Guidance on Choosing a Care Home on Discharge from Hospital

January 2023

Contents

Guiding principles

The potential for **recovery**, **rehabilitation** and **reablement** will be fully considered before any decisions are made on long-term care plans. The aim should always be to return home if possible and appropriate. Wherever possible, decisions about long-term care should not be made in an acute hospital setting. Ideally, the patient should be discharged to a more appropriate non-acute setting such as a community hospital, or intermediate care facility for further rehabilitation and assessment.

The DwD programme was launched in 2021 and aims to improve the patient journey, from the initial point of a hospital stay, preventing any delays through early and effective planning. A key aim is to limit hospital stays to what is clinically and functionally essential, getting patients home at the earliest and, crucially, safest opportunity.

While the challenge is highly complex, ever shifting and dynamic, the foundations of DwD are based on simple patient-centred principles which aim to enhance discharge and prevent delay, through early and effective planning, limiting hospital stays to what is clinically and functionally essential, and getting patients home at the earliest, safest opportunity. These can be distilled down to three basic elements.

1. Prepare and plan for discharge with patients, from admission;
2. Prioritise and protect time to plan as an extended team;
3. Adopting a 'Home First' ethos.

A key element of Discharge without Delay programme is the setting of a Planned Date of Discharge (PDD). Discharge from hospital should take place in line with the agreed PDD. If the person is transferring to an intermediate care facility the PDD should be reassessed on admission and a new PDD established.

Moving into a care home is a major decision for a person and their family, so preparation and planning needs to commence as early as possible in the patient's journey. This process is less likely to be successful when it is rushed, and can have a negative impact on the patient's health and wellbeing. It may also result in the inappropriate use of health and social care services. Ideally, a hospital admission should not be the trigger point for this planning. The patient, family or proxy and, where appropriate, social work services and community health staff will have given thought to long term care needs as part of an **Anticipatory Care Plan**.

The application of the choice guidance at a local level should be embedded firmly in a local admission, transfer and discharge policy/protocol. Consistent, timely and appropriate communication by all professionals involved with the patient and family or proxy will help to address many of the difficulties and misunderstandings that can occur and will ensure the process of moving on takes place in an effective and efficient manner.

A person is not entitled to remain indefinitely in hospital once they are ready for discharge. Failing to make a choice of care home, or reluctance to co-operate with the discharge process **should not prevent discharge taking place**. The NHS

and local authorities will take robust action to ensure that people are not inappropriately delayed in hospital if a placement more appropriate to their needs is available elsewhere. The previous Cabinet Secretary for Health and Wellbeing made it clear that a patient does not have a right to 'choose' to stay in hospital where this goes against best clinical practice.

Where the preferred choice(s) of care home is not immediately available the person will be required to make a temporary (interim) move to another home with a suitable vacancy to wait. The decision to discharge an individual will be based on clinical need and must not be influenced by a person's choice of care home or resolution of financial issues.

Consideration of capacity and the principles and requirements of the Adults with Incapacity (Scotland) Act 2000, Human Rights, and Equality legislation must underpin the application of this guidance.

The issue of the patient's capacity to make informed decisions about future care should be investigated as early as possible in the patient's journey. This will help to avoid unnecessary delays in the patient's discharge.

Purpose and context

1. This document provides updated guidance for local authorities and NHS Boards and their Integration Authorities on the **Social Work (Scotland) Act 1968 (Choice of Accommodation) Directions 1993**. It provides detailed advice on managing choice of care home for people assessed as requiring **on-going long term care**, following a hospital stay. This guidance does not apply to short breaks, respite or periods of Intermediate Care provided in a care home setting.

2. Separate guidance has been issued for individuals who are delayed in hospital and require an interim move to a care home to wait for a package of care to return to their own home.

3. It is aimed at staff involved in the discharge of patients who are **clinically fit for discharge**, and, after all other options have been explored, are assessed as requiring long-term care in a care home. It will also be of interest to patients themselves, their family, carers and advocates. Example public information leaflets and letter templates are also available for use locally.

4. The aim of this guidance is to achieve a clear, consistent approach for staff, patients and their families to arrange timely discharge to a care home. This will in turn improve the patient journey by reducing unnecessary, prolonged and potentially damaging hospital stays as well as freeing up beds for other patients.

5. **Section One** of this guidance provides guidance on, and interpretation of the Directions on Choice. **Section Two** provides a more detailed practitioner's guide for use by health and social care staff involved in discharge planning and care home allocations.

6. Under the Carers (Scotland) Act 2016, unpaid carers have the right to be involved in the hospital discharge process of the person they are or are going to be caring for. They also have the right to have their views taken into account in assessing the needs of the person being cared for. A Good Practice Guide to Involving Carers in Discharge Planning provides more advice.

7. Where a patient lacks capacity to consent staff should make enquiries to ascertain whether a **Welfare Attorney** or **Welfare Guardian with appropriate powers** has been appointed, as per the Adults with Incapacity (Scotland) Act 2000 (see page 7 for further details).

