Llywodraeth Cymru
Welsh Government

GIG CYMRU NHS WALES

HOSPITAL DISCHARGE GUIDANCE

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Background/Context

Providing safe, timely and effective discharge for every person who attends our hospitals is essential. While it is acknowledged that most hospital discharges are simple in nature, the ageing demographic has resulted in an increasing number of older patients being admitted who require very complex discharge planning and coordination. It is estimated that this cohort of patients can occupy up to 80% of acute hospital inpatient beds at any one time. However, it is not age per se that underpins this challenge rather, it is the increasing prevalence of frailty associated with this population.

Frailty is a long-term condition; it describes a state of health whereby body systems gradually lose their biological, physical, and mental resilience. Best practice for the care of those living with frailty depends on early recognition of changes in social, psychological, and clinical needs that have resulted in a change in physical ability or mental capacity. When this happens, the right anticipatory care and early support can avoid the situation deteriorating into crisis, supported by the effective use of intermediate models of care, including reablement. This approach supports 'what matters' most to the population which is to continue to live at home where it is safe for them to do so.

There is currently an imbalance in our health and social care system and missed opportunities for prevention and early intervention in the community are evident. The current health and social care system tends to be weighted towards reactive management. As a result, those living with frailty are more likely to be admitted to hospital, often for avoidable reasons.

This approach, and in particular hospitalisation, can cause a deterioration in frailty and loss of independence resulting from things like exposure to hospital acquired infection, a loss of confidence, and loss of muscle mass (sometimes referred to as deconditioning). The consequence of the latter results in greater requirement for care and support on discharge, the availability and capacity of which remains limited and frequently results in delayed transfer of care back into the community. Delayed patient discharges to the community creates sub optimal flow through the acute hospital environment and places the wider population at risk of being unable to access emergency and planned care when they need it.

The effective and efficient coordination of discharge planning contributes to reducing the inpatient length of stay for patients living with frailty and lowers their exposure to harm. Consequently, reducing length of stay and discharge rates for this population will enhance patient flow throughout the acute hospital.

Introduction

This document sets out guidance on Hospital Discharge standards for health, social care, third and independent sector partners in Wales. All partners are expected to adhere to, and deliver, these standards to support safe, timely and efficient discharge of patients either to their own homes or on to the next stages of care.

The principles and processes that help support, safe, timely and effective discharge are set out in the Discharge to Recover then Assess (D2RA) Pathways Guidance. All patients with a decision to admit to hospital should be assessed and provisionally allocated to one of four pathways – 0 to 3. This will identify early in a patient's admission what level of support and recovery they will need at the point of discharge to best meet their ongoing care needs.

Patients must be placed onto a D2RA Pathway in line with the requirements set out under the "Principles" in the D2RA Pathways Guidance. This will include patients who require any new or increased support at home than they were already receiving before they were admitted. Patients should be provided with a period of rehabilitation, reablement or recovery before a decision is made about their new, long term care needs. Further information on D2RA Pathways can be found on the relevant section of this guidance on page 16.

During a patient's hospital stay, and particularly prior to discharge, a proportionate assessment of their current needs should be undertaken by a variety of health professionals. This should be in the form of a continuous daily assessment.

The Care Co-ordinator and Trusted Assessor roles will support this process by identifying what is required for the patient going forward and who is responsible for any short-term care needed to aid their further recovery, rehabilitation or reablement and where this is to be provided. Further information on Trusted Assessors can be found in the relevant section of this guidance on page 17.

For most patients, a comprehensive assessment of their care needs will be undertaken at the next stage of care. The assessment will identify if a long-term care package at home, or a care home placement, is needed following the completion of a period of recovery-focussed intervention.

This assessment must be undertaken in line with the requirements set out in legislation under the Social Services and Well-being (Wales) Act 2014. Wherever possible a person should return home for this period of supported recovery (Home First). This supported recovery could be in the form of a commissioned service or support from family or unpaid carers. Only where unavoidable should a step-down or bedded D2RA Pathway rehabilitation or reablement provision be provided.

Links with the All-Wales Optimal Hospital Patient Flow Framework

This Guidance must be considered and utilised alongside the Optimal Hospital Patient Flow Framework. Further information is available in the **Delivering Optimal Hospital Outcomes and Experiences for People in Hospital** operational guidance which has been developed under the Six Goals for Urgent and Emergency Care Programme.

The Framework provides an approach that will improve the hospital stay of people within our care system and be meaningful to staff implementing it. The Framework focuses on ward-based care and preventing a patient's clinical deconditioning as well as the key principles of using SAFER, Red to Green and D2RA Pathways.

The Framework focuses on the journey of the patient through the healthcare setting and the Discharge Minimum Standards focus on helping that patient, and their family or unpaid carers, on their discharge home or to the next stage of their care.

The minimum standards for discharge

- No-one should be admitted, especially those who are frail, unless their only option for treatment has to be provided in an inpatient bed in an acute hospital, and they fulfil criteria to reside i.e. a person requires acute treatment in a hospital setting. In line with the **Six Goals for Urgent and Emergency Care** and planned care programmes, an assessment must be made, prior to admitting a person, about the potential for clinically safe alternatives to admission and an assessment of frailty and clinical deconditioning risk in relation to potentially longer admissions.
- Most patients will be able to be discharged to their home or usual place of residence without further support, other than that provided by their usual support mechanisms, which might include unpaid carers such as family, friends, and neighbours. The requirement for active reablement, rehabilitation or other therapeutic interventions is still an essential element of the discharge process for these patients and their unpaid carers and must be factored in accordingly.

Key Tasks, Standards, and Expectations of Relevant Partner Organisations

Health Boards

Health boards must ensure that these standards are adhered to at all levels and that the discharge process they have in place links with the All-Wales Optimal Hospital Patient Flow Framework. Health boards must continue to review and refine their discharge processes and assure themselves that their practices and enabling processes are fit for purpose and resources effectively deployed to deliver the D2RA Pathways.

Ward level (acute and community hospitals):

- A clinically led review of all patients will be undertaken at an early morning board round. Any patient not meeting the criteria to reside, i.e. whose acute treatment is completed, will be deemed clinically optimised and ready for discharge, adopting the standards and principles below:
- A second, brief afternoon board round (huddle) will agree any further patients not required to be in hospital and therefore able to be discharged. The huddle will also agree tasks that need to be completed to enable early next day discharges ("doing tomorrow's work today")
- Appropriate representatives from the integrated discharge team (or equivalent), including where possible, any carers officer/coordinator or liaison, should ideally be involved in ward reviews (especially in a community hospital setting to support discharge planning within D2RA Pathway 2), and/or help support effective multi-disciplinary team decision making. This will help with the early identification by the ward multi-disciplinary team of the most appropriate proposed D2RA pathway (and in accordance with the four "what matters to me" questions) that all professionals must be able to answer for every person within their care (the four key questions are set out in the D2RA Pathways Guidance (page 4) and should be considered on the ward round for patients who may require community support for discharge) and to allow the multi-disciplinary team to undertaken arrangements in good time.
- Multi-disciplinary teams should have appropriate representation in order to review patient progress towards being clinically optimised and the possible support needed to facilitate their discharge. This can include, but not be limited to:

    a. Consultant
    b. Junior Doctors
    c. Nursing
    d. Therapist – physiotherapy/Occupational Therapy/Speech and language
    e. Pharmacists
    f. Social workers
    g. Bed management/Operational Managers
    h. Hospital Administration

- Ensure professional and clinical leadership between nursing, medicine and allied health professions for effectively and collaboratively managing decisions.
- In order to minimise any delays to recovery and discharge, the Red2Green process must be adopted at all times, and be a key feature of board and ward rounds, with appropriate escalation where delays have not been successfully addressed (both within hospital and externally).
- All patients who are not required to be in hospital and are therefore suitable for discharge will be added to the discharge list and allocated to a **definitive** discharge Pathway. Discharge home today ("home first") should be the default Pathway.
- There must be simple, robust and responsive local processes to enable the definitive pathway decision and rationale to be accurately conveyed from the ward to a discharge co-ordination hub to ensure that safe and appropriate onward care and assessment can be arranged via the appropriate D2RA Pathway – this may be in the form of an accurate and comprehensive D2RA Pathways referral (ideally electronically).
- On decision of the definitive discharge pathway, the patient and their family or unpaid carer, existing care providers and any formal supported housing staff must be informed and be provided with details of the decision. At this stage, any key supplemental information should also be shared. Much of this guidance will be accessible through the links within this guidance document. However broader guidance may be necessary depending on the individual's circumstances and, in these cases, any corresponding guidance should be identified and provided.
- In the event that a patient or their unpaid carer is reluctant to accept a reasonable discharge 'offer' and/or leave hospital the 'Reluctant Discharge Protocol' must be followed sensitively. Further information on reluctant discharge, together with a link to the published guidance, can be found in the **Supporting Guidance and Information for Staff** section of this document on page 16.
- Individuals and their families or unpaid carers must be fully informed of the next steps at all stages of the inpatient stay and involved in the discharge planning process. A sample letter template has been prepared which can be used and should be given to patients that highlights that planning arrangements to discharge that person should already be underway and the reasons for getting a person discharged quickly and safely to support their recovery. The sample template can be found at Annex A – 'Planning Your Discharge' letter template. Supporting information for patients, families and unpaid carers that may be used to support this letter can also be found in the relevant section of the guidance on page 22. Each patient's circumstances may be different so you may need to tailor any supporting information that is provided depending on what may be needed.
- The co-ordinator will ensure that all practicalities are addressed, including availability of existing care provider, transport arrangements, medication, discharge communication etc.
- Where safe to do so, and if there is capacity, D2RA Pathway 0 patients should be transferred off ward into a discharge lounge as soon as reasonably possible (ideally within 2 hours of the patient being deemed clinically optimised).
- In limited circumstances, depending on the individual's prognosis (e.g. 24 hours or less), it may be appropriate for hospitals to issue a small amount of palliative care medicines at the point of discharge, to support end of life care in their place of choice. However, hospitals must not routinely do so. Any further supplies required after this timeframe can be accessed via the usual mechanisms.

