

Reluctant Discharge Policy Framework for Cornwall and the Isles of Scilly Health and Care System.

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NHS Cornwall and Isles of Scilly Integrated Care Board

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Introduction

This document provides a process for the health and social care system in Cornwall and Isles of Scilly to support the management of individuals who decline to participate in either the discharge planning process or the transfer to a more appropriate care setting. Whilst likely to be used primarily in hospital settings, the principles and approach can also be used in care homes and community services providing short term episodes of care.

The process set out in this document 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 this policy, the focus should be on the individual, understanding what matters to them and on ensuring their needs are met safely and appropriately. The risks of remaining in an inpatient setting when this has been assessed as not appropriate are significant and the policy also includes actions to ensure the person is fully aware and informed of the additional risks to themselves and the consequences of remaining in an inappropriate setting.

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.

It is based on relevant current national guidance and includes recognition of locally developed processes already in place where these have been available.

Definition

A reluctant discharge is when a person has been assessed as no longer in need of care or treatment in the acute, community hospital, temporary care home, virtual ward or community team they currently occupy, and is declining the onward care proposed.

They will either have been assessed as able to transfer on to the next appropriate stage in their episode of care 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 offered.

Where a first or preferred choice is not available, alternatives will be sourced and offered, with compulsory discharge used as a last resort.

Purpose

Both health and social care partners have a responsibility to ensure resources are used to best effect and a range of services are available for those who need them. From this perspective transferring or discharging a person to a more appropriate setting releases capacity for those in need of that level of care and treatment and maintains system flow and balance.

National policy guidance and regional/local discharge processes operate to ensure that a person's identified and assessed needs on discharge are met and that the person maintains all opportunities for independent living. This is the case for both simple discharges and those more complex. For the purposes of this Guidance the focus is on the more complex discharges where a person is likely to require either ongoing access to rehabilitation and reablement or is assessed to need a package of care and support on discharge.

On occasion a person may, for a range of reasons, decline to participate in the process of transferring them to the next stage of care, be it short term/temporary care and permanent/long term care. This is much more likely if the person's needs are more complex and/or the setting for the next stage of their care pathway is not one they wish to consider. Whilst low in number, such circumstances can lead to significantly extended lengths of stay that threaten what can already be quite fragile independence for the person involved. They can also take a disproportionate amount of management and operational time to resolve.

Ensuring people receive care in the most appropriate setting to meet their needs requires all stakeholders to work together to ensure that:

- National policy requirements reflect and support the discharge and transfer process.
- Actions are in place between partners to ensure discharge planning is a managed process that begins at the point of admission.
- Arrangements are in place and implemented in a timely manner to ensure that any situation where a person is in a care setting inappropriate to their needs is managed and addressed.

This policy framework outlines how health and social care partners will work with the person and/or their advocate and family to ensure the person's needs are met as much as possible where a person's preferred discharge choice is unavailable. It provides a framework for the organisations below to develop their own policies and procedures that are aligned with the overarching policy framework:

- Royal Cornwall Hospitals NHS Trust (RCHT)
- Cornwall Partnership NHS Foundation Trust (CFT)
- University Hospitals Plymouth NHS Trust (UHP)
- Cornwall & Isles of Scilly Integrated Care Board
- Cornwall Council
- Any other hospital where residents in Cornwall are placed
- Care homes providing discharge to assess (D2A) temporary bedded care
- Community services providing temporary reablement and other care

Delivering on these requirements will minimise the threats to independence that a prolonged hospital stay can bring and ensure all partners are able to use their resources to best effect.

Responsibilities

Cornwall & Isles of Scilly Care Board is responsible for maintaining this policy framework.

Chief Operating Officers and Directors of Nursing are responsible for ensuring relevant staff are aware of and follow organisational policies and procedures that link to this overarching framework.

The ward / care home lead / community team in charge is responsible for the overall coordination with partners of effective discharge planning. This includes:

- overseeing the discharge plan for each person they are responsible for
- the assessment, communication, and active management of the discharge process, including explaining that transfer to a more appropriate care setting is anticipated if the person has ongoing care and support needs and no longer requires care in the current setting.

Principles of effective discharge planning and management

Person-centred care

Prioritising the needs and preferences of people and ensure that they are involved with all decisions relating to their care and discharge. There may be situations where an individual's choice cannot be agreed or met either initially or in the longer term. For example, step-down provision may not be in the person's local area requiring a temporary placement in another area.