8. It is universally recognised that once a patient has been deemed clinically fit for discharge from an acute episode, prolonged hospitalisation is rarely the best option. Similarly, once any hospital based rehabilitation has been completed, the patient should move from hospital as soon as possible into a more homely community setting, preferably in their own home; or into sheltered accommodation, a care home or other community setting.

Who will this guidance affect?

9. This policy will apply to:
    - Patients who have been assessed as requiring long-term care in a care home after all opportunities for rehabilitation or reablement, through the use of Intermediate Care, have been fully investigated and discussed with the patient, family or proxy.
    - Patient, family or proxy who have identified a home of choice with no current vacancy.
    - Patient, family or proxy who are repeatedly uncooperative or unwilling to engage with the discharge planning process, by refusing to make suitable care home choices.
    - Patient, family or proxy who are unwilling to move from hospital until a vacancy becomes available at their preferred home of choice.
    - Patient, family or proxy who are unwilling to move to another care home temporarily (an interim move), when their preferred home of choice is currently unavailable.
    - Patients who are not eligible for Hospital Based Complex Clinical Care and do not accept alternative arrangements.

10. This guidance applies equally to all patients, regardless of who is ultimately funding their care (i.e. self-funders, or wholly or partly funded by the local authority).

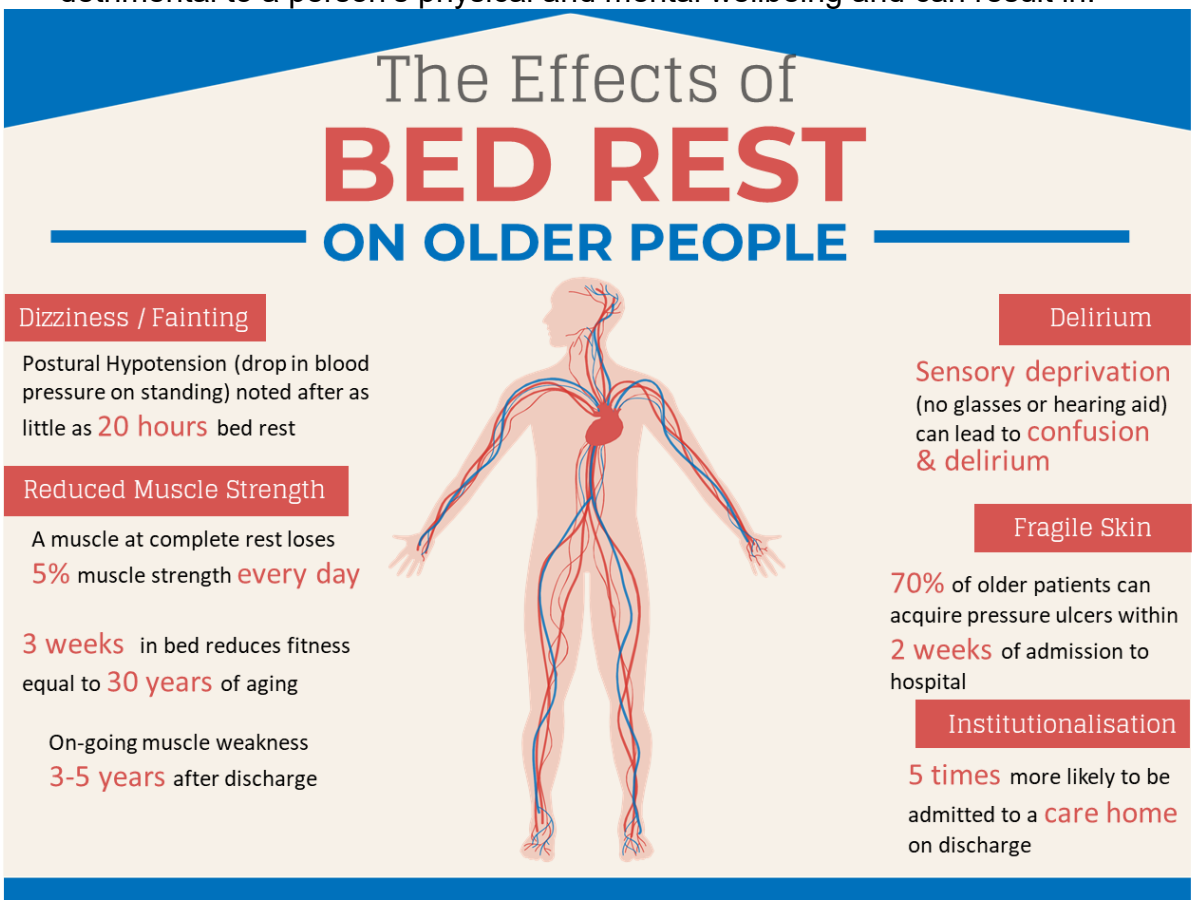
11. However, this guidance **does not** apply to individuals waiting for a package of social care to return to their own home and require an interim move to a care home. As referred to at point 2 above, separate guidance is available on this.