- Identifying an unpaid carer involved with the patient is a vital step in ensuring that a patient's discharge will run smoothly. Guidance is available for frontline staff on identifying, and engaging with, unpaid carers in the 'Support for Unpaid Carers' of this guidance on page 24.

Integrated Discharge teams

- Provide expert advice and support to the ward teams on the appropriate D2RA Pathways. Act as a key problem-solving contact between hospital and community teams.
- Support (where necessary) the nurse in charge of a ward to arrange dedicated ward-based staff to support and manage all patients on D2RA Pathways 0 and 1. This will include:
    - co-ordinating with transport providers
    - local voluntary sector and volunteering groups helping to ensure patients are supported (where needed) actively for the first 48 hours after discharge. This should also include support for carers, where required, by appropriate carers services
    - 'settle in' support is provided where needed
    - any community nursing input following discharge.
- Provide effective discharge planning for people with no home to go to and ensure that a referral to appropriate housing teams is made.
- Where no new or amended package of care is required – support the discharge team to put in place any remaining discharge arrangements as timely as possible so that the patient can return home or to their care home promptly.
- Where new or amended packages of care are required – support the trusted assessor role, where applicable, to undertake any proportionate assessments and help coordinate any necessary packages of care required so that the patient can return to their home or care home promptly. For further information on trusted assessor please refer to the 'trusted assessor' section of this guidance.
- Support with making referrals for D2RA Pathway 3 recognising the complexity of some of the patients.

Hospital clinical and managerial leadership team:

- Create safe and comfortable discharge lounge spaces for patients to be transferred to, ensuring enough space for expected numbers of discharges, and as well as ambulatory spaces adding an area for bed bound patients. Ensure the exclusion criteria are narrow and clear in order to not exclude potentially suitable patients. All Pathway 0 and 1 patients are suitable for the discharge lounge.
- Maintain timely and high-quality transfer of information to General Practice and other relevant health and care professionals on all patients discharged, including relevant information about any unpaid carers identified.
- Senior clinical staff to be available to support ward and discharge staff with appropriate risk-taking and clinical advice arrangements.
- Where applicable to the patient, ensure test results are available BEFORE discharge and included in documentation that accompanies the person on discharge. Where virtual wards are used, patients may be discharged prior to certain results being available but a plan to follow up with the patient must be in place.

- Effectively deploy available therapies staff to support D2RA Pathway 2 patients in a community hospital setting (especially those requiring rehabilitation) to ensure they receive the optimum outcomes and experiences and help control length of stay and avoid unnecessary discharge delays. This may involve ensuring 7 day working, but also ensuring that the nursing skill mix can deliver a maximising, independence model.
- Ensure all patients identified as being in the last days or weeks of their life are **rapidly transferred (via a fast-track pathway)** to the care of community nursing teams who, along with the integrated discharge team, will be responsible for co-ordinating and facilitating rapid discharge to home (which may be a care home) or a hospice. Community nursing and specialist palliative care teams should have arrangements in place to provide advice, training and support to family and unpaid carers and care and support providers.
- Follow the guidance on Continuing NHS Healthcare in line with the detail set in the relevant section below. Further information can be found in the Continuing Healthcare Assessments guidance on page 17 which includes links to the National Framework.

Community Health Services

- Community healthcare teams are expected to take overall responsibility for the safe and effective delivery of the D2RA Pathways, in their areas.
- Identify an Executive Lead to oversee the implementation and delivery of the D2RA Pathways model in the acute hospitals in their area.
- Deploy staff to co-ordinate and manage the discharge arrangements for all patients on D2RA Pathways. This will include patients being discharged from acute and community hospitals, and other bedded D2RA Pathways facilities.
- Have an easily accessible single point of contact (e.g. 'discharge co-ordination hub') which will always accept assessments from staff in the hospital and source the care requested in conjunction with local authorities.
- Provide a named point of contact to receive and respond to queries from care provider, family members or unpaid carers. This could be the hospital care-co-ordinator and/or Trusted Assessor.
- Use multi-disciplinary teams, on the day they are home from hospital, to assess and arrange immediate support for patients on D2RA Pathway 1. Early engagement with any involved unpaid carers should be undertaken prior to the point of discharge to ensure that they are willing and able to provide any agreed care. These arrangements should then be checked and confirmed on the day of discharge.
- Facilitate timely provision of equipment to support discharge in order to prevent unnecessary discharge delays.
- Ensure patients on D2RA Pathways 1 to 3 are tracked and followed up to assess for long term needs at the end of the period of recovery. When this is in a community setting, as a social care provision, the responsibility for tracking/follow up rests with social services. When in an NHS facility as an NHS provision, the role remains with the NHS in liaison with social services as appropriate.
- If supporting D2RA Pathway 3, ensure effective flow through the pathway within maximum LOS agreements, and ensure necessary CHC/FNC assessments are completed and onward care plans agreed, where possible, within 14 days of admission to the bed.
- Maintain the flow of patients from community beds including reablement and rehabilitation packages in care home settings (via D2RA pathway 2), to allow the next sets of patients to be discharged from acute care.

- For patients identified as being in the last days or weeks of their life, Community Nursing teams and specialist community Palliative Care teams, will work with the integrated discharge teams, to co-ordinate and **facilitate rapid discharge** to home, care home or hospice (based upon 'preferred place of death') via the fast-track end of life process.
- Community Nursing: District Nursing and Community Specialist Nursing will be delivered in line with the National Community Nursing Specification and its implementation milestones to ensure a 7-day 24-hour service provision is provided to meet the needs of the local population and community response times are met.

Pharmacy Teams

- It is essential that pharmacy teams are properly integrated in multi-disciplinary teams. Doing so supports efficient patient flow through hospitals, minimises medicines related harm that can occur at transfers of care, and facilitates safe and timely discharge.
- Pharmacy services can help to ensure that patients are discharged from hospital in a safe and efficient way and health boards should ensure they are implementing in full the guidance **Optimising pharmacy services at hospital discharge published in 2022**.

Optimising pharmacy services at hospital discharge sets out **five key recommendations** and enabling actions.

1. **Discharge planning should start from the day of admission (or pre-admission for elective care).**
2. **Pharmacy teams can make a significant contribution to prevent deconditioning by assessment, support and promoting patients' functional and cognitive ability during hospital stays.**
3. **Pharmacy teams should utilise the principles of SAFER and Red2Green to deliver safe and timely discharge.**
4. **Reduce discharge prescription and medicines processing time including unnecessary top-up supply of patients' routine medicines.**
5. **Pharmacy services should have dedicated resources to facilitate timely patient discharge.**

- In addition to mandated measures, health boards should agree standards for the contribution of pharmacy to safe and efficient discharge and regularly measure performance against those standards.

Social Services and Delivery Partners

Actions for Local Authorities:

- Identify an Executive Lead for the leadership and delivery of the D2RA Pathways.
- Agree a single point of contact arrangement for each health board, to approach when coordinating the discharge of all patients.
- Flexibly deploy social worker, social care and occupational therapy staff across hospital and community settings to support patients on relevant D2RA Pathways where such input is identified.
- Safeguarding investigations should continue to take place in a hospital setting, wherever essential.
- Support real time communication between the hospital and the single point of contact, not just by email. This could be arranged in liaison with the hospital care-co-ordinator and/or Trusted Assessor.
- Support communication with the patient, their families and unpaid carers.
- Support the development of "trusted" relationships between health boards, adult social care, third sector and provider services, supported by written organisational agreements, to bring together all stakeholders to codesign "trusted assessor" arrangements to support hospital discharge.
- Work with their partner local health boards and NHS trusts to agree arrangements across the local health board footprint area for delegating practitioners to undertake assessments for care and support.
- Provide capacity to proactively contribute to the timely review of care provision during the D2RA Pathway intervention in order to prevent unnecessary patient delays.
- Provide capacity to undertake an appropriate needs assessment should it appear that any involved carers have a need for support.
- Ensure there is 7-day working for community health and social care teams.
- Support referral of newly identified unpaid carers to the local authority, including for a Carers Needs Assessment, where appropriate.

