The Community Care (Delayed Discharges etc.) Act 2003

Guidance for Implementation

To: Health Authorities (England) - Chief Executive
    NHS Trusts - Chief Executives
    Social Services Directors - England

Cc: Health Authorities (England) - Chairman
    Councils - Common Council of the City of London, Chief Executive
    Councils - Council of the Isles of Scilly, Chief Executive
    Councils - County Council Chief Executives
    Councils - London Borough Council Chief Executives
    Councils - Metropolitan District Council Chief Executives
    Councils - Shire Unitary Council Chief Executives
    NHS Trusts - Chairman

Further details from: Ian Bishop
133 - 155 Wellington House
Waterloo Road
London
SE1 8UG
020 7972 4094
ian.bishop@doh.gov.gsi.uk

Additional copies of this document can be obtained from:
Department of Health
PO Box 777
London
SE1 6XH
Fax 01623 724524
It is also available on the Department of Health web site at
http://www.doh.gov.uk/publications/coinh.html
© Crown copyright
The Community Care (Delayed Discharges etc.) Act 2003

Guidance for implementation

Summary
This circular advises on:

- NHS and social services responsibilities under the Community Care (Delayed Discharges etc.) Act 2003.

Direction
NHS and social services departments are required to comply with the new regulations and obligations created by the Community Care (Delayed Discharges etc.) Act 2003 in shadow form from 1 October 2003 and in relation to full implementation from 5 January 2004.

Background
1. The guidance in the Annex to this circular sets out the new requirements created by the Community Care (Delayed Discharges etc.) Act 2003.
2. The Act places new duties upon the NHS and councils in England relating to communication between health and social care systems around the discharge of patients and communication with patients and carers. The NHS is required to notify councils of any patient’s likely need for community care services, and of their proposed discharge date. These new duties will come into force 1 October 2003 when the NHS and councils are expected to begin operating the system in shadow form.
3. The Act also introduces a system of reimbursement for delayed hospital discharges. This will apply initially to adult patients receiving acute medical care. If a patient remains in hospital because the council has not put in place the services the patient or their carer need for discharge to be safe, the council will pay the NHS body a charge per day of delay.
4. The new duty for councils to pay the NHS for delays comes into force on 5 January 2004, providing a financial incentive for councils to promptly assess and transfer people from an acute ward to a more appropriate community setting as soon as they are ready for discharge, and provide an appropriate range of support to facilitate avoiding unnecessary admissions.
5. Primary Care Trusts have a key role to play in working with NHS bodies and councils in identifying the main causes of delay in their local systems, and in channelling investment to tackle these to reduce delays and thus the need for reimbursement. Strategic Health Authorities have a specific duty under the Act to establish dispute resolution panels. Their composition and duties are set out in the Regulations.

This Circular has been issued by:
Giles Denham
The Community Care (Delayed Discharges etc.) Act 2003:
Guidance for implementation

OVERVIEW – ROLES AND DUTIES FOR HEALTH BODIES AND COUNCILS

INTRODUCTION

Purpose of legislation
New duties and responsibilities
Dates for implementation

DELAYS WHICH ARE COVERED BY THIS ACT

Mental health
Palliative care
Patients delayed in community beds
Patients delayed in PCT-managed beds
Patients delayed in specialist, tertiary centres
Private patients
NHS patients treated in independent hospitals
Patients ordinarily resident in Wales, Scotland and Northern Ireland
Asylum seekers and other foreign nationals
People of no fixed abode

ASSESSMENTS AND SERVICE PROVISION

Multi-disciplinary assessments
Assessment for NHS continuing healthcare and relation to reimbursement
Carers’ assessments
Importance of avoiding over-referrals
Information sharing and patient confidentiality
Safe to assess, safe to transfer
Specific patient categories
Patients near death
NHS-funded nursing care
Patients who are responsible for or will be paying for their onward care

ASSESSMENT NOTIFICATIONS

Content of notices
Identifying ordinary residence
Timing of issuing assessment notices
Minimum interval for assessment
Saturdays, Sundays and public holidays
Withdrawing notices
PATIENT AND CARER INVOLVEMENT 27
  Consent 27
  Direction on Choice 28
  Using alternative forms of care 29

NOTIFICATION OF DISCHARGE DATE 31
  Whole systems investing and planning in the context of reimbursement 33

RESOLVING DISAGREEMENTS 35
  Cross-boundary disputes 35
  Details of dispute panels 35

INTERFACE WITH OTHER LEGISLATION 37

USEFUL LINKS AND REFERENCES 38

ANNEX A 39
Community Care (Delayed Discharges etc.) Act 2003

Overview – roles and duties for health bodies and councils

The Government announced its intention to introduce a system of reimbursement in Delivering the NHS Plan in April 2002. It is based on a system used in Scandinavia that has had a major impact on reducing delayed discharges.