Directions on Choice

12. The Social Work (Scotland) Act 1968 (Choice of Accommodation) Directions 1993 apply to local authorities that arrange care home accommodation to a person under the Social Work (Scotland) Act 1968 (the 1968 Act). The directions place a duty on local authorities in Scotland to arrange places for people in a care home of their choice, provided:
    - The accommodation is suitable in relation to the individual's assessed needs.
    - To do so would not cost the authority more than it would usually expect to pay for accommodation for someone with the individual's assessed needs.
    - The accommodation will be available within a reasonable period
    - The person in charge of the accommodation is willing to provide accommodation, subject to the authority's usual terms and conditions for such accommodation.

    See Annex A for full Directions.

13. There is clear evidence[1] [2] that an unnecessary prolonged stay in hospital can be detrimental to a person's physical and mental wellbeing and can result in:



1 Hazards of hospitalisation of the elderly; MC Creditor 1993 - http://www.ncbi.nlm.nih.gov/pubmed/8417639

2 Reducing Functional Decline in Hospitalized Elderly: Ruth M. Kleinpell, Kathy Fletcher, Bonnie M. Jennings - http://www.ncbi.nlm.nih.gov/books/NBK2629/

14. Patient choice is one of the many factors affecting delays in discharge from hospital. There are a number of reasons why these types of delays occur:
    - patient, family or proxy unwilling to start or engage with the choice process, e.g. not responding to telephone calls, correspondence.
    - patient, family or proxy disputing the hospital discharge, insisting on patient staying in hospital.
    - patient, family or proxy have made a choice of care homes, but have not identified one with a suitable vacancy or interim home.
    - patient, family or proxy refusing to move to (or in the case of self-funders refusing to pay for) an interim care home.

15. This guidance provides advice on how to deal with these cases. However, clear local protocols, that are robustly and consistently implemented with the support of all staff including **senior managers**, **clinicians**, **ward** and **social work staff** are essential to improve discharge planning and improve outcomes for patients.

Capacity, consent and proxy decision-makers

Assessing capacity

16. Some patients may lack capacity to make their own choices about on-going care. This may be because of mental disorder or inability to communicate due to physical disorder. The Adults with Incapacity (Scotland) Act 2000 provides a framework for decisions, including a range of ways to allow others to act or make decisions for an adult in this situation. Also, any individual, including those with a mental disorder, should have access to independent advocacy. There are three broad scenarios in relation to capacity.

Patient has capacity

17. Patients with capacity in relation to the specific decision as to where they should reside will make their own choices. If they wish, they may involve relatives, friends and independent advocates to help them make and communicate their choices. Practitioner staff must do all they can to maximise individuals' abilities to make choices by giving them information in a way they can understand and sufficient time and support to make their own decisions. *(see guidance on assessing and communicating capacity)*

Patient lacks capacity and has proxy decision-maker

18. If a patient does not have sufficient capacity, there may be a welfare proxy. This would be a welfare attorney, guardian or holder of an intervention order.
    - **They may have a specific power to decide where the individual will reside.** However this power **does not** extend to insisting that the patient remains indefinitely in hospital, once they are clinically ready for discharge.
    - This power cannot be assumed - important to check that they have the power to consent to the required decisions about the patients long term placement.
    - Practitioners should ask for written evidence of the powers granted, and retain a copy in case files.
    - Powers can only be used where the granter lacks capacity in relation to the decisions and/or actions to be taken.

19. Whilst an individual retains the capacity to do so, they can grant a **power of attorney** in accordance with the AWI Act. This gives a trusted person, usually a family member, or solicitor, the power to make certain decisions or take certain actions on behalf of the person, should they eventually lose their ability to do so themselves. A person may have the capacity to grant a power of attorney, even though they lack some capacity to make more complex decisions for which they are granting the powers. When considering granting a welfare Power of Attorney, it is important for the granter to discuss in advance with the proposed attorney the powers they wish them to have as well as the circumstances in which they would wish these powers to be used. The granter must not be affected by the undue influence of others in granting these powers.

20. The Law Society of Scotland has issued guidance for solicitors on working with vulnerable clients and preparing a welfare power of attorney.

21. A **Welfare Guardian or holder of an intervention order**, under the AWI Act can have similar powers to a welfare attorney, but is legally appointed by the courts. Anyone claiming an interest in the welfare of the adult can apply for guardianship or intervention orders, including relatives, carers or other parties, such as a local authority. They can also apply to the Sheriff Court should they have concerns about how any of a proxy's powers are being used or not used. When a **welfare guardian** is a relative, carer or other private individual the local authority in which the person lives must supervise the guardian. The supervisor will look at the appropriateness of the use of powers. (Intervention orders are intended for one-off actions or decisions, most often relating to property or finance.)

22. When a proxy is making decisions on someone's behalf they must follow the principles laid down by the Act, these include:
    - Any action or decision taken **must benefit the adult** and only be taken when that benefit cannot reasonably be achieved without it.
    - Any action or decision taken should be the minimum necessary to achieve the purpose. It should be the option **that restricts the person's freedom as little as possible**.
    - In deciding if an action or decision is to be made, and what that should be, account shall be taken of the present and past wishes and feelings of the adult, as far as they can be ascertained. The person should be offered appropriate assistance to communicate his or her views.
    - Where practicable, they should take the views of relevant others into account. This will include the views of practitioner staff and other family members.
    - They must encourage the individual to use existing skill and gain new skills. This includes helping the individual to exercise any capacity he/she has to make choices concerning their property, financial affairs and their personal welfare.