Joint Actions for Local Authorities and Health Boards

Close partnership working will be key to the delivery of Hospital Discharge Minimum Standards, Health and Social Care partners must:

- Work together and pool staffing to ensure the best use of resources and prioritisation in relation to patients being discharged, respecting appropriate local commissioning routes.
- Continue to monitor and review capacity across the system, pooling information from hospital sites, community teams and the National Care and Support Capacity Tool **www.carehomes.wales**
- To minimise the risks associated with multiple contacts for patients, actively seek to implement reciprocal arrangements for delegated tasks between health and social care staff.
- Ensure there are robust tracking mechanisms so that care users do not get lost in the system. Monitor all individuals on Pathways 2 and 3 who may be in bedded facilities. The nominated care coordinators will follow up to ensure patients are able to return to their usual place of residence ("home first") or move to their long-term care home, as soon as possible.

- As well as providing support for patients, health boards and local authorities should work closely to identify any new and existing unpaid carers that may be involved with the patient at the earliest opportunity. Early identification of unpaid carers should mean that any support available can be provided in a timely manner and to maximise its impact. Both regional partners should ensure that all unpaid carers made aware of, and any direct support services that the local authority and/or health board can offer.
- Coordinate work with local and national voluntary sector organisations to provide services and support to people, including unpaid carers, requiring support around discharge from hospital and subsequent recovery, to help them maximise/ maintain their independence, and keep them as well as possible in the community to help avoid the need for future hospital admissions.
- Work together to expand the capacity in domiciliary care, care homes and reablement services in the local area, to also enable sufficient D2RA Pathways capacity.

Care Providers

Residential Care

- Maintain capacity and identify vacancies that can be used for hospital discharge purposes.
- Registered Managers are requested to use the Care & Support Capacity Tool App provided by DEWIS to make vacancy information available to NHS and social care colleagues in real time.
- Providers of Care Homes, in partnership with their local Community Health teams, should consider how best to support residents' health needs, in their familiar environment, wherever possible.
- Where Trusted Assessor relationships and arrangements are not already in place, work with the integrated discharge team to implement these rules and processes (See section on 'Trusted Assessors' for links to further information).
- If supporting D2RA Pathway 3, ensure effective flow through the pathway within maximum LOS agreements, and ensure assessments are completed and onward care plans agreed, where possible, within 14 days of admission to the bed, as well as ensuring care is delivered through a reablement approach where feasible for the patient.

Domiciliary Care

- Work closely with health and adult social care contract leads to maximise existing capacity, and identify additional capacity if required, to support hospital discharge.
- For those providers actively supporting D2RA Pathway 1, ensure effective flow through the pathway within maximum LOS agreements, and ensure assessments are completed and onward care plans agreed within agreed timelines to prevent avoidable delays in the pathway.
- For those providers actively supporting D2RA Pathway 1, ensure that the care is delivered via an 'enabling' model to promote independence and recovery, and titrate care provision through weekly review. There must be formal reviews at 2 and 4 weeks for those patients still in the pathway, to enable decisions and procurement of longer-term care arrangements.

Patient Transport

- Non-Emergency Patient Transport Services (NEPTS) are a critical resource in moving non-emergency patients from one care setting to a more appropriate setting on another site. In Wales all non-emergency transport is co-ordinated through the Welsh Ambulance Services NHS Trust (WAST).
- WAST, NEPTS, independent and voluntary sector providers, are expected to provide support to enable the transfer of patients as part of the discharge process and to support transfers and discharge as a priority in order to maintain flow and maximise patient safety.
- Organisations need to consider implementing mechanisms to inform WAST as escalation and additional capacity is utilised. This may involve alternative transport options and could include:
    - Local Authority owned or contracted vehicles if available
    - Volunteer cars
    - Voluntary sector resources
    - Taxi services.
- NEPTS must work with/facilitate inpatient wards to ensure discharge transport bookings are made the day before discharge (reflecting they should be planned discharges). Exceptions will be for acute assessment/short stay wards/units, where the need for some same day discharges will also be supported and enabled.

Voluntary Sector

Many systems already work with the voluntary sector to facilitate swift and safe discharges. The sector can support this by:

- Providing a continued focus on safety and positive experiences for patients on D2RA Pathway 1, enabling patients and unpaid carers to feel supported at home. They can also help reticent patients feel much more comfortable about being discharged.
- Providing a range of practical support to facilitate discharge within D2RA Pathway 1, including transport home and equipment such as key safes.
- Supporting discharged patients with home settling services to maintain wellbeing in the community (e.g. safety checks and essential food shopping), Pathway 1.
- Supporting unpaid carers, including those who are carers for the first time, with information, advice and practical support, and referring for or delivering a Carers Needs Assessment as appropriate.
- Providing ongoing community-based support to support emotional wellbeing, such as wellbeing daily phone calls and companionship to patients and unpaid carers, Pathway 1.
- Engaging with NHS providers (particularly integrated discharge teams) to provide solutions to operational discharge challenges, freeing-up clinical staff for other activities – focusing on the patients on D2RA Pathway 0.
- Utilising embedded local voluntary organisations in all D2RA Pathways and enhance with input from large voluntary organisations.
- Coordinating support between voluntary organisations and existing volunteers within NHS providers.

Supporting Guidance and information for Staff

Discharge to Recover then Assess (D2RA) Pathways

- Patients must be placed onto a D2RA Pathway in line with the requirements set out under the Principles in the D2RA Pathways Guidance which can be found here: **www.nhs.wales/six-goals-for-urgent-emergency-care**
- The D2RA Pathways model requires that patients should have a period of active reablement/rehabilitation intervention, preferably at home (D2RA Pathway 1) or in a bedded facility (D2RA pathways 2 & 3) before an assessment of long-term need is made. Home First Principles must be applied.
- No patient will normally be discharged to a new, long term care home placement from an acute hospital bed. A period of bedded reablement (D2RA Pathway 2) must precede any assessment for long term care, unless it is clear that the patient is unable to meaningfully engage in rehabilitation/reablement.
- Through D2RA pathway 3, those discharged 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 outside of an acute hospital setting. However, some patients may have their ongoing care needs meaningfully assessed after a period of reablement outside an acute hospital setting. Once the decision is made that a long-term care home placement is required, arrangements will need to be made to move the person to their permanent care home placement. If the care home of their choice is not able to take them at that point, they may need to go to an alternative care home as an interim placement. Supporting guidance on choice of accommodation can be found in under the relevant section on page 22.
- All interim placements must be closely reviewed by the responsible local authority, in line with legislation in place under the Social Services and Well-being (Wales) Act 2014. An interim placement must not lead to a lower priority for a permanent placement than those in NHS beds which may be perceived to be under greater pressure.
- If the person is awaiting a domiciliary care package to support a return home, a level of reablement intervention must be maintained to prevent deconditioning and loss of the skills recovered through the period of reablement. Any unpaid carers supporting the patient should, if appropriate, also be involved in this reablement support. This can assist with patient compliance and engagement with the reablement as well as ensure that both patient and carer are best prepared for their transition back to their home or usual place of residence.
- Based on the Optimising Hospital Patient Flow Framework criteria, acute and community hospitals must discharge all patients as soon as they are deemed clinically optimised to do so. For D2RA Pathway 0 patients, transfer from the ward should happen on the same day of that decision being made, either straight home or to a designated discharge lounge. Discharge from a discharge lounge should happen as soon after that as possible.
- For D2RA Pathways 1-3, patients must leave hospital within 48 hours (maximum) of being declared clinically optimised to do so.
- Hospitals must work in partnership with local partners to maximise the provision of D2RA Pathway capacity and processes to support good homecare for patients and support safe, sustainable discharges.
- Acute and community hospitals must keep a list of all those suitable for discharge and report on the number of patients on the list who have left the hospital through the daily situation report. This reporting should ideally be managed via the discharge co-ordination hub.