The Community Care (Delayed Discharges etc.) Bill was introduced into the House of Commons on 14 November 2002. The Bill received Royal Assent on 8 April 2003.

The Act places duties upon the NHS and councils with social services responsibilities in England relating to communication between health and social care systems around the discharge of patients and communication with patients and carers. The NHS is required to notify councils of any patient’s likely need for community care services, and of their proposed discharge date. These new duties will come into force in October 2003 when the NHS and councils are expected to begin operating the system in shadow form.

The Act also introduces a system of reimbursement for delayed hospital discharges. This will apply initially to adult patients receiving acute medical care. If a patient remains in hospital because the council has not put in place the services the patient or their carer need for discharge to be safe, the council will pay the NHS body a charge per day of delay. This charge has been set to be higher than the costs of providing alternative and more suitable social care and is currently £120 in London and parts of the South East and £100 elsewhere in England.

The new duty for councils to pay the NHS for delays comes into force on 5 January 2004, providing a financial incentive for councils to promptly assess and transfer people from an acute ward (where they are at risk of losing their independence) to a more appropriate community setting as soon as they are ready for discharge, and provide an appropriate range of support to facilitate avoiding unnecessary admissions. The Act thus promotes the independence of older people and means that more people will be cared for in the most appropriate setting for their needs.

As health commissioners, PCTs have a key role to play in working with NHS bodies and councils in identifying the main causes of delay in their local systems, and in channelling investment to tackle these to reduce delays and thus the need for reimbursement.

Strategic Health Authorities have a specific duty under the Act to establish dispute resolution panels, and appoint members to them. These panels are similar in form to continuing care adjudication panels. Their composition and duties are set out in the Regulations.
This document provides detailed guidance on how to put these new responsibilities into practice. Further help, including frequently asked questions, sample protocols for partners to adapt locally, and links to the legislation, is available at www.doh.gov.uk/reimbursement
Community Care (Delayed Discharges etc.) Act 2003 (Part 1):
guidance for NHS bodies and councils

Introduction

Purpose of legislation

1. This Act aims to improve and strengthen discharge planning and the timely provision of the services patients need to transfer from one care setting to another. It does not operate in isolation. It has very important links to, and a role in strengthening, elements of local partnership working, particularly discharge planning, capacity planning and the introduction of the Single Assessment Process.

2. The majority of patients in the NHS are older people, and thus reimbursement is closely tied to the aims of the National Service Framework for Older People. In particular, it focuses on the goal of increasing independence, and supporting people to find care that meets their needs, at home where possible.

3. Services for older people have developed significantly both within the NHS and councils, and a huge amount of work has been done across the country to improve people’s choices and experience of care. However, on any one day at the time of writing there are around 4000 patients experiencing delayed transfers of care in NHS acute beds in England for a variety of reasons, including delays in both NHS and community care services. ‘Delayed discharges’ are people, often frail older people whose future care is uncertain. Hospital is not the ideal place to be while waiting for arrangements for care to be put into place. Hospitals make people more dependent; there is also an increased risk of them acquiring an infection. Whilst they are away from home, older people’s care networks can break down.

4. Part 1 of the Community Care (Delayed Discharges etc.) Act 2003 aims to:
   • strengthen joint working and encourage clear and timely communication with new statutory duties on the NHS and councils;
   • improve assessment and provision of community care services for people in hospital by introducing financial incentives; and
   • encourage development of new service capacity which can facilitate patient transfer to community settings which promote independence or prevent unnecessary admission.