23. As stated previously, this power **does not** extend to insisting that the patient remains indefinitely in hospital, once they are clinically ready for discharge. In situations where a proxy refuses to agree to discharging the patient, on grounds of choice, they should be reminded of the above principles, and their duty to follow them. If the disagreement continues, they should be informed of their right to seek directions from the Sheriff as to whether or not their powers allow them to block the discharge. This is discussed further in the section below Challenging the Proxy's Decision.

Patient lacks capacity and has no proxy decision-maker

24. If an incapable adult has no attorney with suitable powers, it may be necessary for someone to apply to the court for a guardianship order on the adult's behalf. To prevent the adult's discharge being delayed early identification of the need for a guardianship order is recommended. There are certain key actions that should be taken.

25. However, where the adult does not object and there is agreement as to the need for a care home, section 13ZA of the Social Work (Scotland) Act 1968 can be used.

Using Section 13za of The Social Work (Scotland) Act 1968

26. The Social Work (Scotland) Act 1968 ("1968 Act") has been amended to include powers under S.13ZA, to provide services to adults who have been assessed as needing a service but who lack the capacity to consent to receiving that service.

27. Where a local authority considers using their powers under s13ZA of the 1968 Act they must consider whether the proposed action amounts to a deprivation of liberty under Article 5, ECHR. Guidance on this issue is contained in Annex 1 of CCD 5/2007 which now forms part of the Code of Practice for Local Authorities Exercising Functions under the 2000 Act.

28. Where a local authority has, following an assessment of the adult's needs, concluded that the adult requires a community care service but is not capable of making decisions about the service, they may take any steps which they consider necessary to help the adult benefit from that service.

29. Where all parties concerned agree that a move to a care home is required, and agree which care home is most appropriate for the individual, the local authority has the power to place the patient in a care home without the requirement for a guardianship order.

30. Section 13za cannot be used where:
    - Any of the parties with an interest disagree with the decision to discharge, or the next stage of care,;
    - There is a guardian or welfare attorney with powers relating to the proposed steps;
    - An intervention order has been granted in relation to the proposed steps;
    - An application has been made (but not yet determined) for an intervention or guardianship order relating to the proposed steps.

31. In these circumstances the family, carer or other appropriate person (e.g. a solicitor or advocate) should be advised to apply for guardianship. The disagreement with the decision to discharge the patient to a care home should be detailed in the Mental Health Officer's report. It should also explain the course of action the NHS and local authority wishes to take (i.e. discharge the patient to a care home that can meet the patient's assessed needs).

32. A realistic timescale for processing the Guardianship application should be agreed with the applicant, setting out timescales for completing key milestones in the process. If these timescales are not adhered to, or the party refuses to apply then the local authority should apply for guardianship themselves.

33. During this application process staff should continue dialogue with all parties to ensure discharge can progress, once Guardianship is in place. The section

Challenging the proxy's decision provides advice on how to work with Guardian's who continue to refuse to engage with the discharge process.

34. Full details of guidance on all the statutory functions which are conferred on local authorities under the 2000 Act are covered in the Code of Practice for Local Authorities Exercising Functions under the 2000 Act.

Challenging the proxy's decisions

35. The proxy can have no more authority than a capable patient. Therefore, a proxy has no right to insist that the patient remains in hospital once the patient is clinically fit for discharge. The route to challenge a decision to discharge from hospital care is available for the proxy in the same way as for a capable patient. Guidance on disputing discharge is contained in the Guidance on Hospital Based Complex Clinical Care.

36. Where there is conflict between the proxy and the responsible clinician over the decision to discharge, every effort should be made to resolve this by discussion. The proxy should be reminded of their duty to act in the best interests of the patient, as highlighted in the Code of Practice for Guardian's, a copy should be provided if necessary.

37. If resolution about the use of proxy powers is not possible, the AWI Act offers a number of possible solutions:
    - A Sheriff may, on application under section 3 of the 2000 Act **by anyone claiming an interest in the personal welfare of the adult**, give directions as to the use of the powers. The sheriff may also choose to call for additional reports and may appoint a safeguarder to represent the interests of the adult who is the subject of the application
    - A Sheriff on application under section 20 of the 2000 Act, by anyone claiming an interest in the personal welfare of the adult, may revoke any of the powers of a welfare attorney or revoke them entirely.
    - A Sheriff may also order under section 20 of the 2000 Act that a welfare attorney is subject to supervision by the local authority when exercising powers and may require the welfare attorney to report back to him as to how the attorney is exercising his powers

38. If the proxy disagrees with the decision to discharge the Adults with Incapacity Act allows for directions to be sought from the Sheriff by any person claiming an interest in the patients welfare, as to whether the proxy's powers allow them to refuse to move the patient to a suitable care home. A realistic timescale for lodging the application should be agreed by all parties and closely adhered too.