- All bedded facilities must be commissioned for the purpose of recovery prior to an assessment of the person's needs. Although most older people will do best returning to their own homes, some will require a space for recuperation and building personal resilience prior to return home. The main purpose of the bedded facility, whether in a care home or a community hospital, should be to support people to return home. Without this focus there is little prospect of D2RA Pathway 2 delivering desired outcomes and short-term placements are likely to become permanent. (**Developing a capacity and demand model for out-of-hospital care (local.gov.uk)**)
- The D2RA Pathways model can only be achieved through close partnership working. Local discharge co-ordination hubs will work together closely and on a daily basis to:
    - Review provision of reablement and rehabilitation to deliver the requirements of the D2RA Pathways (bedded or own home).
    - Minimise the risks associated with multiple contacts for patients, and actively seek to implement reciprocal arrangements for delegated tasks between health and social care staff (ie: optimising trusted assessments frameworks).
    - Ensure there are robust tracking mechanisms so that care users do not get lost in the system.
    - Coordinate with local third sector organisations providing support for patients and unpaid carers.
- There needs to be clear accountability and escalation mechanisms at each stage of the D2RA Pathways process in each locality, to identify and problem solve any avoidable delays.

Continuing Health Care Assessments

Assessments must be undertaken in line with the requirements set out in the National Framework for Continuing NHS Healthcare in the most appropriate location in relation to the D2RA pathway the person is on.

Wherever possible these should not be completed in the acute setting (unless they fulfil any exemption as set out under the D2RA Pathways criteria – see D2RA Pathways Guidance in the relevant section on page 16). The current Framework issued in March 2022 can be accessed here: **National framework for Continuing NHS Healthcare | GOV.WALES**

Care Co-ordinator

The role of the care co-ordinator is pivotal in the discharge process. Whilst the nurse in charge of each ward is responsible for the overall co-ordination of effective discharge planning, a care co-ordinator is responsible for overseeing the discharge plan for each patient they are responsible for. This includes the assessment, communication and active management of the discharge process, including explaining that transfer to a more appropriate care setting, including a care home, is anticipated if the person has ongoing, more complex, long-term care and support needs.

Trusted Assessors

A trusted assessment involves a trusted assessor – someone acting on behalf of and with the permission of multiple organisations – carrying out an assessment of health and/or social care needs in a variety of health or social care settings. The aim is to avoid unnecessary duplication and delays to discharge.

Guidance, together with a supporting toolkit, has been prepared on the trusted assessor role. This sets out key principles, functions and responsibilities and contains a set of examples, as well as a trusted assessor implementation checklist. This guidance can be found here: **www.nhs.wales/six-goals-for-urgent-emergency-care**

Reluctant Discharge/Transfer of Care to a more appropriate setting

A reluctant discharge is where a person has been assessed as no longer in need of care or treatment in the hospital setting they currently occupy. They will either have been assessed as able to transfer onto the next appropriate stage in their episode of care, e.g. from an acute bed to a rehabilitation/reablement bed in an alternative setting, or that they no longer require any form of inpatient care. These individuals will have been assessed as clinically optimised for discharge and have been reviewed in relation to their ongoing needs, with safe and appropriate arrangements confirmed as in place where required.

Guidance on Reluctant Discharge has been produced. It **should only be considered where all other avenues to ensure care is provided in the most appropriate setting have been considered and not been possible** for a range of reasons.

In all circumstances when implementing the guidance, the focus should be on the individual, understanding what matters to them and on ensuring their needs are met safely and appropriately.

The process refers to the principles to be adopted, allowing for local systems and arrangements to be shaped in a way that provides local/regional partners with the most effective operational process for local implementation.

The Reluctant Discharge/Transfer of Care to a More Appropriate Setting Guidance is available here: **executive.nhs.wales/functions/six-goals-uec/goal-6/goal-6-resources/the-management-of-reluctant-discharge-transfer-of-care-to-a-more-appropriate-care-setting-guidance-pdf/**

D2RA Pathway Step-down to Recover (SD2R) – National Minimum Standards (D2RA Pathway 'bridging')

Where recovery and assessment at home is not currently possible, a short-term, time limited stay based on individual needs, in a D2RA Pathways Step Down to Recover facility, is the next step on the pathway home, with review and transfer to D2RA Pathway 1 wherever and as soon as possible. A timely planned return home is the desired outcome. These beds are often referred to as D2RA Pathway 'bridging beds'.

The stay in the D2RA Pathways step-down bed for people whose care and support requirements at home are not available must still add value to the individual by providing reablement, thus potentially requiring less care and support to be commissioned to discharge home.

There is an expectation that work is underway to ensure that care and support will be available following the stay in the D2RA Pathways step-down bed.

All individuals transferred onto this care pathway will require a discharge plan with clear goals, a reablement/recovery plan, including a clear exit strategy (plan for the person to return to their own home), including an estimated date of discharge.

Detailed national minimum standards for D2RA Pathways step down to recover can be found here: **executive.nhs.wales/functions/six-goals-uec/goal-6/goal-6-resources/step-down-to-recover-sd2r-national-minimum-service-standards-18-sept-23-e-pdf/**

Independence Checklist

Through the use of Discharge to Recover then Assess we want to ensure that a patient's onward care needs are identified early in their pathway. This will allow discharge teams to begin to make the necessary connections, with the right support services, ahead of discharge. An important factor in determining the right level of support a person may need will be their level of independence. By considering these factors early in a person's discharge planning we can ensure that patients, their families and unpaid carers have the right level of support they need.

British Red Cross Five Part Independence Checklist

The British Red Cross have developed a 5 part independence checklist that sets out some of the key factors that could impact on a person's independence as guidance for staff and multi-disciplinary teams working with the patient to consider.

These include:

- Practical independence (for example, suitable home environment and adaptations).
- Social independence (for example, risk of loneliness and social isolation, if they have meaningful connections and support networks).
- Psychological independence (for example, how they are feeling about going home, dealing with stress associated with injury).
- Physical independence (for example, washing, getting dressed, making tea) and mobility (for example, need for a short-term wheelchair loan).
- Financial independence (for example, ability to cope with financial burdens).

Homelessness

Homelessness is where a person lacks accommodation or where their tenure is not secure. Rough sleeping is the most visible and acute end of the homelessness spectrum, but homelessness includes anyone who has no accommodation, cannot gain access to their accommodation or where it is not reasonable for them to continue to occupy accommodation.

Homelessness, or the risk of it, can have a devastating impact on individuals and families, affecting their physical and mental health and well-being, isolating them from their local communities and negatively impacting society.

It is well recognised that housing alone cannot prevent homelessness and all public services and the third sector in Wales have an important role in collaborating and working in an integrated way to prevent homelessness.

NHS Wales delivers services through 7 local health boards and 3 NHS trusts. Local health boards are responsible for planning and delivering NHS services in their areas and include reducing health inequalities across their population and commissioning services from other organisations to meet the needs of their residents. This includes the provision of appropriate care and support for people experiencing homelessness.

Consideration of people experiencing homelessness prior to discharge.

People at risk of homelessness use more acute hospital services and emergency care than the general population. When admitted to a hospital, the length of stay is usually much longer because of multiple unmet needs. People experiencing homelessness have far worse health and social care outcomes than the general population. According to the **Office for National Statistics** The average of death for the homeless population is around 30 years lower than for the general population.

Discharge from hospital can exacerbate vulnerability and frailty for those who are homeless, at risk of homelessness or those for whom a hospital admission increases the likelihood of them becoming homeless (due to current accommodation no longer being suitable for example).

As with any other potential onward care needs, hospital ward staff must try to establish actual/ potential homelessness status of an individual as near to the point of hospital admission as possible to ensure timely referrals to **local authority homelessness prevention services and where appropriate, multidisciplinary services**. This will enable appropriate care and provision at the right time, thereby improving outcomes for people experiencing homelessness on discharge from hospital and avoiding re-admission.

The shift in focus, to **planning for discharge at the earliest stage**, means that support in any form (social care, health, housing, etc.) should be in place and ready for that individual when their treatment has completed, before they are ready for discharge.

Further background reading:

Ending Homelessness in Wales – A High Level Action Plan – 2021-2026 (updated)

Integrated health and social care for people experiencing homelessness

Faculty of Homelessness and Inclusion Health

Frailty in homelessness populations

Trauma informed care principles

Assistive equipment and technology

Community equipment and adaptation services provide specialist responses which enable people to live safely and independently as possible. This can support people to avoid admission and remain in their own home: It may be an essential part of enabling timely discharge and implementation of home first and D2RA Pathways.

The provision of assistive equipment, adaptations and technology will also help reduce the need for double handed care packages, reducing delays in discharge because of avoidable requests for social care support.

Assistive equipment and technology may be a part of enabling discharge on Pathway 0, but it is highly likely to be essential in supporting on Pathways 1 – 3. It may also be required to support people following reablement provision for the long term as they move out of the D2RA Pathways. Every health board and local authority will have in place a community equipment service, ideally an integrated service, which delivers timely and safe equipment/ technology.

All potential need for assistive equipment to enable discharge must be identified as early as possible as part of the planning for optimal hospital care and discharge.

The key principles underpinning equipment and technology provision:

- The safety and well-being of individuals is paramount.
- Community equipment services should be person centred providing a flexible response to need which promotes the independence of the individual.
- Users have expertise about the challenges they face on a daily basis and must be partners in assessment decisions and choice of equipment.
- Equipment provision is underpinned by timely and clear clinical decision making.