Balanced and Fair

Everyone, irrespective of funding route, will be provided with the same advice, guidance. Self-funders may incur a charge if asking the Local Authority to source care.

Information and communication

People should be provided with clear, accurate and timely information about their condition, treatment options and discharge planning process. Communication between professionals and people should be open, transparent, and respectful.

Collaborative working

Healthcare professionals should collaborate with people and their families, as well as other healthcare professionals and social care providers, to ensure that people receive the most appropriate and effective care.

Timeliness

Discharge planning should be initiated as early as possible in a person's stay, with regular reviews and updates to ensure that plans remain appropriate and timely. Decisions will be taken within reasonable periods so as not to result in a bed/care placement being occupied when an individual no longer requires care.

Lawful

Decisions and actions should be in accordance with relevant legislation, regulations, and policies, including the Mental Capacity Act 2005 and should not breach people's legal rights.

Quality and safety

The discharge process should be safe, effective and of high quality, with appropriate checks and balances in place to ensure that people are discharged to safe and appropriate settings.

Non-discrimination

People should be treated with respect and dignity and should not discriminate against them based on age, sex, gender, race, ethnicity, religion, disability, or any other personal circumstance.

Discharge to Assess

People's long-term health and care needs should not be determined in an acute hospital setting. Instead people should be discharged and then these needs assessed.

Feedback and improvement

Mechanisms should be in place for people and their families to provide feedback on their experiences of the discharge process, and for healthcare professionals to learn from this feedback and continually improve the quality of care and support provided.

Management of Reluctant Discharges

Some people and/or their family/carers may refuse to engage with the discharge process despite having been assessed as clinically optimised for discharge and agreement from the MDT that it is safe for discharge to the next stage of care to proceed.

This can be for a range of reasons including, but not confined to:

- Concerns regarding the location of care, for example a reluctance to receive ongoing rehabilitation and reablement care in a non-hospital setting such as a residential care home.
- Previous negative experiences
- Anxiety at moving to a different care setting.
- Concerns regarding any financial contributions that may apply to care provided post discharge from hospital.
- Location compared to their normal residency or family.

This policy framework aims to assist multidisciplinary teams to manage these circumstances. A high-level process diagram setting out the discharge process has been developed for staff to use as a reference guide alongside this policy framework (see Appendix 1 – High Level Discharge Diagram).

In implementing the framework, specific attention should be given to:

- Where an individual lacks capacity to decide about matters concerning their daily life and future accommodation needs, an assessment of a person's capacity must

be based on their ability to make a specific decision at the time it needs to be made, in accordance with the principles of the Mental Capacity Act (2005) and documented.

- For people who have been assessed as lacking capacity to make decisions about their care needs, or place of discharge, a Best Interest Meeting (BIM) will need to take place. N: B – discussions can be held virtually but does need to include all relevant people.
- If the person has a Lasting Power of Attorney (LPOA) for Health and Welfare, the named attorney must be involved, and in this case is the decision maker on behalf of the person in relation to the decision needed on which D2A pathway but not onward resource (subject to any restrictions in the Mental Capacity Act 2005). Evidence (in the form of a copy) of an authorised LPOA for Health and Welfare from the Office of the Public Guardian should be obtained, reviewed, and retained in the patient's notes. This decision will be based upon the relevant options available to the individual and reflect their assessed level need.
- If the person has a Court Appointed Deputy in place (for Personal Welfare or Property and Financial affairs) then the Deputy may also need to be involved in any discharge planning and be the decision maker for that person subject to the express terms of the Court Order, subject to any restrictions in the Mental Capacity Act 2005. A copy of the Order from the Court of Protection should be obtained, reviewed, and retained in the patient's notes.

Strategic requirements

At a strategic level local and regional partners should ensure they have systems and processes in place that:

- Provide clear information on discharge planning arrangements which is provided to people at, or in the case of elective admissions before, admission (see Appendix 2 – Sample Hospital Discharge Leaflet).
This information includes the risks of remaining in hospital when it is no longer necessary and the need to ensure that care is provided in the most appropriate setting.
- Have systems in place to monitor the effectiveness of the discharge arrangements and can identify, report, and escalate any emerging issues regarding failure to engage with the discharge process to a more senior level.
- Provide ongoing senior scrutiny and support in striving to achieve a safe and appropriate discharge to the next stage of care.

