SCOTTISH EXECUTIVE

Health Department
Directorate of Service Policy and Planning

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Local Authority Directors of Social Work/Chief Social Workers
Local Authority Directors of Housing
Local Authority Directors of Finance
NHS Chief Executives
Relevant Voluntary Sector Organisations

13 January 2004

Dear Colleague

CHOICE OF ACCOMMODATION – DISCHARGE FROM HOSPITAL

Summary

1. This circular outlines how Local Authorities and NHS Boards should actively manage choice of care homes for people moving from hospital, in a way which is consistent and fair and which minimises delays.

2. The Social Work (Scotland) Act 1968 (Choice of Accommodation) Directions 1993 apply to Local Authorities that are to provide accommodation to a person under the Social Work (Scotland) Act 1968. The Directions make it a duty of Local Authorities in Scotland to arrange places for such persons in care homes of their choice, subject to certain conditions. The Directions provide that if an individual expresses a preference for particular accommodation, the Local Authority has to arrange it provided:

- the accommodation is suitable to the person's needs as assessed by the Local Authority;
- it will not cost the authority more than it would usually expect to pay;
- the accommodation will be available within a reasonable period; and
- the person in charge of the accommodation is willing to provide the accommodation subject to the authority's usual terms and conditions.

3. The Scottish Executive has become aware that these Directions are being applied inconsistently. This may be due to uncertainty as to the meaning of "reasonable period" in paragraph 3(c) of the Directions and to misunderstanding of their respective responsibilities on the part of Local Authorities and NHS Boards.

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4. This has had a negative impact on discharge from hospitals. The Scottish Executive's Delayed Discharge Action Plan (*Delayed Discharges in Scotland: March 2002*) committed the Executive to clarifying existing guidance on the Directions to introduce a consistent national approach.

5. This guidance clarifies the way in which the Directions should be implemented. It explains that indefinite occupation of a hospital bed by a patient who is ready for discharge, while awaiting his/her choice of care home, is not appropriate. It explains that patients should be asked to make choices of care homes, and interim accommodation should be secured if none of these choices becomes available within the discharge planning period. It explains the right to move to a care home of choice at a later date, should one become available. The respective roles of Local Authorities and NHS Boards in the discharge process are also clarified.

Purpose

6. This guidance is for the attention of Local Authorities and NHS Boards. It is a description of best practice which should be adopted by each body involved in the process and is issued as statutory guidance to Local Authorities for the purposes of section 5(1) of the Social Work (Scotland) Act 1968. It provides extended and specific guidance on how choice of care home should be managed for people leaving hospital settings. It supplements the guidance contained in Scottish Executive circular SWSG5/93, which accompanies the *Social Work (Scotland) Act 1968 (Choice of Accommodation) Directions 1993*. Paragraphs 11, 14 & 15 of this guidance replace paragraph 26 in NHS MEL(1996)22 *NHS Responsibility for Continuing Health Care* and paragraph 37 in SWSG 10/1998 *Community Care Needs of Frail Older People: Integrating Professional Assessments and Care Arrangements.*

7. Local Authorities and NHS Boards, working in partnership (Local Authority and NHS Board Partnerships), should manage choice actively in a way which is consistent and fair and which minimises delays. The guidance indicates how responsibilities should be shared between those partners (Annex C). The effective management of discharge, and of choice, should rest on effective and integrated working among partners at all stages in the process within the context of an agreed joint local hospital discharge protocol. All Partnerships should put in place such protocols which will be audited and placed on the Executive Website (http://www.scotland.gov.uk/Topics/?pageID=248). As joint services are increasingly developed and put in place, staff roles in the NHS and Local Authorities may change. It is for Partnerships locally to take account of such developments when dealing with choice issues, and to ensure that joint local hospital discharge protocols reflect current organisational and practical arrangements.

8. In some areas, lack of available places in the care home sector makes the management of choice more difficult. Local Authority and NHS Board Partnerships have a vital role to play in tackling this. They should assess need and undertake capacity planning, taking a whole system approach, to ensure the appropriate balance of services is locally to meet health and social care needs. This is a longer-term action which must take place in tandem with the short-term challenge of managing choice in the context of scarce capacity. Paragraphs 4 – 9 of NHS MEL (1996) 22 remain relevant in this context.

Action

9. The arrangements in this guidance should be implemented immediately by all Local Authority and NHS Board Partnerships.

Enquiries

10. All enquiries relating to this letter and annexes should be addressed to John Waugh (e-mail JohnD.Waugh@scotland.gsi.gov.uk, telephone 0131 244 3748).