Access to assistive and rehabilitation equipment must be quickly (same day where needed) and easily facilitated. Utilising mutual aid with neighbouring areas or redeployment of community-based staff if required.

Effective processes must be established to ensure speedy response and provision even when equipment is provided across borders and where the individual is being discharged to the home of a relative outside of their normal Local Authority of residence.

It is expected that in order to facilitate timely provision of equipment Regional Partnership Boards, local partners and Integrated Community Equipment Services with the support of the Trusted Assessor.

Partner agencies and community equipment services must use the Occupational Therapy Advisory Forum Cross Border Guidelines to operationalise these processes. The guidelines can be used as the basis of negotiation between individual agencies who provide equipment across local borders, including where adults with additional learning needs reside outside of its borders or where there is joint residency across borders. The guidelines do not cover wheelchairs, or any other equipment provided via Welsh Health Specialised Services Committee (WHSSC). The guidelines can be provided via local occupational therapy services.

Housing Adaptations for discharge

Adaptations which enable and support discharge, particularly minor adaptations, must be planned for as early as possible during admission as part of the recovery plan. The SAFER Guidance can be found here: **executive.nhs.wales/functions/six-goals-uec/goal-5/goal-5-resources/safer-national-minimum-standards-for-the-application-of-safer-red2green-and-d2ra-pdf/**

There are many D2RA Pathways and considerations in providing the right adaptation. Referrals to local services must be anticipated and undertaken as soon as practicable. Every health board must ensure that integrated discharge teams know how to arrange adaptations that are essential to enable an individual to be discharged. These are most likely to be identified under D2RA Pathways 1-3. Referral processes must be simplified and streamlined for all ward staff needing to make timely referrals.

Covid/Other Outbreaks

This guidance covers the hospital discharge process more generally, however there may be situations where external factors override some or all of the sections within this guidance and may require health boards and supporting partners to adopt different practices in order to safely support patients. These factors may occur nationally or may be localised and isolated.

In these circumstances it is expected that the health board will make staff aware that new guidance is in place and staff should refer to, adopt and follow any overriding guidance. The duration of time that any overriding guidance will be followed will also be communicated.

Supporting guidance on infection, prevention and control practices in respect of covid and other respiratory infections is available for health and social care – links are provided below – this discharge guidance should be read and considered in parallel to these.

Social Care guidance – Controlling Acute Respiratory Infections – **Social care guide to controlling acute respiratory infections from winter 2023 to 2024 [HTML] | GOV.WALES**

Public Health Respiratory Framework – **Public Health Respiratory Framework 2023 to 2024 | GOV.WALES**

Useful Supporting information for Patients, Families and Unpaid Carers

Social Care Charging and Financial Assessment Arrangements

Unlike healthcare, social care and support is a chargeable provision. The Social Services and Wellbeing (Wales) Act 2014 provides local authorities with discretion to charge for care and support should they choose to do so. **Social Services and Well-being (Wales) Act 2014**

Where a local authority has undertaken an assessment under the 2014 Act of a person's care and support needs and is to provide or commission care to meet identified needs, it can apply a charge. Where a local authority wishes to charge, it must apply the requirements set out in Regulations and a Code of Practice in place under the 2014 Act. This legal framework helps ensure charging, where it occurs, is consistent, fair and affordable to a person by including a number of financial protections. The Regulations and Code of Practice are reviewed on a regular basis. A person and, where relevant their carer, should be informed by their local authority of its charging policy in advance of their agreement to the social care support. Essentially, the charging arrangements:

- set a maximum weekly charge (currently £100 per week – April 2023) that ensures no one pays more than this amount for any form of social care and support provided in their own home, in the community or for a short stay (no more than 8 weeks) at a care home (eg: D2RA Pathway 2)
- require social care and support in the form of reablement to be provided free of charge for up to 6 weeks
- require that, where a permanent care home placement is needed, a person must be able to protect £50,000 (April 2023) of their capital assets
- require that partners and families cannot be charged for any form of social care and support a local authority has determined a person as requiring to meet their assessed social care and support needs in full.

Further information, which can be shared with patients if required, can be found in Annex B.

Choice of Accommodation Following a Hospital Stay

Where a person is clinically optimised and ready for discharged (they no longer meet the criteria to reside as their period of acute treatment has completed) they cannot remain in hospital if the care home they have expressed a wish to move to is not suitable to meet their needs or it does not have an immediate vacancy. In these instances they will need to move to a care home on an interim basis until any issues are resolved.

Supporting documents relating to choice have been developed for staff to refer to and use as necessary and are provided at:

Annex C1 which sets out the arrangements and legal requirements concerning choice of care home accommodation.

Annex C2 which provides supporting patient information that hospital staff may wish to share with patients and their families, or use as a base for information produced by the health board, when discharging patients directly to a care home on a permanent or long-term basis.

The arrangements and legal requirements around choice of care home accommodation, involving the person and their carer, must be applied where a person is being discharge from hospital to a care home on a permanent or temporary basis (more than eight weeks but usually fewer than 52 weeks as set out in legislation). Choice does not apply where a care home stay is for a short term (fewer than eight weeks), perhaps as D2RA Pathway 2 (Reablement), or as D2RA Pathways step-down type care ('bridging') for D2RA Pathway 1). Essentially, potential care home residents and the position and responsibility around choice of care home accommodation is as follows:

- **Local authority placements**: where a person's care home placement is to be provided or arranged by their local authority (as a result of their financial assessment), under current legislation, they must be able to express choice for particular care home accommodation.
- **Self-Funding clients**: a person deemed responsible for funding their care home costs in full owing to the level of their financial resources (again, usually determined following a financial assessment by their local authority) will be responsible for identifying, arranging and funding their care home placement in full. In these circumstances the person, and their family/unpaid carer must be supported to help make informed decisions about their care home and will enter into a Service Agreement with the provider of a care home that is able to meet their needs.
- **Continuing NHS Healthcare (CHC)** placement arrangements are set out in the National Framework must be applied when CHC is to be provided in a care home. The Guidance can be found here: National framework for **Continuing NHS Healthcare | GOV.WALES**.

Unpaid carers

A carer is anyone who cares, unpaid, for a friend or family member who due to illness, disability, a mental health need or an addiction cannot cope without their support.

Unpaid carers in Wales have legal rights which are set out under the Social Services and Wellbeing (Wales) Act 2014 carer is defined as: "a person who provides or intends to provide care for an adult or disabled child."

A carer can be an adult, a child or young person. Children have additional rights, including under the UNCRC and the 2014 Act, and children and young people may have different needs to support their development than adult carers.

People who are caring, or intending to care for someone, such as those who are supporting a family member or friend being discharged from hospital who needs care as they recover or on an ongoing basis, have the right to:

- Access information, advice and assistance.
- Be assessed if it appears they have a need for support, and to have all eligible needs met.

is clear that a person must be "willing and able" to provide care. The extent to which a carer is able to provide care and willing to do so is assessed as part of the formal statutory Carers Needs Assessment but the 2014 Act makes clear that all professionals encountering people who need care and support are responsible for proportional assessments of a carer's needs.

- Exercise voice and control and be fully involved in decisions that affect them.
- Access advocacy to support involvement in decisions.

Support for unpaid carers

Each hospital will have its own Carer Support service, which will either be a member of the hospital staff or staff from a local carer organisation who is connected to the hospital. Discharge staff should know how to refer unpaid carers who are identified when a patient is admitted and/or discharged from hospital to the Carer Support Service.

Further information about joint working between health boards and the carer support service can be found here: **involving-unpaid-carers-in-hospital-discharge---policy-guide-for-service-planners-final-may23-eng.pdf**

Unpaid carers can also access support from local carer organisations, such as Carers Trust Network Partners. You can find your local service here: **Local Carers Support Services Near Me | Carers Trust**

Carers Needs Assessments

All unpaid carers have the right to request a statutory Carers Needs Assessment to assess their right to support from their local authority to undertake their caring responsibilities.

Access to information and advice

All hospitals should have information available for unpaid carers. Carers Wales 'Coming out of Hospital – A Guide for Carers' can be found here: **2023-2024-eng-coming-out-of-hospital.pdf (carersuk.org)**

Support and guidance for healthcare professionals encountering unpaid carers through the hospital discharge process can be found here: **involving-unpaid-carers-in-hospital-discharge---guide-for-clinical-staff-final-may23-eng.pdf**

Annex A

‘Planning Your Discharge’ letter template.

Dear Patient

May we welcome you to our ward and take this opportunity to talk to you about how we will be supporting your discharge from hospital when it is the right time for you to leave.

We know most people don’t like being in hospital, and once they are over their initial episode of acute illness, staying in hospital isn’t the safest or best place for them to be. People recover better, are less likely to catch infections and are more likely to regain the best level of independence when they go home or into a community-based care.