Operational requirements

At an operational level, the relevant professional who assumes lead care co-ordinator responsibilities should:

- Seek to ensure that communication channels remain open and effective with both the person and their family/carers, taking every opportunity to understand the reasons for the refusal and whether any further explanations or discussions may assist to resolve their reasons for refusal. Appendix 3 provides information to

support conversations with the patient regarding their discharge planning. These discussions should be carefully documented.

- Check, confirm and document that the person remains clinically optimised and that the discharge option remains a viable, safe, and appropriate option based on the recommendation of the MDT. This process should include the documentation of any meetings and/or conversations which have taken place.
- Continue to engage with the person/their family/carers to try to resolve the reason for their reluctance to be discharged to a more appropriate setting. This may assist with resolution, particularly if the risks of remaining in the current setting and the benefits of transfer to a more appropriate setting are explained. This should include ensuring the plan of care is up to date and identifies the risks associated with an inappropriately extended hospital stay. The risks should be shared with the person as part of the regular 'what matters to me' conversations to ensure they remain fully informed of the plan of care including the assessed risks. These discussions should be documented in their patient's records.
- Seek to consider any alternative options that the person and/or their family/carers may find more acceptable that would provide an appropriate alternative care setting.
- Be satisfied that the person and/or their family/carers understand that remaining in their current care location is not possible and the consequences of what is happening, including the continuation of the actions involved in the discharge process.
- Be aware of the system in place locally to escalate the matter through to more senior managers for advice, support, and guidance and how this can be accessed. If this further engagement does not resolve the refusal of discharge, then a nominated senior member of the relevant organisation should take the lead in communicating to the person and/or their family/carers that it is not possible to remain in the current setting as this would not be in the person's best interests, and that the organisation would now proceed to seek legal advice. The person/their representative should be advised they should also consider seeking legal advice specific to the individual case.

The Steps for Implementing Reluctant Discharge process.

If the steps outlined above do not result in the discharge/transfer to a more appropriate setting, then the Reluctant Discharge Steps set out below should be progressed. These should only be pursued when:

- All other reasonable options for long-term and temporary care have been considered and discounted.
- The organisation is satisfied that the person has been made fully aware of the risks associated with a delay in transferring to a more appropriate setting and that these discussions have been fully documented.
- Any specific or exceptional considerations, i.e. safeguarding concerns of the individual's circumstances that may indicate it is inappropriate to continue to enforce the discharge have been considered and documented in the persons notes.

- Agreement to proceed to implement discharge has been given by a relevant and appropriate executive manager.
- The local authority social worker is informed of and aware of the planned approach where necessary.

If all actions set out above do not result in engagement with the discharge plan the following staged actions should be progressed:

Step 1 –Discussion to seek resolution.

A meeting should be held between:

- the person and, if appropriate, their family and/or carers.
- senior members of the MDT.
- the person's allocated social worker / social care practitioner (if applicable)
- their lasting power of attorney or court appointed deputy (if applicable)

The purpose of this meeting would be to explore the issues that they have in relation to discharge including any concerns that they may have about the discharge and attempt to seek resolution. This should include setting out the risks associated with a delay in moving to a more appropriate setting.

Appropriate copies of any assessments or reports undertaken by specialists such as therapists or social workers would need to be made available for senior staff prior to any meeting, to refer to and clarify any questions that may be raised; it may be relevant for therapy staff to also attend the meeting depending on the nature and extent of their involvement. This would be particularly relevant for any reablement/rehabilitation planned under Discharge to Assess (D2A).

During this meeting it should be explained to the person, or their representative if applicable, that it is not appropriate for them to continue to occupy a hospital bed /care placement when they no longer have a clinical need to do so; remaining in the current setting could place them at additional risk of harm and deny others access to care. The person should be given a discharge time and date and informed they will be expected to leave by this time. In the case of those requiring ongoing care and support the date and time provided should align with the commencement of care planned to be provided in a different setting.

It should also be stressed sensitively but firmly in the meeting that unless the person is discharged on the given date, the organisation would seek legal advice that could result in making an application to the Executive Team to seek an order that would require them to leave the premises.

An appointed person should carefully document the discussions and agreed actions and a copy should be retained in the person's clinical records.