5. Reimbursement is a way of reflecting where costs are borne across the different parts of the health and social care system. It is about incentives to improve services, and developing capacity in partnership across the whole of health and social care, not shifting money around.
6. In fact it is desirable for councils to act to minimise reimbursement payments. The focus should be on developing capacity in partnership with the NHS, identifying the main causes of delay in local systems, and investing the new funding provided via the Access and Systems Capacity Grant and the Delayed Discharges Grant in new ways to reduce those delays and move people into more appropriate places for assessment and care.

7. This guidance should be read in conjunction with the Department of Health’s discharge planning workbook, *Discharge from hospital: pathway, process and practice* (2003).

New duties and responsibilities

8. The Act places certain duties on NHS organisations and councils:

- NHS bodies have a new statutory duty to notify social services of a patient’s ‘likely need for community care services’ (referred to as an ‘assessment notification’) and their proposed discharge date (referred to as a ‘discharge notification’). These measures help to clarify responsibilities and promote good partnership working.
- There is then a defined timescale for social services to complete the individual’s assessment and provide appropriate social care services.
- A reimbursement charge of £100/£120 per day is paid by social services to the acute trust if the fact of social services not having met their obligations – that is, to assess the patient (and carer if appropriate) and provide social care services within the set time – is the sole reason for the delay in discharge from hospital. If any element of the delay is related to NHS areas of responsibility then reimbursement does not apply. Delays should be calculated on a daily basis, although it is a matter for NHS bodies to decide in consultation with councils how and when invoices for delays will be issued.

Dates for implementation

9. From 1 October 2003 NHS acute trusts and councils are expected to operate the system in ‘shadow’ form. In other words, partners should be carrying out the assessment and discharge notification processes to the required timescales, operating multi-disciplinary discharge planning, and identifying where reimbursement charges would be payable, while continuing to identify and invest in solutions to particular local problems which may be contributing to delays.

---

1 This can be viewed online at [www.doh.gov.uk/hospitaldischarge/index.htm](http://www.doh.gov.uk/hospitaldischarge/index.htm) and can be ordered free of charge in hard copy from the website or from Prolog, Department of Health, PO Box 777, London SE1 6XH, fax 01623 724524

2 The list of councils liable to pay at the higher rate is available at [www.doh.gov.uk/jointunit/delayeddischarge/higherratecouncils.PDF](http://www.doh.gov.uk/jointunit/delayeddischarge/higherratecouncils.PDF)
10. From 5 January 2004 the full reimbursement charging regime will apply. From that date councils will be required to reimburse NHS bodies for any delays in arranging transfers of care which are solely the councils’ responsibility.
Delays which are covered by this Act

11. Reimbursement applies to delays in discharging adults who have been receiving acute medical care and who qualify for community care services under the National Health Service and Community Care Act 1990. In this guidance, ‘acute care’ means ‘acute medical care’. Reimbursement applies to those patients who are safe to be discharged subject to being provided with community care services and who are now delayed awaiting provision of those services. A lack of capacity in a community care service does not exempt social services from needing to make alternative arrangements or from their liability to pay reimbursement.

12. The Regulations made to accompany the Act define acute medical care as ‘intensive medical treatment provided by or under the supervision of a consultant which is for a limited time after which the patient no longer benefits from that treatment’. Maternity care, mental health care, palliative care, intermediate care and care provided for recuperation or rehabilitation are excluded from the definition of acute care.

13. Three main principles apply to the definition of acute medical care for reimbursement purposes:

- **The policy is not age-related**, though the majority of people delayed in hospital are older people. Reimbursement applies to all delays in assessment of service provision for adults after an episode of acute care. Delays in children’s services are excluded, because children (i.e. under the age of 18) do not receive community care services as defined in the Act.

- **The definition of acute care is based upon the patient, not the hospital bed**. Variations in capacity may mean that on any one day there are patients receiving acute care who have to be placed on a non-acute ward. It is particularly important that the needs of these patients are not neglected because they are ‘medical outliers’ and thus at a distance from the usual acute discharge planning arrangements.

- **Services are defined as acute in relation to the care the patient is receiving in hospital**. The services they are waiting for are not used to exclude patients from the scope of the Act. So, for instance, if a person with dementia is admitted to hospital for treatment for a broken hip, and their council is unable to provide them with appropriate support to leave hospital, reimbursement is payable.