We are following guidance called Discharge to Recover then Assess. This is designed to support people to recover either at home, or in another community setting, like a care home, while any ongoing future support or care they might need is put in place.

Our job is to help you through this period when you are acutely unwell, so you can then continue your recovery at home, or in another community setting, like a care home, as soon as possible.

So, even as you join us, we will be planning to discharge you as soon as the clinical team looking after you agree you are medically well enough to leave our care. This is because evidence tells us that going home, or into a temporary care home place, is much better for patients’ wellbeing than a prolonged stay in a hospital bed.

Leaving hospital when you are medically well enough has a number of important benefits for your wellbeing:

- You are more likely to have opportunities to move around in your own home, or in a care home, strengthening your muscles and regaining your confidence.
- You are less likely to pick up an infection as you won’t be around sick patients.
- Being in a less busy environment than an acute hospital ward gives you the best chance to rest, sleep well and recover.

If necessary, health and social care staff will provide information, advice and assistance to enable you to leave. Some people may require short term assistance from family and friends when they leave hospital, and some may need a package of care and support to help them live at home.

However, there can sometimes be a delay in getting these support packages arranged. If this happens in your case, it would not be appropriate to keep you in hospital when you no longer need our urgent care so health and social care staff will work with you to identify suitable arrangements to allow you to continue recover in an appropriate temporary setting while the care package is finalised.

If possible, you may want to ask your family or friends to help you leave hospital on time or make your own arrangements for additional support so you can go home while you wait for your longer-term care package to be arranged. If this is the case, then staff can work alongside you to direct you to any available support that might be of assistance to you and your family or friends.

For patients where this isn't a practical option, we will arrange to transfer you to a community setting for a temporary period while your care and support arrangements are put in place.

In some situations, it might be the case that you are you are not immediately able to leave hospital while these packages are assessed and arranged. If this happens health and social care teams will continue to support you while you are in the hospital and will make all the necessary arrangements to temporarily transfer you to a care home or another appropriate community setting, as soon as possible after your clinical team have agreed you are medically well enough to leave.

The health and social care staff involved in your treatment and support for discharge will have access to a range of information on future support services you may need. In most cases this will be provided to you as soon as it becomes clear that you may need ongoing support following your hospital stay. However, if you do have any questions please speak to the nurse in charge of your ward or the social care team who will be able to assist you.

Annex B

Social Care Charging and Financial Assessment Arrangements Guide

Key Principles

- Healthcare provided or arranged by the NHS is free of charge.
- Social Care and Support provided or arranged by local authorities is a chargeable provision.

Legal Context

Where a local authority has undertaken a social care and support needs assessment, in line with the requirements set out in legislation under the Social Services and Well-being (Wales) Act 2014 (the 2014 Act), and is to provide or arrange care and support, a charge can be applied. The current social care and support charging and financial assessment framework in place under Part 4 and Part 5 of the 2014 Act provides local authorities with discretion to charge for care and support should they wish to do so.

Where a local authority applies discretion and charges for the care and support it provides or arranges for a person, or support provided or arranged for a carer, it must apply the requirements set out in Regulations and a Code of Practice in place under the Act. This framework includes a number of safeguards to help ensure charging, where it occurs, is consistent, fair and affordable to a person. Partners and families cannot be charged for any form of care and support the local authority has determined a person requires. The Regulations and Code of Practice came into effect in April 2016 and are reviewed annually.

Local Authority Charging Policy Requirements

Beyond the requirements of the Act, Regulations and Code, where a local authority decides to use its discretion and charge for the care and support it provides directly to or arranges for person, the design and content of its policy for that charging is a matter for that authority. Authorities decide what care and support they make a charge for, the nature and level of any charge and how these charges are applied to care and support recipients. Within the framework, authorities also need to determine how their processes for undertaking various stages of the charging procedures operate and ensure compliance with the legal requirements. Authorities must decide what allowances, disregards and other aspects they wish to incorporate within their financial assessment process beyond those required by legislation. Authorities also need to ensure they are consistent in the way they apply the legal requirements and their local charging policies.

Non-Residential Care and Support

Where, as an outcome of their care needs assessment, undertaken in line with the requirements in place under the 2014 Act, a person requires care and support at home or within the community, a financial assessment of their ability to meet that charge is undertaken. Regulations set a maximum a person can be charged for this form of care and support. This amount has been set at £100 per week since April 2020.

The financial assessment will consider a person's income (such as state and private pensions and welfare benefits) together with any capital (such as savings and investments but not the value of their only or main home) they hold over the Capital Limit (set in Regulations) of £24,000, this amount has been in place since April 2016. Income in the form of earnings is disregarded in full.

The Regulations and Code set out the assessment process that must be applied in calculating how much a person pays up to the maximum. Based on the outcome, they can be required to pay the maximum weekly charge although they can be charged a lower amount or no charge depending on the level of care required and the level of their income and/or capital.

Residential Care and Support

Where, as an outcome of their care needs assessment, undertaking in line with the requirements in place under the 2014 Act, it is considered that a person's needs would be best met in a care home, again a financial assessment is undertaken. The assessment will again consider a person's income (such as state and private pensions and welfare benefits) together with capital (such as savings, investments and the value of any property they own which is not to remain the home of their partner, former partner or a dependant relative once they move into care). Income in the form of earnings is disregarded in full.

The Capital Limit has been set (in regulations) at £50,000 since April 2019. Where a person holds capital at or under this limit they become the responsibility of their local authority who will arrange their care home placement and meet their costs in full. No element of capital a person holds at or under the Capital Limit can be used towards their care costs and they retain this amount to spend as they choose. However, in this situation a person will be required to pay towards their costs based on and assessment of their eligible weekly income.

A person with capital over the Capital Limit will be required to meet their care home costs in full. This category of care home resident is known as a self-funder. However, the value of their property will be disregarded for the first 12 weeks of a permanent stay at a care home where the value of any other capital they hold is below the Capital Limit. During this time they will receive financial support from their local authority. Following this period, the person will become liable to meet their care costs in full and will enter into a contract with their care home.

Short-term and Temporary Stays at a Care Home

Where a person's stay is short-term (defined in regulations as not exceeding 8 weeks) they must be charged as if they were receiving care at home or in the community – ie no more than £100 per week. This is to enable them to continue to meet their on-going daily living costs. If their stay is on a temporary basis (defined in regulations more than 8 weeks but unlikely to exceed 52 weeks) they may be required to pay more than £100 per week based on their financial resources but the value of their property will be disregarded.

Additional Cost Payments for Care Home Placements

Where a person's care home placement has been made and is being paid for by their local authority, they must be able to express a choice for their preferred accommodation. The local authority can make such placements as long as certain conditions are met as set out in Regulations and the Code. Where their preferred accommodation is more expensive than their local authority's usual rate to meet a person's care needs in full, or where a person requests additional services or facilities that do not form part of their assessed needs, an additional cost payment can be requested. In these circumstances an additional cost payment arrangement must be entered into by a third party (a family member or friend) willing and able to meet the additional cost for the duration of the arrangement.

Reablement

Under regulations, where a person is assessed as requiring some form of reablement, perhaps to help prevent the need for further care and support or to aid rehabilitation following a hospital stay, this provision must be provided free of charge for up to 6 weeks, although it can be extended beyond 6 weeks where a person's outcomes would benefit. This provision is set out in the Code. Reablement can be provided in, for instance, a person's own home or community or in a step-down facility which could be within a care home.

Legislation in Place under the Social Services and Well-being (Wales) Act 2014

Social Services and Well-being (Wales) Act 2014 (legislation.gov.uk)

Below are links to the key sets of Regulations that must be applied by local authorities that decide to apply discretion and charge for social care and support. A link to the Code that supports the application of the Regulations is also provided. The Code expands on the requirements of the Regulations and also contains references to specific sets of amending legislation that will have made updates to the principle Regulations since they became effective in April 2016.

The Care and Support (Charging) (Wales) Regulations 2015 (legislation.gov.uk)

The Care and Support (Financial Assessment) (Wales) Regulations 2015 (legislation.gov.uk)

Code of practice on charging for social care services | GOV.WALES

Reader-Friendly Factsheets

Below are links to Age Cymru factsheets that cover some of the main areas around social care charging.

- Paying for a permanent care home placement in Wales
  Microsoft Word - FS10w - April 2023 (ageuk.org.uk)
- Paying for Care and Support at Home in Wales
  Microsoft Word - FS46w - May 2023 (ageuk.org.uk)
- Paying for temporary care in a care home in Wales
  Microsoft Word - FS58w - April 2023 (ageuk.org.uk)
- Reablement, intermediate care and preventative services in Wales
  Microsoft Word - FS76w - December 2021 (ageuk.org.uk)

Annex C1

Choice of Care Home Accommodation Following a Hospital Stay

What is Choice and When Does it Apply?