Step 2 – Letter to person / family / advocate / LPOA

Following the meeting a letter should be given to the person confirming the date that any ongoing needs were assessed and how those needs are intended to be delivered in an alternative care setting. A sample letter is attached as Appendix 4 to this document.

The letter should address any of the concerns raised and make it clear that the person has been assessed as ready for discharge and should specify the date and time by which the person will be discharged.

Where relevant, it should also make clear that the provision of care in a hospital is temporary and linked to a persons assessed health need. Patients in a hospital bed as a licensee. The hospital as the owner of the hospital grants the patient a licence to be on its premises. This licence exists for such time until it is deemed appropriate for the licence to be revoked i.e., the person is deemed clinically optimised for discharge. A person does not have an enforceable legal right to occupy a hospital bed indefinitely and hospitals are under no legal duty to accommodate them where other alternative safe discharge venues have been identified.

Step 3 – Legal advice

If following the letter the person still then refuses to leave, then the organisation should seek additional legal advice that is specific to the individual and the circumstances around the refusal of discharge.

Step 4 – Eviction Notice

The final resort is an application to the organisational executive team (which may include the chief medical officer, chief nursing officer, chief finance officer, chief operating officer) to request an order for possession, with the associated legal costs in applying for such an order being claimed from the person.

This stage must be subject to and informed by specific and additional legal advice.

Steps will be taken to ensure that there is appropriate follow-up following a reluctant discharge – this may include notifying the GP or relevant community team that the person has been discharged, and any care or support needs that may be required.

The Legal Position

Organisations are advised to seek specific further legal advice tailored to each individual case, particularly if a case reaches Steps 3 and 4 of the Implementing Reluctant Discharge process set out above.

Before proceeding with enforcing discharge and seeking legal advice, the organisation should ensure all discharge policies have been complied with.

The following key points should be considered and confirmed before a referral for specific legal advice is made.

- Ensure the discharge planning processes in operation reflect the Government policy guidance ([Hospital discharge and community support guidance - GOV.UK \(www.gov.uk\)](https://www.gov.uk/government/publications/hospital-discharge-and-community-support-guidance)) and confirm that all local discharge policies and resolution processes have been followed and can be evidenced.
- Ensure all formal and informal discussions relating to the specific person's discharge planning are detailed and documented. This must include the regular 'what matters to me' discussions and confirm the person has been made aware of the risks to their health and wellbeing of remaining in hospital / current care setting when that is no longer necessary.
- Review all necessary case conferences, discharge planning meetings or round table meetings with person and their families/carers where concerns have been raised or issues arise and ensure that all opportunities to resolve the matter have been exhausted.
- Ensure the actions set out in this Guidance have all been undertaken.
- As a last resort, once the above steps have been taken, legal action can be pursued to enforce the discharge process. This should clearly be considered when all other options have been exhausted and it is inappropriate for the person to continue to occupy the in-patient bed/current care placement. Such a decision should only be taken when the organisation has sought additional specific legal advice that will reflect the circumstances of each individual case.

If all the stages set out in this Guidance have been taken and there is a need to proceed to make an application for a possession order, the organisation must seek additional legal advice before any application is made.

Exclusions

- People receiving care on specialist mental health wards. This will be reviewed and incorporated into this policy framework later.
- Individuals who are subject to home office restrictions section 41 of Mental Health Act.
- Individuals who are also a serving prisoner receiving care in the NHS

Funding considerations

This policy applies equally to those self-funding care.

Self-funders should be provided with the same level of information and advice as people whose care is being funded by the NHS or the local authority (see [Adult Social Care Needs assessment - Cornwall Council](#) – Care Needs Assessment information leaflet).

Update and review.

This Policy Framework will be reviewed and updated by the Cornwall & Isles of Scilly Integrated Care Board at least every three years or as and when any changes in national policy guidance impact on the processes outlined in this document.

Policies referred to in this document.

[Hospital discharge and community support guidance - GOV.UK \(www.gov.uk\)](https://www.gov.uk/government/guidance/hospital-discharge-and-community-support-guidance)

Appendix 1: High Level Process for managing discharges.