14. Local partners are also advised to agree between themselves which beds within a Trust count as acute beds (as they should already be doing for SITREP reporting) and how to track acute patients who are cared for outside those acute beds at any one time. This will minimise the risk of

---


4 A protocol on applying this definition of acute care for local partners to use within local systems is available at [www.doh.gov.uk/reimbursement/protocols.htm](http://www.doh.gov.uk/reimbursement/protocols.htm)
later disagreement between health and social care partners and encourage good joint working and communication.

15. It is important to note that reimbursement does not just apply to people who come into hospital via A&E, nor is it just related to people with medical conditions. It also applies to elective patients and surgical patients. In order to minimise reimbursement, it is essential that discharge planning extends to pre-admissions clinics etc., and is not restricted to hospital wards.

16. There may be circumstances where a delayed patient is awaiting another NHS service, e.g. transfer to another NHS facility, transport home, or where NHS services such as pharmacies are involved in the discharge process or a care package. For example, social services may have arranged a package of home care for the person, but the PCT has not arranged the nursing component of the care package in time. In these situations reimbursement does not apply because the immediate cause of the actual delay is a wait for further NHS provision. However, where one service is not available, again, consideration must be given to providing alternative forms of care, at least for a temporary period (see section on alternative forms of care, para. 104). Where social services have made care services available, but actual discharge is delayed because of e.g. the lack of transport or availability of pharmacy, then any social services' liability for reimbursement ceases.

**Mental health**

17. To begin with, reimbursement will apply to patients receiving acute care that is not for mental health, maternity or palliative care needs. Social services will not be liable for reimbursement for delays in transfers from mental health services at the moment and will not become so until Parliament has debated an extension of the provisions of the Act.

18. Reimbursement is only triggered for delays in the provision of services provided by the council following care which is defined in the Regulations as acute care. Some patients will have a mixture of mental health and acute needs. Reimbursement is triggered if the delay is in the provision of council services for post-acute care, for example care home provision for people with dementia who were under the care of an acute medical consultant for a physical condition rather than for their dementia, but not where the patient is under the care of a consultant psychiatrist. This would be the case whether the patient’s mental health condition was known before admission, or only became apparent during their hospital stay. Providing such a patient remained under the care of a consultant in an acute medical specialty, and was not transferred to the care of a consultant psychiatrist, the patient would fall within the scope of the Act. So an elderly person who has broken a hip, seems depressed or confused, and therefore receives an initial check from a psychiatrist as part of their assessment would still be counted for reimbursement. But inpatients with mental health needs within psychiatric hospitals or units would not be.
19. If a person comes into hospital with an acute medical condition, but is subsequently diagnosed with a mental health condition and transferred or re-admitted to the care of a consultant psychiatrist for the remainder of their stay, then delays to that person’s discharge would not count towards reimbursement.

20. In accordance with the Regulations, a separate Order prescribes those health services relating to mental health which are excluded from the provisions of the Act\(^5\). These are defined as psychiatric services, together with any other services provided to a patient for the purposes of prevention, diagnosis or treatment of illness, where the person primarily responsible for arranging those services is a consultant psychiatrist. This definition includes old age psychiatrists, sometimes referred to as psycho-geriatricians. Eligibility should be relatively straightforward to determine as a patient will generally be admitted under the care of an individual consultant, regardless of whether they receive input to their care from other consultants or professionals in the course of their assessment and treatment.

21. None of the provisions in the Act alters existing statutory duties on local authorities and NHS bodies to provide timely and appropriate assessments and services to mental health patients and service users. The principles in the Act, of clear and timely communication between health and social care partners, together with targets for improved access to assessment and services, are equally applicable to mental health patients.

Palliative care
22. Patients receiving specialist palliative care, for example in hospices or palliative care units, are also currently excluded from the definition of acute care, because in many cases they will continue to be the NHS’s responsibility whichever setting they move to. This does not mean that their discharge should not be planned according to good practice as outlined in *Discharge from hospital: pathway, process and practice*. Further work will be undertaken on whether the principles of reimbursement will benefit this group of patients in terms of securing them the further care of their choice. (See also para. 54 on patients near death.) Further information on good practice in this area is being developed by the National Institute for Clinical Excellence, and is due to be published in February 2004. The draft *Guidance on Cancer Services: Improving Supportive and Palliative Care for Adults with Cancer* has sections on social support services and general and specialist palliative care\(^6\).