Yours sincerely

MS JINNY HUTCHISON

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ANNEX A

GUIDANCE

Moving from hospital into a care home

1. Although the provisions in this guidance relate to all client groups, the majority of people moving from hospital to a care home are older people who have been admitted to hospital directly from their own homes. Once clinical treatment and community care assessment in hospital are complete, these people may have to make the major life transition of moving into a care home, possibly for the rest of their lives.

2. Careful management of this major change is important both for the person involved and his/her families and carers. Local Authorities and NHS Boards should work jointly, demonstrating open and consistent management of choice, to minimise the stress that can be involved. Where appropriate, social work and NHS staff should involve families, carers and advocates throughout the discharge process.

3. Many of those leaving hospital for a care home will have their assessed needs met in a home of their choice. Where that home of choice is not available, however, Local Authority and NHS Board Partnerships should adhere to this guidance and clear guidelines laid out in local joint hospital discharge protocols. This will assist people in making alternative choices as they move from hospital to care home settings.

Early Action - Providing Information on Care Homes

4. Health and social work staff should take a proactive approach to managing choice of care home on discharge from hospital. Patients, or where appropriate their carer or family member(s), should be given information at the earliest practicable stage in the process, bearing in mind that it may not always be appropriate to introduce discussion of care home options at a very early stage. Many people are able to return home, in some cases with appropriate care and support or following a period of rehabilitation. When it becomes obvious, however, that a care home placement is likely to be appropriate, social work staff should lead the process of ensuring the patient is given information about this and what it would involve. Staff should make patients, or where appropriate their carer or family member(s), aware of the Partnership's local hospital discharge protocol and policy on choice and on the circumstances in which moves to interim accommodation may be necessary. Comprehensive information on the range of homes available in their area should be provided. Patients, and where appropriate their carer or family member(s), should be advised on likely availability and waiting times, costs, and on their right to seek inspection reports from the Scottish Commission for the Regulation of Care.

5. In giving information, social work staff, in liaison with health staff, should take account of problems resulting from lack of care home places. This could mean that in rural or remote areas a person's choice of care homes may be restricted and he/she may have to consider moves further afield on an interim or even permanent basis. Moving to a different area in a town or city can present similar issues. Lack of places may also result in extensive waiting lists for some of the more popular care homes. Patients, or where appropriate their carer or family member(s), should be helped to make informed choices which can be realised within the timescales required.

Deciding to discharge patients

6. The consultant in charge (or in some community hospitals, GPs) should decide, in consultation with other health care professionals, whether a person is clinically ready for discharge from hospital. This decision should not be influenced by lack of availability of a person's choice of care home or the outstanding resolution of financial issues. NHS MEL 1996 (22) (paragraphs 27 – 32) clearly outlines the responsibility of the NHS to make decisions on whether someone requires continuing in-patient care, and the process for reviewing such decisions prior to their implementation.

Appeals process against decision to discharge

7. Sections 30-32 of NHS MEL (1996)22, set out the procedure for NHS Boards and NHS Trusts in processing appeals against the decisions of clinicians to discharge persons from inpatient care. This procedure is reproduced at Annex B of this guidance and should be followed if the individual or his or her family/carer/advocate wish a review of the decision to discharge.

Timescales for discharge

8. Discharge from hospital arrangements should normally take *no longer than six weeks* to put in place from the moment when it is decided that the person is clinically fit for discharge. This six-week discharge planning period should be seen as the maximum timescale within which discharge should be arranged. Timely discharge, planned from the point of admission and effected as soon as clinically appropriate, should always be the aim. Within this overall time framework Partnerships should agree timescales for the various parts of the discharge process. These should be included in joint local hospital discharge protocols.

9. There will be some circumstances in which the process takes longer. The need to seek Guardianship or Intervention Orders under the Adults with Incapacity (Scotland) Act 2000 may delay processes, though early identification of the potential need for such orders should minimise delays. Only a Welfare Attorney, Welfare Guardian or holder of an Intervention Order, where choice of residence is specified in the powers held, may legally determine where the patient should live. Where none of a patient's choices of care home is available and there is disagreement over alternative arrangements, the process may also take longer to reach a conclusion. The aim throughout, however, should be to minimise delays at each point in the process whilst trying to secure the discharge of the patient to a suitable home which meets his/her needs.

10. The practical arrangements for the person to move into a care home should be made jointly by the social work authority and the NHS. The social work authority should take the lead in this process. The move should normally be made as early as is possible and normally *no longer than six weeks* after the patient is clinically ready for discharge.