1. Person admitted to care setting

- Provide appropriate discharge leaflet

2. Person ready for discharge

- Ward/service co-produces discharge plan with person / family / advocate and obtain consent to refer
- If the person needs care / support after discharge – the service will send a Referral via Strata to the Transfer of Care Hub (ToCH)

3. Referral sent to ToCH

- ToCH triage and send to onward service(s) to confirm service offer
- ToCH notifies service for triage outcome and service offer

4. Ward/Service communication re: discharge planning

- Discuss with the person (and if requested, the family / carer / advocate) the service offer and discharge plan
- If declined – the ward meet with the person again to notify them that they have 24 hours to find alternative arrangements to secure a discharge – otherwise, the original plan applies

5. 24 hours after the person has declined the service offer – if still no agreement

- Ward/Service confirm with Execs to send Compulsory Discharge Letter template
- Letter is sent to patient / family (using template) regarding compulsory discharge

Appendix 2: Suggested Text - Hospital Discharge Leaflet



Royal Cornwall Hospitals
NHS Trust



University Hospitals
Plymouth
NHS Trust

Cornwall Partnership 
NHS Foundation Trust

Your discharge from hospital

DRAFT

Your admission

It is important for us to work together to make sure you're not in hospital any longer than you need to be.

As a patient on our ward, you can expect for our staff to talk to you about your care and treatment. They will involve you in decisions about your care and if you wish (and with your consent), they will also involve your family and/or carer.

Please talk to us about your home circumstances and wishes as soon as possible.

Please let us know if you have a personalised support plan or a key worker. We will make every effort to ensure you receive your treatment as soon as possible and will review your progress with you regularly.

What happens when I no longer need to be in hospital?

During your stay we will start planning your discharge from hospital with you as soon as possible.

We do this to ensure you do not have to stay in hospital any longer than you need. This is called a discharge plan.

When you no longer need to stay in hospital, we will involve you (and with your permission, your family and/or carer) in putting your discharge plan into action.

You will then be safely transferred either back to your home or another place for your ongoing care.

Staff will discuss with you (and with your permission, your family and/or carer) the appropriate ongoing care and support that will be offered.

Why can't I stay in hospital?

When you no longer need hospital care, it is better to continue your recovery out of hospital. Staying in hospital for longer than necessary may reduce your independence, result in you losing muscle strength or expose you to infection.

Leaving hospital when you are ready is not only best for you but will free-up a bed for someone who is very unwell.

Our top priority is to ensure you are in the right place at the right time for the best recovery possible. The best place for you right now is at home where you can continue to recover in a familiar environment.

What might I expect?

The team caring for you will discuss transport and other arrangements with you (and your carers, family and/or friends if you wish).

If you need more care and support now than when you came into hospital, the team caring for you will discuss options for how you receive that care and support following discharge. The team will also discuss when you should be assessed for the provision of any long-term care and support. You may be required to contribute towards the cost of your care and support, if you need it.

In exceptional circumstances, decisions may be made to place you in an interim/short term bedded care placement if services are not available for you to return home.

Medication

If you need any medications, you will be given a supply to take away. Before you leave a nurse will explain what the medications are for, how to use them and will tell you about any side-effects to look out for.

Transport

If you are being discharged to your home, you or your family will need to arrange your transport, unless you have been assessed as requiring hospital transport. We will aim to discharge you in the morning of your last planned day with us.

If you are being transferred to another hospital within Cornwall, we will arrange this for you. If you are being discharged to a location outside of Cornwall, you will be asked to arrange your own transport. We will give you help and assistance to do this.

What happens if I don't agree to the care and support offered after my discharge?

If you do not agree to the fair offer of care or support offered as part of your discharge plan, the ward will meet with you (and your carers, family and/or friends if you wish) and discuss.

Social Care Payments

Whilst NHS care is free to everyone, social care is not.

If you need more care and support now than when you came into hospital, this will be provided free of charge for a period to support your recovery. The team caring for you will be able to advise how long this period might be.

Assessments of your needs, as well as decisions about the provision of any long-term care and support, will be made during this time. After this time, you may be required to contribute towards the cost of your care and support, if you need it.

A social worker can assist you with this process

Leaving the hospital

On the day of your discharge, you may be transferred to our discharge area or to a comfortable seated area of the ward, where you will be looked after until you leave the hospital.

We will aim to get you home before lunchtime wherever possible, so you are not kept waiting in the hospital and have time to settle in at home or in the place you are transferred to. Upon leaving the hospital if you have any questions about your medication or require more medication you should contact your local pharmacy or family doctor (GP), or the hospital ward if you have been advised to do so.

When you are discharged from hospital you will return to the care of your GP who will receive a summary of your treatment from the hospital.