---

\(^5\) The Mental Health Order is published at [www.legislation.hmso.gov.uk/si/si2003/20032276.htm](http://www.legislation.hmso.gov.uk/si/si2003/20032276.htm)

\(^6\) *Guidance on Cancer Services. Improving Supportive and Palliative Care for Adults with Cancer*. This draft guidance has sections on social support services and general and specialist palliative care. A consultation draft is available at [www.nice.org.uk/pdf/supppalldraftmanual.pdf](http://www.nice.org.uk/pdf/supppalldraftmanual.pdf)
Patients delayed in community beds
23. It is doubtful that under the current regulations reimbursement will apply to patients delayed in community, or other ‘step-down’ beds, as these patients are unlikely to be receiving acute care involving intensive medical input.

Patients delayed in PCT-managed beds
24. As above, reimbursement is not likely to apply, as beds managed by PCTs are not generally beds in which patients receive acute care. Careful note must be paid to each element of the definition of acute care in the Regulations; a weekly visit by a consultant does not constitute ‘intensive medical treatment’. However, PCT-managed care of the elderly beds within an acute hospital, where the PCT was responsible for staff and budgetary management, would be a legitimate if rare example of a PCT managing acute beds. Patients treated in such beds would therefore come within the scope of the Act.

Patients delayed in specialist, tertiary centres
25. The definition of acute care in the Regulations applies equally to secondary, tertiary and specialist NHS hospitals. As with all other delays, patients delayed in specialist or tertiary beds will fall within the reimbursement system if they were admitted to hospital with acute care needs, as defined in the Regulations and covered by a local acute care protocol, and are waiting for council community care services.

Private patients
26. The definition of ‘prescribed care’ used in the Regulations does not apply to patients who are paying for their own care, either directly or via a health insurance scheme. This means that patients who are receiving private acute medical treatment, whether or not this is provided at an NHS hospital, do not fall within the scope of the Act. However, patients who are admitted to NHS hospitals as private patients but who subsequently elect to change their status and become NHS patients while still receiving acute medical treatment fall within the scope of the Act from the point at which they start to be treated as NHS patients.

NHS patients treated in independent hospitals
27. NHS patients can receive acute treatment which is arranged and funded by an NHS body, but takes place in an independent sector hospital. Such patients fall within the reimbursement system if they are delayed in an acute bed awaiting local authority community care services. The Act allows an NHS body which has commissioned acute treatment at an independent hospital within the UK to make arrangements for the independent provider to issue assessment or discharge notifications on its behalf. This means that independent providers can take decisions such as whether the patient is likely to need community care services, when the patient is to be discharged, what follow-up health needs they may have, etc. However, the NHS body will retain ultimate responsibility for the functions that are carried out on its behalf and the services that are
provided and will want to be certain that the independent provider is able to carry out any delegated duties.

28. It is for the commissioning NHS body to decide whether it wishes an independent provider to carry out these duties on its behalf and then to work with the independent provider to ensure that they are aware of their duties around issuing notices and have any necessary support and information to do so. If the NHS body does not put such arrangements in place, it will need instead to arrange for the independent provider to inform the NHS trust or PCT which commissioned the private treatment in order for that trust or PCT to issue the assessment and discharge notifications as the private provider could not directly inform social services within the meaning of the Act that a patient seemed likely to need community care services after discharge. All these arrangements should be set out in the NHS body’s contract with the independent provider.

29. The Act requires delayed discharge payments to be made to the NHS body which has arranged or provided the care. If an NHS patient is delayed in an independent hospital awaiting community care services the delay will attract the normal daily charge. The NHS body which commissioned the treatment and not the independent hospital itself will then invoice the relevant social services department. The NHS body will need to bear in mind issues around paying an independent provider for extra days of hospital stay when setting up contracts.

Patients ordinarily resident in Wales, Scotland and Northern Ireland

30. The provisions of the Act relating to reimbursement are being implemented in England only at present; although the National Assembly for Wales has the option of implementing them in Wales, it has no intention of doing so for the foreseeable future. This means that if a patient ordinarily resident in Wales is delayed in an English hospital, that delay cannot be charged for, and vice versa.