Arrangements for Discharge from Hospital to Choice of Accommodation

Making Choices of Care Home

11. Where a person is assessed as requiring care in a care home, he/she should be encouraged by the social work authority to identify at least three suitable care homes that are acceptable as future accommodation, although in some rural or remote areas it may not be possible for as many as three suitable care homes to be identified. The care homes chosen should be ranked in order of preference, but all choices should be pursued simultaneously. The relevant Partnership staff should provide appropriate help. This may include providing, or arranging for the provision of, further advice to the

person and the family/carer/advocate on the practical and financial implications of the options, and visits to homes if this is practicable.

12. If a patient refuses to make choices, the social work authority should explain that refusal to make a choice will not prevent the discharge process proceeding and seek to progress, in liaison with health staff, the practical arrangements which would enable the patient to be moved to an available and suitable care home place. Relevant staff should continue to try to persuade patients to make choices on their own behalf throughout this process. Refusal to make a choice about available accommodation must not lead to the patient's remaining in hospital indefinitely.

13. The guidance given in NHS MEL 1996 (22) paragraph 29 is restated below and should be adhered to. The focus should be on reaching an amicable solution with patients and their family or carers.

"If these other options are rejected it may be necessary for the hospital in consultation with the Health Board, social work authority and where necessary the housing authority, to implement discharge to the patient's home or alternative accommodation, with a package of health and social care within the options and resources available."

Interim Placements

14. If it becomes apparent that no place will be available in any of a person's preferred care homes within *six weeks of the patient being clinically ready for discharge*, the Local Authority should examine availability in any appropriate care home that has a place available. The Local Authority must take into account affordability for itself and the patient. The person should then be assisted to move into this interim choice care home until a place in one of his/her chosen care homes is available. This interim move should normally be made within the six-week discharge planning period, i.e. within six weeks of the date of the clinical decision that the person is fit to be discharged. An interim move is not the same as a 'temporary' move (when residence in a care home is for a temporary period, either for respite or before returning to live at home) for charging purposes. Where people make an interim move into a care home, the Local Authority should ensure the person's name is retained on a waiting list for the preferred choice care homes for at least a year, if that is the person's wish. Unless circumstances determine otherwise, Local Authorities should ensure that people who need to make an interim move should make only *one* such move before entering the care home of their choice.

15. If a person staying in an interim choice care home indicates he/she would prefer to stay there, either when offered a place in one of the care homes originally chosen or during the waiting process, the social work authority should try to arrange this. Any waiting lists the person is on should be amended accordingly if he/she is accepted on a permanent basis. If the person is not accepted on a permanent basis, he/she should remain on the waiting lists as before.

Disputes over discharge to interim or permanent placements

16. Where there is a dispute relating to the proposed discharge to interim or permanent accommodation, Partnership staff, including the consultant, should jointly decide a discharge date within six weeks of the date of the clinical decision that the person is ready for discharge, and work with the patient and his or her family/carer/advocate to find an appropriate means of meeting the patient's care needs at the point of discharge. Social work staff should lead the process of making arrangements for the person to move at that date to an appropriate care home or alternative accommodation as per NHS MEL (1996) 22 paragraph 29.

17. The Local Authority and NHS Board Partnership's joint hospital discharge protocol should include actions to be taken in the event that no agreement is reached by the date set for discharge. This may include an agreement to implement discharge of the individual to an available care home or another location, such as the person's own home or alternative accommodation, which is appropriate to his or her assessed needs. The NHS Board has responsibility for implementing the discharge and should consider taking advice from its legal advisers on the procedures to be followed. This guidance should in no circumstance be taken as authorising the forcible removal of such a person from hospital.

Managing waiting lists for care homes

18. Waiting lists for care homes should be carefully managed by the social work authority for people whose care costs will be met partly or fully from public resources. Independent care home provision will make this more complex, but the social work authority should attempt to negotiate agreements with care home providers which will ensure that people who have to move into interim accommodation can make a subsequent move at an appropriate time should they so choose.

Self-funding individuals

19. A small number of people choose fully to meet care home costs independently. These people should be provided with the same advice, guidance and assistance on choice as fully or partly public-funded individuals. If such persons refuse to accept advice, guidance and assistance from the social work authority, they will be expected to make their own arrangements for care on discharge from hospital. The NHS Board is responsible for ensuring that such patients are timeously discharged from hospital, under the provisions in the joint local hospital discharge protocol. Where reasonable, this should be done within the six week discharge planning period.

Travel Arrangements for Families

20. In a small number of cases, people may take up an interim placement which is some way from their home of choice and their families and carers may have to incur significant additional travel costs to visit them. Local Authority and NHS Partnerships should consider the circumstances in which they might offer financial assistance and publicise local arrangements in their information leaflet.