Appendix 3: Suggested Discharge guided conversation template.

People's experiences of discharge are particularly important in understanding how the process can be improved for others in future. National guidelines highlight the importance of effective communication and access to information throughout the discharge journey.

The value of clear communication and information provision when leaving a care setting is crucial, and having information available and communicated in a way that was easy to understand and process was reassuring, whilst lack of information and unclear communication can lead to experiences of worry. Introduce the Conversation Frame the conversation as a two-way discussion on options the patient may have upon discharge. The information people highlighted as being particularly important to them included:

- **What is wrong with my health?**
 - Some people may feel unsure why they were in hospital / care setting and may need information about their current state of health. People also may need information about what may happen next with their health so that they could be prepared for any changes.
- **What about my mobility?**
 - People may be concerned about their ability to move around independently after their stay/care episode and may need more information and support to help them get back to being more mobile.
- **How do I get home?**
 - Getting home may be a key issue for many people. Individuals who were expecting to get a lift from a friend or family member often expressed that it was important to give that person enough notice to prepare.
- **What is going to happen about my food?**
 - Discuss the practical things that need to be done when they got home to make sure that they would be safe and well. People may be worried about having food in the house and being able to cook proper meals.
- **What about my medication?**
 - Where medication is required, detailed and timely information relating to taking and collecting the medication is important.
- **What else do I need at home?**
 - Discuss any support people would need at home to continue living as independently as possible. Types of support can range from mobility aids to care at home, and people may want to know in advance about the support they would get with doing everyday tasks.
- **Going to residential care/community hospital**
 - For those waiting to be discharged to a care home or community hospital, discuss how to prepare for this and knowing where they are going - having answers to the small, practical questions is helpful.

Recommendations

1. A person who does not have family or friends to help, or who may find it difficult to understand, communicate or speak up, should be informed of their right to an advocate in health and social care as set out in the [Care Act \(2014\)](#).
2. The Multi-Disciplinary Team (MDT) providing care should agree who will take on lead responsibility (with supporting deputies) for involving people and their representatives/carers in conversations about hospital discharge.
3. An Expected Date of Discharge (EDD) should be set at the first consultant review or MDT review. The EDD should be discussed and agreed with a person and their representatives/carers and reviewed throughout their hospital stay/care episode.
4. At the earliest opportunity, the agreed MDT lead should establish expectations around discharge with people and their representatives/carers. This will enable concerns to be anticipated and prevented from arising, and issues to be identified and resolved in a timely manner, thus minimising the risk of delays down the line.
5. Wherever possible, if an existing package of care (POC) exists, the hospital / care home / service lead should make early contact to confirm a restart - with or without additional reablement.
6. Staff should ensure that people are supported to ask key questions about the process of leaving the service, considering people's confidence, ability, and the time required to process information in preparation for leaving (e.g. flexible use of written/verbal communication, jargon-free language)
7. Discharge teams should ensure that processes are in place to identify and record a trusted contact for each patient and that, where consent is provided, the contact is informed of plans for (and changes to) discharge and follow-up care in a timely manner.
8. All patients, and/or their trusted contact, should be involved in planning transport arrangements for leaving hospital/care setting to ensure that safe and timely transport is available at the point of discharge. Help to get home can be considered ONLY after other options such as family have been explored.
9. Social care teams and providers of on-going care should work together to consider how transfers to other care settings can be communicated to patients so that they feel reassured about their change in living circumstances. (for example, supply brochures with pictures, arrange a telephone call)
10. Discharge teams should consider how patients (and/or their trusted contact) can be put in touch with services offering practical, short-term home support prior to them being discharged (e.g. Red Cross, Age Concern)
11. Discharge teams and social care teams should explore how technology (e.g. iPads, teleconferencing) can be used to:
 - a. Involve trusted contacts, identified by the patient, in conversations about leaving
 - b. Allow patients to find out more about other care settings prior to transfer, to support adjustment to changes in their living circumstances.

This guidance is informed from a survey undertaken by Healthwatch Surrey 'It's difficult to know what to ask - Communicating information throughout the hospital discharge journey' (Jan 2018) [Healthwatch Surrey 2018 Communicating information throughout the hospital discharge journey](#)

Appendix 4: Suggested template - Confirmation of Hospital Discharge Letter

To be given by the Ward/Service Manager following the reluctant discharge meeting and adapted to reflect the discussions of the meeting. If a person refuses to accept this letter, it should be read out to them, and a copy left at their bedside and a copy included within their medical records. This letter can also be adapted for use in other care settings such as care homes or community services intended to provide short-term reablement care for example.