Where a local authority is to meet a person's needs for care and support under the Social Services and Well-being (Wales) Act 2014 ("the 2014 Act") and their needs have been assessed as requiring accommodation in a care home setting, legislation under the 2014 Act enables such a person to express a preference to be placed in a particular care home and, if certain requirements and conditions can be met, the person's local authority should arrange a placement at their preferred care home.

The duties of the local authority set out in the legislation apply:

- once a formal, social care and support needs assessment, and a formal financial assessment has been completed by the **local authority** responsible for meeting the person's needs for care and support ("the responsible authority") with input from hospital staff as appropriate;
- where the outcome of these assessments has determined that the person requires a permanent or long term care home placement and the responsible local authority is to meet their care needs by arranging, managing, and funding that placement;
- where a person is to self fund their care home costs as they are ineligible for financial support, asks the responsible local authority to arrange their placement.

Legislation regarding choice does not apply to any other form of care home stay (for example, a short stay at a care home to receive step down/reablement care), or to Continuing NHS Healthcare (CHC) care home placements. Separate guidance on CHC placement arrangements can be found here: **National framework for Continuing NHS Healthcare | GOV.WALES**

Who is Responsible?

The local authority will have overall responsibility for the placement process and arrangements. If a person has expressed a preference for a particular care home, then arrangements should be made to place them at their preferred care home as long as the four conditions specified in the Regulations can be met in full.

Essentially, local authorities are required to ensure:

- the care home is suitable to meet the person's assessed needs;
- a place in the care home is available;
- it would not cost the local authority more than the amount it would usually expect to pay for accommodation of that type;
- the provider of the care home is willing to enter into a contract with the local authority to provide the accommodation on the local authority's terms and conditions.

If required, more information on a local authority's legal functions and duties around choice of care home accommodation can be accessed via the links at the end of this annex.

A person's choice is not limited to care homes or individual providers that the local authority already commissions places at, or limited to care homes within the local authority's geographical boundary.

If the responsible local authority refuses to arrange or secure a placement at a person's preferred care home, it must provide a statement in writing setting out the specific reasons for not doing so.

What Happens if a Person's Care Home Placement is not to be the Responsibility of the Local Authority?

Where the outcome of a person's financial assessment means they are not eligible for any financial support from their local authority and are to "self-fund" their costs, social services staff should still provide the person and their family/carer/advocate with information, advice and support in helping to identify suitable care homes, if that is what the person wants.

In addition, a person self-funding their care home costs can ask their local authority to make all the formal arrangements and manage the placement for them if they wish. In these circumstances the local authority must apply the same principles in response to the person's expression of a preference for their accommodation.

How does the Choice Process Work with the Hospital Discharge Process?

When a person is admitted, health board staff should be following the principles of the Discharge to Recover then Assess (D2RA) Pathways Guidance **nhs.wales/sa/six-goals-for-urgent-emergency-care/goal-6/goal-6-resources/discharge-to-recover-then-assess-report-pdf/** when determining what onward support a person may need when they are ready to be discharged. In the majority of cases, a person being discharged from hospital directly to a care home will be placed on Pathway 3 (Complex Support) as they have new or more significant needs that may require care home support.

The choice process therefore applies to individuals on Pathway 3 and where it has been determined that their local authority will have overall responsibility for the placement process and arrangements.

The Hospital Discharge Guidance: **HOSPITAL DISCHARGE GUIDANCE (gov.wales)** sets out the formal requirements and discharge processes that must be followed where a person is deemed clinically optimised and ready for discharge. Hospital discharge should be completed in an appropriate, safe and timely manner and in line with the requirements set out in the Discharge to Recover then Assess (D2RA) Pathways guidance.

How can Health Boards Support the Choice Process and What Timeframes may Apply?

Once a person is clinically optimised and ready to leave hospital they must be supported to be discharged as quickly as possible. They should not remain in hospital for extended periods of time once their treatment has come to an end. The overall process of moving from hospital to a care home should be **completed as quickly as possible, ideally within around a three week timeframe**. This applies regardless of whether the person is being placed by their local authority or entering into a private arrangement, as a self-funder, with their care home provider. If social services are not involved with the placement, then the care home provider/manager should be engaged at each stage.

However, this timeframe should be considered as a general guide. In some cases it might be necessary to adjust the timeframes to allow this process to fully conclude. In these cases the Health Board should consider the most reasonable and sensible approach to support the person which can be flexible, taking into account the individual circumstances of the case, and in line with any locally agreed arrangements. In some circumstances it might not be possible to adhere to this timeframe or there may be mitigating factors that require more time. Health boards and local authorities should maintain an awareness of individual circumstances and take this into account when deciding on a reasonable timeframe. No matter what approach is taken, any decision on the overall timeframe should be recorded, and details of the timeframe that will be worked to should be communicated to the person.

Initially, the care co-ordinator should support the process by meeting with the person and their family/carer/advocate to explain the process. Local authority social services staff, usually an appointed social worker, must support this process by providing the names of care homes that can meet the person's assessed care needs in full and either have current availability or are **expected to have availability shortly**.

Supported by their family/carer/advocate, a person should be asked to identify their preferred care homes from those identified by social services. If they prefer another care home, they should name the home so that social services can consider and determine if the care home can meet their identified care needs in line with the four conditions specified under **Who is Responsible?**.

The outcome of the meeting must be documented and a summary produced to support the identification of appropriate care homes, which should be shared with the person or their nominated representative. This should be completed within three working days of the meeting.

One week after the initial meeting, the care co-ordinator should follow up to check on progress in identifying and securing a placement.

If the person's preferred care home can meet their assessed care needs but it is highly unlikely to have a vacancy within two weeks, the local authority must examine the suitability of other appropriate care homes that have a place available and can accommodate the person on an interim basis. Local authorities have no legal obligation to meet choice where a care home placement is to be on an interim basis. Interim placement arrangements are set out in legislation at the end of this annex.

A discharge date should be agreed between the hospital and social services teams in liaison with the care home provider together with the person and their family/carer/advocate. The discharge date and timeframes for supporting discharge to the person's preferred care home should be kept under review at regular intervals to ensure that it remains appropriate.

What happens if the person is self-funding or seeking a private placement?

In instances where a person is to self-fund their care home costs, but does not wish to involve social services in any aspect of the arrangements, hospital discharge teams should still aim to maintain a balance of jointly working towards a timely and safe discharge, alongside allowing reasonable time for the individual to undertake the process and necessary steps to identify and arrange their care home placement.

In cases of self-funded/private placements, where the individual is not seeking any support from their responsible local authority, the person would be responsible for liaising directly with their preferred care home provider, supported by their family/carer/advocate.

In these instances, hospital discharge teams may wish to adapt and apply the same steps/timings, as set out below. Similarly, whatever timings are agreed these should be communicated to the individual, ideally in writing, so that they are made aware that they cannot remain in hospital indefinitely, but that a reasonable amount of time will be granted to allow them to participate in securing their care home placement. If there is no satisfactory resolution within the specified timeframe, then alternative arrangements may need to be considered including moving the person to an interim care home or following the management of reluctant discharge procedure. **nhs.wales/sa/six-goals-for-urgent-emergency-care/goal-6/goal-6-resources/the-management-of-reluctant-discharge-transfer-of-care-to-a-more-appropriate-care-setting-guidance-pdf/**

General Outline of a Timeframe for Supporting Discharge of a Person Expressing a Preference for Particular Care Home Accommodation

Week 1

Care Coordinator to:

- engage with the person and explain the discharge process. Patient Information at Annex C2 provides a useful support in this process.

Social Services to:

- identify care homes that can meet the person's care needs and have a vacancy or expect to have a vacancy shortly;
- enable the person to express a preference for an alternative care home.

Within 3 days

Care Coordinator to:

- document the meeting to include the identification of appropriate care homes.

Week 2

Care Coordinator to:

- check in with the person and Social Services team on progress in securing a care home placement.

Week 3

Care Coordinator and Social Services team to:

- work together to review position and consider next steps if a care home placement cannot be progressed imminently.

Jointly consider and agree options, such as:

- extending the person's hospital stay (only recommended for a short period to allow for final plans to be put in place);
- Social Services team arranging an interim placement at another care home until a placement becomes available at the person's preferred care home;
- giving consideration to liaising with the person and their family/carer/advocate for them to return home/family member's home until their preferred care home has a vacancy;
- considering the reluctant discharge procedures if it appears that the person and their family/carer/advocate is unwilling to engage in the discharge and placement process.

What if Agreement Cannot be Reached and a Place in the Person's Preferred Care Home Cannot be Secured?

Where there is a dispute relating to the proposed discharge, this could be because the person and/or their family/care/advocate:

- is reluctant to engage in the discharge process;
- is unwilling for a placement to be made in a care home that can meet the person's care needs if their preferred care home is unable to do so;
- is unwilling for a placement to be made at an alternative care home on an interim basis as, although the person's preferred care home can meet their needs, it has no immediate vacancies;
- the person (or their family/carer/advocate) wants to remain in hospital awaiting discharge to their preferred care home.