Information Leaflets

21. A short information leaflet on Choice of Accommodation is provided at Annex D. This is written in plain language for individuals and their families and/or carers and explains Executive policy on choice. Partnerships should also produce their own local leaflets which give more detail on local joint protocols to be operated between the NHS and its Local Authority partners. Patient and carer organisations should be consulted on these leaflets and involved in the development of information strategies. Appropriate staff should present these leaflets to patients as soon as it appears that they may need to move to a care home setting after treatment in hospital.

ANNEX B

NHS MEL (1996) 22 - NHS RESPONSIBILITY FOR CONTINUING CARE

Paragraphs 30 – 32 – Review Procedures

30. In his statement to the Scottish Grand Committee on 1 March, Lord Fraser of Carmyllie announced his decision to introduce a procedure for patients who wish to appeal against the clinician's decision that they can be discharged from NHS hospital care. The following procedures are to be adopted by Health Boards and NHS Trusts to ensure the speedy processing of such appeals.

30.1 Patients are to have readily available information about how to appeal, and to have related help and advice from hospital staff on request. Information on independent advocacy services should also be provided. The patient's GP may also be able to offer advice and guidance as appropriate. This information (in a format appropriate to the patient's needs) should include the name, address and telephone number of the staff member(s) responsible for dealing with the appeal process.

30.2 Where a patient (or his or her relative/carer/advocate) questions the appropriateness of the clinician's decision on his/her future health care, the Director of Public Health at the Health Board in whose area the patient is being treated will in the first instance review the decision.

30.3 NHS care for the appellant is to continue for the duration of the appeal process.

30.4 Such appeals to the Director of Public Health should be lodged within 10 (calendar) working days of notification to the patient of the clinician's recommendation on the future health care.

30.5 The Director of Public Health will ensure that the criteria set out in this guidance have been correctly applied. The Director's consideration will also extend to the grounds of appeal. The outcome of the initial review to be reported (in writing) to the patient or his/her representative within 14 (Calendar) days of the appeal submission. The Director of Public Health may designate a medical practitioner to assist his consideration of the appeal.

30.6 If, following that review, the objection is continued, an independent clinician review will be instituted. This second stage review must be notified to the Director of Public Health within 10 (calendar) days of receipt by the appellant of the outcome of the initial review.

30.7 Patients wishing to continue their appeal against their own clinician's recommendation may (after seeking whatever guidance they wish e.g. from their local health council or GP) select any Health Board area in Scotland (including the one in which they reside) from which a consultant would be nominated to arbitrate on the appropriateness of the decision to discharge for NHS continuing care. The review at this stage to be on the clinical decision only. The Health Board advising the appellant should explain any special difficulties that arise where the Health Board area selected operates on the basis of "single handed" consultants. The Health Board selected, working with its NHS Trust(s) (and Directly Managed Units (DMUs), where

appropriate) should ensure that the appeal is considered and a decision announced in writing to parties within 25 (calendar) days of the second stage appeal submission.

30.8 NHS Trusts (and DMUs) are to make available consultants (at no charge) to act as arbiters in cases of second stage appeals by patients against proposals for their discharge from an NHS hospital.

30.9 The arbiter consultant will restrict consideration to the clinical aspects of the case (decisions on nursing home or residential home placements and the level of social care at home will continue to be made by the Social Work Authority).

30.10 For as long as the clinical assessment remains relevant the appeal outcome to be binding on all parties; the NHS Trust (or DMU) providing care to the appellant, the purchaser responsible for funding that care and; on the appellant and anyone representing his or her interests. (Paragraph 32 refers as regards continued access to alternative review and complaints procedures.)

31. Health Boards and NHS Trusts should ensure compliance with these arrangements (both in terms of availability of staff to consider appeals and in terms of service delivery) through their contracts for NHS continuing care services. The arrangement will be kept under regular review.

32. Appeals at either stage of this process will not debar individuals from access to existing procedures for review of cases including NHS complaints procedures or the referral of their case to the Health Service Commissioner.

ANNEX C

LOCAL AUTHORITY AND NHS PARTNERSHIP RESPONSIBILITIES IN RELATION TO HOSPITAL DISCHARGE – CHECKLIST

1. LOCAL AUTHORITY LEAD ROLE

Ensuring community care assessment is carried out.

Giving information on care home options to patients whose care home place will be wholly or partly publicly funded.

Pursuing vacancies in patient's choices of care home and setting up contractual arrangements with care home proprietors.

Making arrangements for transfer of patient to care home.