Insert Date

Insert Person's Name and Address

Dear

As you will know from discussions with the team caring for you since you were admitted to **(INSERT NAME OF HOSPITAL/CARE SETTING)** on **(INSERT DATE OF ADMISSION)**, you have now been assessed and deemed clinically optimised and ready to leave **HOSPITAL/CARE SETTING**.

The initial reason for your admission was **(INSERT REASON FOR ADMISSION)**. **(INSERT CLINICIAN NAME)** confirmed in our meeting on **(INSERT DATE OF MEETING)** that this episode of care has now resolved, and your ongoing care and support needs no longer require you to be an inpatient.

After consultation with you and after careful consideration of your needs, the organisation now considers it appropriate for your ongoing care and support needs to be met in **(INSERT AS APPROPRIATE)**.

DELETE FOLLOWING AS APPROPRIATE

Remaining in hospital is inappropriate, places you at additional risk of harm and could impact on your health and wellbeing. It is therefore now necessary to ask you to:

DELETE FOLLOWING AS APPROPRIATE

Transfer to another setting appropriate to meet your needs for the next stage in your care. **IF THIS OPTION IS SELECTED INCLUDE A SHORT SUMMARY OF THE FOLLOW-ON CARE THAT IS TO BE PROVIDED**

Vacate the **HOSPITAL/CARE SETTING (INSERT DATE AND TIME BY WHICH THE PERSON IS EXPECTED TO LEAVE)** as you have been assessed as no longer requiring care in this setting.

The provision of hospital accommodation and/or accommodation is temporary and linked to a persons assessed health need.

A person is accommodated in a hospital bed under a licence. This licence, granted by the hospital, exists for such time until it is deemed appropriate for the licence to be revoked, for example in circumstances where a person is deemed clinically optimised to leave hospital and a safe and appropriate place of discharge for them to go to has been identified.

A person does not have an enforceable legal right to occupy a hospital bed indefinitely and the hospital is under no legal duty to accommodate a person where other alternative safe discharge venues have been identified.

Leaving hospital as soon as you are clinically optimised has important benefits for you and your wellbeing:

- You are more likely to have opportunities to be more mobile, strengthening your muscles and regaining your confidence and greater independence.
- You will have a reduced risk of infection.
- Being away from a busy hospital ward will give you chance to rest and sleep better, helping with your recovery.
- In addition, your engagement with the discharge process will create additional capacity on the ward and allow the Hospital to admit and treat patients in need of acute medical treatment.

We appreciate that this may be a difficult time for you. We will continue to keep you informed and support and assist with your discharge/transfer arrangements, including the provision of medication to take home (if appropriate) and transport arrangements should they be required.

In the unfortunate event that you continue to refuse discharge, the hospital will seek legal advice as to its options to affect your discharge. This may include making an application for a possession order requiring you to leave the hospital. We would hope that such action will not be necessary, and that you will engage with us to affect your discharge at the earliest opportunity.

I hope this letter clearly explains the hospitals position and provides clarity regarding next steps in the facilitation of your discharge.

If you have any queries regarding the content of this letter, please let me know and I would be happy to discuss them further.

Yours sincerely

To be signed by organisational representative at executive level

Appendix 5: Equality Impact Assessment

Title of policy or document for assessment: Reluctant Discharge Policy Framework

Is this a new or existing document? Existing

Date of assessment: 21 May 2024

Officer responsible for the assessment: Emma Cook, Programme Manager, NHS
Cornwall and Isles of Scilly

What is the main purpose of the document?

This document provides a process for the health and social care system in Cornwall and Isles of Scilly to support the management of individuals who decline to participate in either the discharge planning process or the transfer to a more appropriate care setting.

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.

This policy framework outlines how health and social care partners will work with the person and/or their advocate and family to ensure the person's needs are met as much as possible where a person's preferred discharge choice is unavailable.

It is based on relevant current national guidance and includes recognition of locally developed processes already in place where these have been available.

Who is affected by the document?

☒ Staff ☒ Patients ☐ Visitors ☒ Carers ☐ Other ☐ All

The document aims to improve access, experience and outcomes for all groups protected by the Equality Act 2010.