39. The NHS (and local authority partners) must be able to demonstrate that they have come to a clear legal decision that the patient is clinically ready for discharge, and would be better cared for in a care home setting than a hospital.

40. The next section of this guidance contains further advice on challenging the proxy's decision and dispute resolution (page 19).

Section Two

The Choice Process

Roles and responsibilities

Patients, family members and proxies

1. The patient, family or proxy should participate fully in discussions with health and social care professionals regarding the patient's future care needs, and choice of care home.

2. If it appears the patient lacks capacity to make these decisions, and a proxy has not already been appointed, and s13za cannot be used as justification for moving the person, the family, carer or representative will need to consider applying for Welfare Guardianship. This should be done as quickly as possible to ensure the patient is not delayed unnecessarily in hospital.

3. Family members applying for Guardianship should take into account the guidance contained in A guide for Carers to making an application for Guardianship and Intervention Orders.

4. Proxies should also take into account the guidance contained in the Code of Practice for persons authorised under intervention orders and guardians under the Adults with Incapacity (Scotland) Act 2000.

5. Patients, family or proxies will need to choose a care home which is able to meet the patients assessed needs. They can choose up to three homes, one of which should have a suitable vacancy that will be available within a reasonable period. This should be done in consultation with social work or social care staff.

6. If the preferred home(s) are unlikely to have a vacancy available by the agreed discharge date the patient, family or proxy will need to choose a temporary (interim) home to move to and await a vacancy in their preferred home of choice.

7. **The patient or proxy cannot ask to wait in hospital until their preferred home becomes available.**

All Professionals

8. All staff involved in the patient's care should give a clear and consistent message that remaining in hospital, once the patient is clinically ready for discharge, is not an option (see page 7).

The Clinician

9. The clinician in charge of the patient's care will assess and decide when the patient is clinically ready for discharge. A PDD will then be agreed as part of the multi-disciplinary assessment process.

10. It is not the role of the clinician alone to make decisions regarding the next stage of the patients care (i.e. whether or not the patient will need to go home, or to a care home). These decisions are best made following a thorough assessment process, with early involvement of health, social care and other relevant agencies.

11. The clinician will support all decisions regarding the next stage of care made by the social work team, and other relevant agencies and should not agree to patients remaining in hospital purely to wait for their preferred choice of care home to become available.

12. The clinician will be informed by the case worker of any cases where the patient, family or proxy are unwilling to engage with the choice process or accept an interim move. Where resolution cannot be attained with the support of the clinician the case should be referred immediately to the Medical Director.

Senior Charge Nurse & Ward Staff

13. The Senior Charge Nurse will work with the nursing staff to ensure there is effective and inclusive communication with patient, family or proxy throughout the discharge and choice process. And ensure that patients, families and carers have a positive experience during the hospital stay, and understand when discharge is planned.

14. The Senior Charge Nurse will also manage and develop the nursing teams knowledge and experience in discharge planning through appropriate regular training, to ensure the best quality care, information and advice is provided at all times.

15. Similarly, it is not the role of nursing staff alone to decide on the next stage of care for the patient. This assessment process will be led by social work staff, involving healthcare professionals, and other agencies as appropriate.

16. In cases where the patient, family or proxy continue to refuse to actively engage with the choice process or refuse to leave the hospital on the agreed discharge date the Senior Charge Nurse will escalate cases to the Medical Director for action. This should be done through the clinician in charge.

Social Work / Social Care Staff

17. Social work staff have lead responsibility for the assessment of needs, and provision of social care services on discharge from hospital. They also have lead responsibility for convening and chairing meetings with the patient, family and/or proxy to discuss future care arrangements.

18. As part of setting the PDD, social work and ward staff should ensure that the choice process is started as early as possible in the patient's journey; always ensuring that any possibility of the patient returning home, with support is explored first. The assessment should be carried out jointly with other health and social care staff, and should fully involve the patient, family (where the patient agrees) or proxy from the outset. Results from the assessment should be communicated to the patient, family or proxy in an appropriate format.

19. Social work staff are also responsible for carrying out a financial assessment, and discussing likely costs of care with the patient, family or proxy.

20. Social work staff should provide the patient, family or proxy with a list of appropriate care homes, able to meet the patients assessed needs. They should work with the patient, family or proxy to help them make appropriate choices. They should also clearly explain the choice process to all concerned, highlighting that:
    - The patient cannot remain in hospital to wait for their preferred choice of home to become available once they are clinically fit for discharge.
    - Up to three choices should be made – one of which should have a vacancy available by the agreed ready for discharge date (see page 16).
    - If none of the preferred homes have a vacancy available then the patient will have to move to another care home to wait for a vacancy in a preferred home.

21. In cases where the patient, family or proxy refuse to engage with the choice process social work staff should inform the Senior Charge Nurse within 24 hours, so that the case can be escalated to the Medical Director, through the consultant in charge, for action.

Medical Director

22. Once informed by the Consultant the Medical Director will write to the patient, family or proxy informing them that a discharge date has been set and that the patient will be discharged from hospital on that date to a care home that can meet the needs of the patient and has a vacancy available.