2. NHS LEAD ROLE

Giving information on care home options to patients whose care home place will not be wholly or partly publicly funded.

Making decisions on discharge and implementing discharge.

3. JOINT ROLES

Agreeing joint local hospital discharge protocol which adheres to Scottish Executive Guidance.

Producing an information leaflet for patients, carers and families which outlines Partnership joint local hospital discharge protocol and treatment of choice issues.

Agreeing procedures for handling disputes over discharge arrangements (NB – not over the decision to discharge, which is an NHS responsibility, but over discharge to an interim place).

ANNEX D

MOVING FROM HOSPITAL INTO A CARE HOME – YOUR CHOICES

The Social Work (Scotland) Act 1968 Choice of Accommodation Directions 1993 concern the rights of individuals to choose where they receive residential care. Community Care Circular CCD 8/2003 provides new guidance to Local Authorities and the NHS on how they should discharge their responsibilities relating to choice of accommodation. This leaflet gives information on this. It should be read in conjunction with any local leaflets produced by the Local Authority and NHS Board Partnership.

Who is this leaflet for?

The leaflet is for anyone who may need to move into a care home from hospital. Friends, family, carers and those who work in advocacy services or the care sector may also find this leaflet useful.

What happens when the decision is made that you need to move from hospital into a care home?

Moving into a care home from hospital is a major change in anyone's life.

Social workers and hospital staff will help you to make important choices and provide you with information about making a move to a care home at the point when it appears that this is a real possibility. They will inform you of the local hospital discharge protocol and give you a local leaflet on what you should expect to happen and on the options that are available to you. You should be given comprehensive information on the range of care homes available in your area and advised on likely availability, waiting times and on costs. You will also be advised on how to obtain inspection reports from the Scottish Commission for the Regulation of Care.

What if I don't think I should be discharged from hospital? Can I appeal?

Unnecessary time spent in hospital can affect your health and well-being and lead to lower skills, confidence and independence, sometimes to the extent that moving from hospital to a care home would no longer be an option. If, however, you believe that a decision to discharge you is not appropriate, the first thing to do would be to discuss this with the people who have made the decision and with your care manager or named nurse. If after doing so there is still disagreement, health and/or social work staff will be able to advise you about the appeals system and how to go about lodging an appeal. The NHS has procedures for this which it has to follow.

How do I choose a care home?

When it is agreed that you need to move into residential care, you will have the chance to make several choices of care home, where this is possible. When you have made your choice(s), social work staff will try to get you a place in one of the care homes that you have chosen. Normally, a place will be found in one of these homes within six weeks of the decision to discharge you from hospital.

How long should the move to a care home take?

Discharge from hospital arrangements should normally take **no longer than six weeks** to put in place from the moment the decision is made that you are clinically ready for discharge, i.e. after medical and clinical treatment which requires to be given on an inpatient basis is complete.

What if the care homes I choose are full?

If no place is likely to be available in your preferred care home choice(s) within six weeks of your being declared ready for discharge, the Local Authority will look at the availability of other affordable care home places. In the event that an alternative placement is found, it will help you to move into this as an interim choice care home. This would normally happen within six weeks of your being declared ready for discharge. If possible, you would remain on the waiting lists for the care homes you originally selected, if that is what you want.

The Local Authority does not directly manage the waiting lists of care homes it does not run, but staff will endeavour to keep you informed of the local situation.

The Local Authority will try to ensure that you do not make more than one interim move if the care home(s) of your choice is(are) full.

What if I want to stay in the interim care home?

If you have been placed in an interim choice care home and decide that you would prefer to stay there, the Local Authority will try to ensure that this is possible. In some circumstances this may not be possible.

What if the care home is a long distance away from my family or friends?

If you move into an interim placement that is some distance away from your care home of choice, your family, friends and carers may face significant additional travel costs to reach you. Local agreements between Local Authority and NHS partnerships may in some cases provide financial assistance. This should be explained in their local leaflet.

Whom can I get help or advice from?

Health and social work staff will be able to offer help and advice as well as directing you to other sources of assistance. The Scottish Commission for the Regulation of Care will be able to provide information about the care homes in your area.

How do I fit in if I plan to fully fund my own care?

If you decide to fully fund your care costs, you will be offered the same advice, guidance and assistance on care home choice as someone who is fully or partly public funded.

If you refuse to accept this advice, guidance and assistance from the Local Authority, you will be expected to make your own arrangements for post-hospital care. In this situation the NHS is expected to ensure that you are discharged from the hospital within six weeks, so as not to affect other people's treatment.

If you would like any further information or have any queries please contact us at:

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