Concerns

Are there concerns that the procedural document could have a differential impact on the following areas?

Concern area	Response	If yes, what existing evidence (either presumed or otherwise) do you have for this?
Age	☐ Yes ☒ No	
Disability	☐ Yes ☒ No	

Concern area	Response	If yes, what existing evidence (either presumed or otherwise) do you have for this?
Sex	☐ Yes ☒ No	
Gender reassignment	☐ Yes ☒ No	
Pregnancy and maternity	☐ Yes ☒ No	
Race	☐ Yes ☒ No	
Religion and belief	☐ Yes ☒ No	
Sexual orientation	☐ Yes ☒ No	
Marriage and civil partnership	☐ Yes ☒ No	
Groups at risk of stigma or social exclusion such as offenders or homeless people	☐ Yes ☒ No	
Human rights	☐ Yes ☒ No	

Are there any associated objectives of the document? If yes, what existing evidence (either presumed or otherwise) do you have for this?

In all circumstances when implementing this policy, the focus should be on the individual, understanding what matters to them and on ensuring their needs are met safely and appropriately. The risks of remaining in an inpatient setting when this has been assessed as not appropriate are significant and the policy also includes actions to ensure the person is fully aware and informed of the additional risks to themselves and the consequences of remaining in an inappropriate setting.

Both health and social care partners have a responsibility to ensure resources are used to best effect and a range of services are available for those who need them. National policy guidance and regional/local discharge processes operate to ensure that a person's **identified and assessed needs** on discharge are met and that the person maintains all opportunities for independent living.

Signature of person completing the equality impact assessment:

Name: Emma Cook **Date:** 21 May 2024

Appendix 6: Pre-ratification checklist

Question	Yes or no	Comments
Have you made the title clear? Will people know what the document is about?	Yes	
Have you stated the reason for the document?	Yes	
Have you made a reasonable attempt to include relevant expertise?	Yes	Task and finish group established to inform document
Have you consulted with stakeholders and users as necessary?	Yes	Joint working group established. 3-week consultation in home organisations
Have you had clinical input (if relevant)?	Yes	Clinicians and professionals were in the working group – clinicians were consulted to inform the final version.
If appropriate, have you consulted the joint partnership committee?	N/A	We have consulted each partner organisation (RCHT / CFT / UHP) throughout the development of this document.
If appropriate, have you involved the counter fraud specialist?	N/A	N/A
Have you made the objectives and intended outcomes of the document clear?	Yes	
Have you been clear about the target audience for the document?	Yes	
Have you cited key references, if appropriate? If so, have you cited them in full where appropriate?	Yes	
Have you cross-referenced any supporting documents?	Yes	
Does the document meet accessibility expectations? Have you used the accessibility and branding checklist ?	Yes	
Have you completed an equality impact assessment or full impact assessment, and had it reviewed as required?	Yes	
If appropriate, have you used gender neutral language, and is the policy explicitly inclusive of same-sex couples?	Yes	

Question	Yes or no	Comments
If appropriate, does the policy clearly state that the ICB will not tolerate discrimination against employees on the grounds of sexual orientation or gender identity and/or trans identity? You may list these along with other protected characteristics.	Yes	EIA completed
If appropriate, does the policy include guidance on facilities and dress code for non-binary people?	Not applicable	
Have you identified how the document will be ratified?	Yes	Document was circulated for a 3-week period - consultation and feedback in RCHT / UHP / CFT. Once feedback is collated – the final version will be presented to SEG (System Executive Group) for sign off
Do you have an outline plan to identify how the ICB will implement the document?	Yes	Once ratified at SEG – each organisation will communicate and implement by embedding within their own policies.
Does the document refer to any training or support available to ensure compliance?	Yes	Tools and guidance are incorporated into the document for users to follow. References to National guidance is also incorporated. Each organisation will identify appropriate training for staff.
Have you been clear whether the document can be published on the organisational website? If it cannot, is a clear, valid reason given for this?	Yes	
Have you identified how often the document will need reviewing? If so, is it reasonable?	Yes	
Have you included any information about the plan to review or audit compliance with the document?	Yes	Implementation will be the responsibility of each organisation to monitor. The document review will be scheduled for every 3 years.
Have you been clear about who will be responsible for coordinating the dissemination, implementation, and review of the document?	Yes	