Stage 1: Planned Date of Discharge (PDD)

1. PDD should begin the moment someone is admitted to hospital. This process should begin with engaging with the patient, carer and family, indicating when the person is likely to be going home. Discharge planning should be across 7 days and should be particularly focussed in getting someone home during day time hours.

2. PDD should consider not just the position from the acute ward but what matters to the person, what (they can do) and how they want to continue to live.

3. It is good practice to have one person responsible for coordinating a patients discharge plan. This could be a member of ward staff, discharge facilitator, AHP or other. The discharge plan and PDD should be clearly placed in the notes and shared with the patient, carer and family.

4. Local information on discharge planning should be given in an accessible format. National resources explaining the Discharge without Delay programme and Planned Date of Discharge are also available. These include a video explaining Planned Date of Discharge, and a Discharge without Delay Comms Starter pack. NHS Lanarkshire have also developed a range of material explaining the DwD programme and PDD.

4. If the assessment of the patient concludes that that the patient's needs and abilities may prevent them from returning home, and their long term care needs can only be met in a care home, it is essential that the MDT have considered whether the patient can be moved and assessed outwith the hospital to review whether:
   - All other care options have been explored including the potential to support needs with care (including equipment and adaptations) at home, or in another community setting.
   - The potential for reablement and/or rehabilitation has been fully explored.
   - The patient, family or proxy have been fully involved throughout the process.

5. Patients, family and proxy's have the right to challenge the clinical decision that the patient is ready for discharge. However, this right does not extend to insisting that the patient remains in hospital, purely on grounds of choice. The Guidance on Hospital Based Complex Clinical Care provides guidance on appealing the discharge decision.

6. The outcome of the multi-disciplinary assessment, and any further assessments or meetings and conversations must be appropriately recorded in the patient's records, along with copies of all letters or leaflets issued during the discharge process.

7. Clear information is essential to ensure that everyone, including professionals, understand what will happen during the hospital stay and beyond. However, staff should not rely on the provision of written information alone. It is essential that medical, nursing and social work staff spend time with the patient, family or proxy to discuss discharge and post-discharge issues in an open and sensitive manner.

There is national information available on PDD which can be shared with the patient and family.

8. **Information** relevant to the discharge process, will be provided to the patient, family or proxy. This should be written in plain language, and in a format appropriate to the patient, and should clearly explain:
    - Admission, transfer and discharge policies
    - The local choice policy
    - Why a care home is the most appropriate place for a person to move to
    - Why remaining in hospital is not an option
    - The need to make **realistic** choices from **suitable, available** care homes
    - Procedures for interim moves, if a home of choice is not available.
    - Any costs to the individual.
    - The NHS and local authority complaints procedures.

Stage 2: Choosing a preferred care home and, where necessary, an alternative interim home

Further Interpretation of the Directions on Choice

The Directions on Choice state that local authorities should make arrangements for people to move to a care home of their choice, provided the caveats below are met.

a) The accommodation is **suitable** to meet the person's eligible needs, as assessed by the local authority. This should be interpreted as:
   - The home is able to meet the person's assessed needs.
   - The home is registered with the Care Inspectorate and is of an acceptable standard. In considering this, local authorities should take account of any outstanding enforcement action being taken by the Care Inspectorate. They should also take account of Care Inspectorate inspection reports, including their recommendations and requirements.

b) It will not cost the authority more than **it would usually expect to pay.**
   - The placing local authority will provide advice and guidance on their local charging policies and care home rates normally paid.

c) The accommodation will be **available within a reasonable period.** This should be interpreted as:
   - **One** of the care homes of choice has a suitable vacancy, and is prepared to allocate that room to the patient in time to facilitate discharge by the agreed date of discharge.
   - If it is unlikely that a preferred home will be available by the agreed date of discharge then the patient will be asked to make interim arrangements that will facilitate discharge within that period.

d) The person in charge of the accommodation is **willing** to provide the accommodation, subject to the authority's usual terms and conditions.
   - If the home is unwilling or unable to provide accommodation the patient should be advised immediately and asked to make another choice

Choosing a preferred home

1. The assigned care manager will explain the outcome of the MDT assessment to the patient, family or proxy and discuss the need for them to choose a suitable care home.

2. The care manager will also clearly explain the **choice policy**, and provide the patient, family or proxy with a copy of the leaflet *Moving to a care home from hospital .*

3. Patients, families or proxies will be asked to identify a **preferred home** of choice, suitable to meet the assessed needs of the patient. **Up to three homes** can be identified but ideally, one of these should have a suitable vacancy available by the agreed date of discharge.

4. The caveats listed on the previous page should be fully explained to the patient, family or proxy along with any additional restrictions specific to the patient's assessed needs, e.g. relating to specialist care needs. Advice should also be given by social care staff on the practical and financial implications of the options available, and assistance with visits to homes should be provided, where necessary.

5. **All staff involved must be clear that the patient cannot remain indefinitely in hospital once they are fit and ready for discharge**.