In these instances, or any other instance that is preventing discharge, health and social services staff should continue to work with the person and their family/carer/advocate to resolve issues. Whilst it is the responsibility of the NHS to discharge patients, social services must lead the process of making arrangements for the person to move to an appropriate care home on the jointly agreed date. Beyond the agreed timeframe, if a person refuses to be discharged, detailed guidance on reluctant discharges should be considered and can be accessed here: **nhs.wales/sa/six-goals-for-urgent-emergency-care/goal-6/goal-6-resources/the-management-of-reluctant-discharge-transfer-of-care-to-a-more-appropriate-care-setting-guidance-pdf/**

Local Authorities' Legal Obligations

Choice of Accommodation Regulations
The Care and Support (Choice of Accommodation) (Wales) Regulations 2015 ("the Regulations") (legislation.gov.uk)

The Care and Support (Choice of Accommodation, Charging and Financial Assessment) (Miscellaneous Amendments) (Wales) Regulations 2017 (legislation.gov.uk)

The Regulations set out local authorities' legal responsibilities associated with enabling a person to express preference for a particular care home. The Regulations include requirements around criteria and circumstances where choice must be offered, conditions to be met, additional costs payments, refusal to provide preferred care home.

Choice of Accommodation – Code of Practice Chapter 10 and Annex C
Code of practice on charging for social care services | GOV.WALES
The Code is reviewed and updated on a regular basis. Where the Regulations that govern choice are amended or updated, these charges will be identified within the Code.

Local authorities must comply with the requirements set out in the Code of Practice. Chapter 10 and Annex C are dedicated to Choice of Accommodation requirements and provisions, and act to support and expand on the Regulations, including areas such as interim care home placements, and additional costs payment arrangements.

Annex C2 – Patient Information

Moving to a Care Home Following a Hospital Stay: Including Information about Care Home Choice

If you are moving directly to a care home once your hospital treatment has been completed, the information below will provide you, your family and any unpaid carers that support you, with a general guide on what to expect, processes and arrangements.

What can I expect to happen if I am moving to a care home?

First, it is important that a formal "social care and support assessment" is completed if you are moving directly to a care home. Social services staff, perhaps a social worker from your local authority (your Council), supported by hospital staff, will complete the assessment. You might also need a financial assessment to work out if you need to pay towards your care home costs. You, with your family if you wish, will be involved throughout the whole process to help make sure your next stage of care is right for you.

The outcome of these assessments will work out if your local authority is to be responsible for your care home placement and the funding arrangements. If your local authority is to become responsible, and your stay is on a permanent basis, or if not permanent, for a reasonable length of time, the information below will be a useful guide.

What happens when I am ready to leave hospital?

Moving into a care home is a big change in anyone's life. You will be supported throughout this process by your hospital Care Co-ordinator who will help make sure all the necessary arrangements are in place. You will be told about your discharge arrangements and given information on what you should expect to happen. Ask your ward staff for the name of your Care Co-ordinator if you have not already been told.

Hospital and social services staff will help and guide you through the stages and be responsible for making sure this process happens appropriately, safely and timely. Arranging your move to a care home requires both teams to work together to make sure the care home will suit your care needs. They will also support you in making important choices about which home might be right for you.

What if I don't think I should be leaving hospital?

You can't stay in hospital once your treatment is complete and you are classed as "clinically optimised", meaning you no longer need to be in hospital to receive on-going care. It's really important that you are discharged and able to move on to your next stage of care as soon as possible.

Being discharged once your treatment is complete and you are medically well enough to leave has a number of important benefits for you and your wellbeing:

- You are more likely to have opportunities to be more mobile (where appropriate), strengthening your muscles and regaining your confidence.
- You are less likely to pick up an infection as you won't be around sick patients.
- Being away from a busy hospital ward will give you chance to rest and sleep better, helping with your recovery.
- And of course, your bed can be used by a new patient needing medical treatment.

Who is responsible for arranging my care home place and will I have to pay?

Based on the outcome of your financial assessment, social services will work out if you need to pay your care home costs in full or if you are eligible for financial support. If you are eligible for financial support, then social services will become responsible for making your care home arrangements and will work with care home staff to put arrangements in place for your arrival. They will also provide you with information on any financial contribution you might need to make towards your care home costs.

How long should my move to a care home take?

The time from when you are well enough to leave hospital and move to your care home should generally take no longer than 3 weeks as it is important you do not stay in hospital any longer than necessary. Your Care Co-ordinator will keep you informed of your likely discharge date and how the arrangements are progressing.

Can I choose a particular care home?

Yes – you can express a preference for a particular care home if it is able to meet certain conditions that enable you to be placed at the home.

If your local authority is responsible for your placement, it will have a legal requirement to make sure you have a genuine choice and must make sure that more than one care home option is available that can meet your care needs in full. These legal requirements also make sure you can express a preference for another care home if you want to. So, if you prefer another care home, let your Care Co-ordinator or social services staff know as soon as possible. However, arrangements can only be made for you to live at the care home you prefer if it can meet a number of conditions, these include being able to meet your care needs and having a current vacancy. Social services staff will be able to explain these conditions in full.

If the care home you would like to move to can meet the necessary conditions regards your care needs but is more expensive than your local authority would usually pay, or you would like to choose some additional services, you may still be able to move to the care home. However, it could mean an additional weekly payment is needed. This is called an "Additional Cost Payment" and must be paid by a third party (a family member for instance). You can't usually make the payments yourself. Your local authority will provide information on Additional Cost Payments and why one may be necessary at your preferred home.

What if the care home I prefer doesn't have a vacancy, can I wait in hospital?

No – you can't remain in hospital indefinitely. However, hospital and social services staff will work with you and your family to agree a period of time to enable you to express your choice and consider options. This will be communicated to you.

If your preferred care home can meet your needs but doesn't have a vacancy, you'll be discharge to another care home for a short period of time. This is called an "interim arrangement". Social services don't have to offer any choice about the care home that you stay at as an interim arrangement. However, social services must make sure you are placed on a waiting list while your interim arrangement is in place and let you know as soon as a vacancy becomes available at your preferred care home. You can then decide if you would like to move to that care home, but you may be able to remain at the one you have been staying at if you wish.

Might I need to make my own care home arrangements and will I need to pay?

Yes – this may be the case if the outcome of your financial assessment means you are not eligible for any financial support from your local authority.

In this case, you may need to pay your care home costs in full but social services staff must provide you and your family with advice and support in helping choose and arranging your move to a care home, if that is what you want. If you are to pay your costs in full you will still need to consider the care homes that can meet your care needs in full and have a vacancy. The "care provider" of the care home you would like to move to will need to be involved in the process. On moving to the care home, you will enter into formal arrangement with the care provider, or you can ask your local authority to make all the formal arrangements for you if you want, even if you are paying your care home costs yourself.

You cannot wait in hospital if a vacancy is not currently available. You will need to move to another care home until a vacancy arises.

What happens if I'm unable to choose a particular care home?

If social services are unable to arrange a placement at your preferred care home, you must be provided with a written statement that explains the reasons this has not been possible. This communication can be undertaken after you have left hospital.

What if I'm unhappy with the discharge process or the arrangements being put in place?

As a first step, raising your concerns with hospital or social services staff could be the best way of resolving things quickly. If you remain unhappy, both the NHS and local authority social services departments have complaints processes to help you to raise concerns about any aspect of your care or care arrangements.

Are there any organisations that can offer help and advice?

Hospital and social services staff, particularly your Care Co-ordinator and social worker, if one is appointed, can provide help and advice throughout your hospital discharge process and onto your care home and be able to direct you to other sources of advice and information.

The following organisations provide lots of helpful information and support:

- **Age Cymru** – has some helpful information and factsheets including this one that explains people's rights and gives information on care home choice: **Microsoft Word – FS60w – July 2024 (ageuk.org.uk)** Age Cymru's website can be accessed here: **www.agecymru.org.uk** or you can contact their Advice Line on **0300 3034 498**.
- **The Older People's Commissioner for Wales** – provides an independent voice and champion for older people throughout Wales, providing information and advice on older people's rights. The Older People's Commissioner for Wales' website can be assessed here: **www.olderpeople.wales** or telephone: **03442 640 670** for information.
- **Llais** – an independent body that supports people using health care and social care services and provides assistance with concerns about services through their confidential complaints and advocacy services. Llais' website can be accessed here: **www.llaiswales.org** or telephone **029 2023 5558** for information.
- **Care Inspectorate Wales** – can provide information about care homes in your area. Its website can be accessed here: **Home | Care Inspectorate Wales** or telephone **0300 7900 126** for information.
- **Care Homes Wales** – is an online tool that provides up to date information on care homes in your area and can be accessed here: w**ww.carehomes.wales**