 1**

Likely to be minimum of 45% of people discharged: able to return home with new, additional or a restarted package of support from health and/or social care. This includes people requiring intensive support or 24-hour care at home.

Every effort should be made to follow Home First principles, allowing people to recover, reable, rehabilitate or die in their own home.

**Pathway 2**

Likely to be maximum of 4% of people discharged: recovery, rehabilitation, assessment, care planning or short-term intensive support in a 24-hour bed-based setting, before returning home.

**Pathway 3**

For people who require bed-based 24-hour care: includes people discharged to a care home for the first time (likely to be a maximum of 1% of people discharged) plus existing care home residents returning to their care setting (for national data monitoring purposes, returning care home residents will count towards the 50% figure for Pathway 0).

Those discharged to a care home for the first time will have such complex needs that they are likely to require 24-hour bedded care on an ongoing basis following an assessment of their long-term care needs.

## Appendix 4: The principles guiding discharge arrangements

**Health factors**

a) The patient is assessed by the responsible MDT as being fit for a safe discharge from hospital.

b) The proposed placement and support plan can meet the assessed health and physical care needs of the patient.

c) The proposed placement and support plan will support the patient's future health and physical well-being.

d) The proposed placement and support plan will deliver any assessed rehabilitation needs of the patient.

**Social factors**

a) The proposed care and support plan meets the assessed care and support needs of the patient having regard to their desired outcomes and the importance of promoting their wellbeing.

**Financial factors**

a) The cost of the placement is within the amount of the persons personal budget and which the Council usually pays for similar levels of need.

## Appendix 5: Summary of Legal Rights and Responsibilities

This appendix includes a 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 optimised and no longer meet the criteria to reside.  In some cases, where the patient’s refusal to leave hospital when optimised 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 transfer of care 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 have such needs (this happens now post discharge from the acute setting)  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, where this can be accommodated within the individual’s personal budget, or where an additional payment (top-up) has been agreed.  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 an independant advocate if a patient would experience substantial difficulty in participating in the assessment of need or care planning process unless there is another (unpaid) appropriate person to fill this role.  Responsibility to authorise deprivation of liberty in care homes and hospitals. | Care Act 2014 s9  Care Act 2014 s10  Care Act 2014 s30, Care and Support and After-care (Choice of Accommodation) Regulations 2014  Care Act 2014 s4  Care Act 2014 s25  Care Act 2014, s67  MCA Schedule A1 paras 21, 50 |
| Integrated Care Board [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].  Discharge to Assess process responsible for ensuring safe and timely discharge. | NHS Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) Regulations 2012, reg 21  National Hospital Discharge Policy amended Aug 2020 |
| 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 optimized and have no criteria to reside.  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, where this can be accommodated within the individual’s personal budget, or where an additional payment (top-up) has been agreed (but no right to remain in hospital when medically optimized while preferred choice is awaited).  Right to respect for family life and to not be treated in an ‘inhuman or degrading’ way. | Care Act 2014, s9 and NHS Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) Regulations 2012, reg 21  Barnet PCT v X [2006] EWHC 787; R (Burke) v GMC [2005] EWCA Civ 1003  NHS Constitution  Care Act 2014 s30, Care and Support and After-care (Choice of Accommodation) Regulations 2014  Human Rights Act 1998 s6 in relation to Articles 3 and 8 of the European Convention of Human Rights |
| Carer | Right to carer’s assessment / support and choice about caring i.e., willingness to provide care. | Care Act 2014 s10 |

## Appendix 6: National Choice Leaflets

|  |  |
| --- | --- |
| Initial Factsheet - on admission |  |
| Planning together: leaving hospital when the time is right |  |
| Returning Home |  |
| Moving or returning to another place of care |  |
| Advice for family and friends of people needing ongoing care or support with day-to-day life. |  |