Waiting for a preferred care home: Interim arrangements

6. Waiting for the **preferred home** does not mean that the person's care needs are not met in the interim, or that they wait in a setting unsuitable to their assessed needs, **including a hospital bed**.

7. If there is unlikely to be a vacancy in any of the preferred homes by the agreed date of discharge the **Care Manager** should ask the patient, family or proxy to choose an alternative interim home from a list of care homes, **with vacancies currently available,** that are able and willing to meet the patient's assessed needs.

8. The need to proceed with discharge, though the **preferred home(s)** is not available, must be reinforced during this process. It needs to be explained to the patient, family or proxy why an interim move is considered to be in the best interests of the patient, and they need to be reassured that they will remain on a waiting list for their **preferred home(s)**, and will be offered the opportunity to transfer there when a place becomes available, if that is their wish.

Stage 3: Dealing with Reluctant Discharges

1. The procedures outlined below should be followed if, at any stage, the patient, family or proxy are unwilling to engage with the choice process by either:
    - disputing the decision to discharge, or
    - refusing to make a choice of preferred home, or
    - refusing to make a choice of interim home, or
    - are unwilling to accept/pay for a move to the interim home.
    - any other dispute affecting timely discharge.

When the patient (with capacity) disagrees

2. If the patient declines to reasonably co-operate with the Choice Guidance or discharge planning arrangements, the **Care Manager** will continue to make the practical arrangements for the patient to move to a suitable care home. A further meeting should be arranged with the patient, family or proxy to discuss the reasons they are unwilling to make the necessary choices, or move to a temporary home, and discuss a way forward.

3. **It must be made clear that refusal to make a choice does not mean the patient can remain indefinitely in hospital.** If no progress is made the patient will be discharged to one of the listed homes with a vacancy, where the patient can be more appropriately cared for whilst awaiting a vacancy in their preferred home, or can be supported to continue to look for a preferred home.

4. **If no progress is made the case should be referred to the Medical Director . The Medical Director should then write to the patient, reiterating the planned date of discharge and the urgent need for the patient, family, carer or proxy to choose a suitable care home, from the list of vacancies provided.**

When the patient (without capacity) family or carers (without proxy powers) disagree

5. If the patient or any family members disagree with any decision about the patients future care needs (including making an interim move) **Section 13za of the 1968 Act cannot be used**. Where this occurs the family should be advised that a Welfare Guardian is required.

6. Social care staff should continue to work with the family to ensure the patient is discharged to an appropriate care home once guardianship is in place. In cases where it is clear that the family are unwilling to agree to discharge to an appropriate interim or permanent care home the local authority should consider applying for Guardianship.

7. Where a private application for Guardianship is being progressed, a realistic timescale for processing the application should be agreed with the family. They should be advised that if this is not adhered to the local authority will apply for guardianship themselves.

When the proxy disagrees

8. The proxy should be reminded of their duty to follow the principles of the 2000 Act when making decisions on behalf of the adult. Specifically, actions or decisions taken '**must benefit the adult'** and should be the options that '**restricts the person's freedom as little as possible'**. The Health Board should explain why it believes that remaining in hospital is not in the best interests of the patient. The reasons highlighted in section one, paragraph 11 are relevant to this.

9. A proxy is in no stronger a position than the adult, had they retained capacity . As such, they cannot make a decision requiring that the adult remains in hospital once they are fit for discharge.

10. If a proxy continues to object to the patient being discharged they should be urged to go to the Sheriff that granted Guardianship under Section 3 of the 2000 Act to ask for directions as to whether they can use their power to insist the adult is not moved.

11. Section 3 of the AWI Act states that "On application by any person (including the adult himself) claiming an interest in the property, financial affairs or personal welfare of an adult, the sheriff may give such directions to any person exercising functions conferred by this Act".

12. This means that any professional, including the consultant or social worker involved in the patients care, can also apply to the sheriff at any time for direction on the decision to discharge the patient to a care home.

Progressing reluctant discharges

13. This section does not aim to provide formal legal advice. Health Boards are advised to consult their own solicitors before taking any legal action.

14. As stated elsewhere in this document remaining in a hospital bed once all treatments are complete is not good for the health and wellbeing of the individual concerned. Furthermore, the hospital is health service property and patients are allowed on that property because the Health Board consents to them being there. There is no legal provision entitling a person who no longer requires treatment to remain in hospital.

15. Where the patient, family or proxy continue to unreasonably refuse to engage with the choice and/or discharge process a Health Board can choose, as a last resort, to seek enforcement of the discharge through the courts.

ANNEX A: Choice Directions

SOCIAL WORK (SCOTLAND) ACT 1968
(CHOICE OF ACCOMMODATION) DIRECTIONS 1993

The Secretary of State, in exercise of the powers conferred by section 5(1A) of the Social Work (Scotland) Act 1968[3] and of all other powers enabling him in that behalf, hereby makes the following Directions:

Citation and Commencement

1. These Directions may be cited as the Social Work (Scotland) Act 1968 (Choice of Accommodation) Directions 1993 and shall come into force on 1 April 1993.

Local authorities to provide preferred accommodation

2. Where a local authority has assessed a person under section 12A (assessment) of the Social Work (Scotland) Act 1968 ("the 1968 Act")[4] and have decided that accommodation should be provided under Part Il of the Act[5], the local authority shall, subject to paragraph 3 of these Directions, make arrangements for accommodation under Part Il of the Act for that person at the place of his choice (in these Directions called "preferred accommodation") if he has indicated that he wishes to be accommodated in preferred accommodation.

Conditions for provision of preferred accommodation

3. Subject to paragraph 4 of these Directions the local authority shall only be required to make or continue to make arrangements for a person to be accommodated in his preferred accommodation if -

(a) the preferred accommodation appears to the authority to be suitable in relation to his needs as assessed by them;
(b) the cost of making arrangements for him at his preferred accommodation would not require the authority to pay more than it would usually expect to pay having regard to his assessed needs;
(c) the preferred accommodation will be available within a reasonable period;
(d) the persons in charge of the preferred accommodation provide it subject to the authority's usual terms and conditions, having regard to the nature of the home, for providing accommodation for such a person under Part Il of the 1968 Act.

Preferred accommodation outside range of cost regarded by local authority's as reasonable

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3 1968 c.49; section 5(1A) of the Act was inserted by section 51 of the National Health Service and Community Care Act 1990 (c. 19)("the 1990 Act")

4 Section 12A was inserted by section 55 of the 1990 Act. This amendment comes into force on 1 April 1993

5 The relevant amendments to Part Il of the 1968 Act are as follows. Section 12 was amended by the 1990 Act, Schedule 9, paragraph 10(5); section 13B was inserted by section 56 of the 1990 Act; section 13A was also inserted by section 56 of the 1990 Act; and this amendment comes into force on 1 April 1993

4. (1) Subject to sub-paragraphs (2) and (3) below, paragraph 3(b) of these Directions shall not apply to a local authority which makes arrangements which cost more than the local authority would usually expect to pay in order to provide a person with his preferred accommodation if a third party's contribution to that person (which is treated as that person's resources as assessed under the National Assistance (Assessment of Resources) Regulations 1992[6] is such that he can reasonably be expected to pay for the duration of the arrangements an which is at least equal to the difference between -

(a) the cost which the local authority would usually expect to pay for accommodation having regard to the person's assessed need, and

(b) the full standard rate for that accommodation as specified in section 22(2) of the National Assistance Act 1948[7] (liability to pay full cost of local authority accommodation, the "standard rate") or pursuant to section 26(2) to (4) of that Act[8] (liability to pay full cost of other accommodation arranged by local authority).

(2) Sub-paragraph (1) shall not apply in respect of cases in which the third party's contributions are made by a person who is liable under section 42 of the National Assistance Act 1948[9] to maintain the person who wishes to be provided with preferred accommodation.

(3) Nothing in these Directions shall prevent a local authority from making or continuing to make arrangements for a person to be accommodated in his preferred accommodation where the cost of making such arrangements is more than the local authority would usually expect to pay having regard to the person's assessed needs.

Under Secretary
Scottish Office
Edinburgh

16 March 1993

6 SI 1992/2977

7 Section 22(2) of the National Assistance Act 1948 was amended by section 44(3) of the 1990 Act, and applied in respect of accommodation provided in Scotland under the 1968 Act by section 87(3) of that Act

8 The relevant amendments to section 26 of the 1948 Act are as follows. Subsection (2) was amended by section 42(3), and subsection (3) by section 42(4), of the 1990 Act and these amendments come into force on 1 April 1993. Subsection (4) was amended by the Schedule to the Housing (Homeless Persons) Act 1977 and section 20(1)(b) of the Health and Social Services and Social Security Adjudication's Act 1983 (c.41). Section 26(2) to (4) is applied for Scotland by section 87(3) and (4) of the 1968 Act

9 As respects Scotland, section 42 of the 1948 Act was amended by the Law Reform (Parent and Child) (Scotland) Act 1986, Schedule 1, paragraph 5 and is applied by section 87(3) of the 1968 Act

Annex B: Escalation Letter Template

Date
Patient Name
CHI No
READY FOR DISCHARGE DATE: [DATE]

Dear ____

I understand that you were assessed as ready for discharge on dd/mm/yy, and it was agreed that your long-term care needs could only be met in a care home.

However, I have been advised that you have been unable to confirm your choices of care home(s), as requested by social work staff at a meeting with you on dd/mm/yy.

OR

However, I have been advised that your preferred care home(s) do not have vacancies currently available and you are unwilling to move to an interim home, suitable to meet your assessed needs, to wait for your choice to become available.

As you were assessed as ready for discharge on dd/mm, you do not have the right to remain indefinitely in hospital. Long stays in hospital can increase the risk of people losing confidence and independence, and could be detrimental to your health. In addition, in order for the Health Board to meet the care needs of others, the hospital needs people who have finished their medical treatment to be discharged to make way for others who are just starting theirs.

I can now confirm that a suitable interim place has been identified for you in [care home name]. Arrangements will now be made for you to be discharged to this care home on [date].

Yours sincerely

MEDICAL DIRECTOR

Annex C: Discharge Flowchart