## Appendix 7 - Sample Choice Letters

|  |  |
| --- | --- |
| Choice Letter A - Initial Discharge notification |  |
| Choice Letter B - Offer of discharge destination |  |
| Choice Letter B2 - Care homes |  |
| Choice Letter B3 - Care Package at Home |  |
| Choice Letter B4 - Notification of plan to transfer to interim care whilst waiting for a preferred home |  |
| Choice Letter B5 - Notification of plan to transfer to interim care whilst waiting for a preferred care at home |  |
| Choie Letter B6 - Notification of plan to transfer to interim care whilst waiting for housing support services |  |
| Choice Letter C - Invite to formal meeting |  |
| Choice Letter D - Formal meeting - patient absent |  |
| Choice Letter D - Formal meeting - patient present |  |
| Choice Letter D2 - eviction letter |  |

## Appendix 8: Choice on Discharge Policy Implementation Checklist

|  |  |  |  |
| --- | --- | --- | --- |
| No. | Key Lines of Enquiry | Completed | Date |
| 1 | Do you have an SRO with responsibility for implementing this policy |  |  |
| 2 | Has the Policy been shared at Executive Board |  |  |
| 3 | Has the Policy been seen by Medical Director |  |  |
| 4 | Has the Policy been seen by Director of Nursing |  |  |
| 5 | Has the Policy been seen by Director AHPs |  |  |
| 6 | Has the Policy been stored on your intranet or equivalent |  |  |
| 7 | Has you Communications Team been approached to support the mobilisation and implementation of this policy |  |  |

## Appendix 9 - Definition/ Explanation of Terms

|  |  |
| --- | --- |
| **Advocacy:**  **.** | a service to help people be involved in decisions, explore choices and options, defend their rights & responsibilities, and speak out about issues that matter to them |
| **CHC:** | NHS Continuing Healthcare is defined as a package of ongoing care for an individual aged 18 or over which is arranged and funded solely by the NHS where the individual has been found to have a ‘primary health need’. |
| **Deprivation of liberty:** | when an individual without mental capacity to consent is under continuous supervision and control and is not free to leave, and this is imputable to the state. |
| **EDD/ PDD: Estimated or expected or predicted date of discharge:** | This means when the patient is clinically assessed as ready for discharge. The EDD is initially based on average length-of-stay data and may change several times in response to the patient’s specific needs. |
| **Independent Mental Capacity Advocate (IMCA):** | will represent patients assessed as lacking capacity under the Mental Capacity Act 2005 to make important decisions, such as change of accommodation, and who have no family and friends to consult. |
| **Interim care:** | A provisional placement that is suitable and able to meet the patient’s assessed needs whilst they wait for their preferred option. |
| **Intermediate care:** | Short-term care provided free of charge by the NHS for people who no longer need to be in hospital but may need extra support to help them recover. It lasts for a maximum of six weeks and can be in the patient’s home or in a residential setting. |
| **Lasting Power of Attorney** **LPA:** | Is a way of giving someone the legal authority to make decisions on your behalf if you lose the mental capacity to do so in the future, or if you no longer want to make decisions for yourself. |
| **MDT:** | Multidisciplinary team of health and social care professionals involved in the care and assessment of patients. |
| **Medically optimised:** | 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. |
| **Personal Health Budget (PHB)** | An amount of NHS money that is allocated to support health and wellbeing needs. It allows people to manage healthcare and support such as treatments, equipment and personal care, in a way that suits them. |
| **Reablement:** | Reablement services are meant to help people adapt to a recent illness or disability by learning or relearning the skills necessary for independent daily living at home. Reablement should be provided free of charge by the local authority for up to six weeks. It can be extended at the local authority’s discretion. |
| **Self-funder:** | A person who financially meets the full cost of their social care needs (apart from reablement care and the 12 week property disregard), because their financial capital exceeds the threshold for adult services funding, their level of need is not deemed to be high enough for local authority funding, or because they or a representative choose to pay for their care. |
|  |  |