31. As neither Scotland nor Northern Ireland is covered by the provisions of the Act, patients ordinarily resident in these countries do not fall within the reimbursement system.

Asylum seekers and other foreign nationals

32. The basic principle to be applied here is that where councils are responsible for providing community care services for an individual, they are also liable to pay reimbursement for any delays in providing assessments or services to that individual when they have been admitted to hospital for acute care.\(^7\)

People of no fixed abode

33. Where delays occur for people of no fixed abode, the crucial issue is to identify the council responsible for providing them with community care

\(^7\) Guidance on councils’ responsibilities in providing community care services to asylum seekers and other foreign nationals is available at [www.doh.gov.uk/jointunit/asylums54clarification11mar03.pdf](http://www.doh.gov.uk/jointunit/asylums54clarification11mar03.pdf)
services. If they are admitted to hospital from a public place then the postcode of that place should be used to identify the council responsible. That social services authority is liable for reimbursement if the person is delayed in hospital due to a failure to assess them or provide services to enable them to leave hospital safely. However, if the patient were waiting only for accommodation rather than for adaptations to existing accommodation or other community care services arranged or provided by the council, reimbursement would not apply, as housing is not a community care service.

---

8 A search tool to identify the relevant council for any given postcode in England is available at [www.doh.gov.uk/reimbursement/links.htm](http://www.doh.gov.uk/reimbursement/links.htm)
Assessments and service provision

Multi-disciplinary assessments

34. Effective discharge planning for patients with complex needs is best achieved with input from a variety of professionals: nurses, occupational therapists and social workers alongside clinicians. The multi-disciplinary team, including representatives from social services, should be involved in the discharge planning process as early as possible. It is not necessary to wait for a clinical decision of ‘medically fit’ before referring for assessment of needs and most appropriate care options for patients after leaving acute care. However judgement will be needed about the most appropriate time to begin the assessment. Good practice means that interdisciplinary communication about the patient’s needs should take place as early as possible. The formal assessment notification should be given when professionals judge that an accurate assessment can be made of the care the person may need when they leave hospital. Similar judgements should be made where there is a delay in gaining the patient’s agreement to co-operate with the assessment.

35. If the patient is unsure about the extent to which they wish to involve social services in assessing their needs, or if they wish to wait for family views not immediately available, then firstly the NHS should make a judgement about the potential length of the hospital stay and whether waiting for confirmation will significantly constrain the time available for assessment and planning before discharge. If it will, or if the patient’s acute health needs have already been met, consideration could be given to completing the assessment from home or from a non-acute setting. NHS and social care staff should take a joint approach to interim arrangements that move the patient from the acute bed.

36. The Act makes clear that the assessment for discharge is part of the existing arrangements for community care assessment (under section 47 of the NHS and Community Care Act 1990), but not necessarily all of it. Assessments for community care services and for discharge should be carried out as part of the Single Assessment Process, as described in the National Service Framework for Older People (DH 2001) or as part of equivalent assessment processes for other adults. Assessment for discharge covers the services needed to allow the patient to move from the acute bed – a further assessment may then be needed to put in place a longer term package of care or the next step, e.g. from intermediate care to home.

37. The patient’s accommodation is a key element in the decision that it is safe to discharge. Where the care package is to be eventually delivered in the person’s own home, the home environment should be considered as part of the assessment. Social services, or joint teams where these

---

9 For further guidance see the Reimbursement Implementation team’s protocol on safe transfer, www.doh.gov.uk/reimbursement/pdf/safetotransferprotocol.pdf

10 The NSF is available at www.doh.gov.uk/nsf/olderpeople/docs.htm
are in place, should be able to arrange the prompt provision of aids and minor adaptations where these are needed to enable a safe discharge, and ensure that heating facilities are adequate.

38. Where more major adaptations or alternative housing arrangements are needed, social services staff should inform and work with housing counterparts to arrange the necessary services. In these circumstances a reassessment and alternative interim care plan will often be appropriate whilst the patient waits for their home to be ready. It remains the duty of social services to make such interim provisions if the patient is deemed to be a vulnerable adult, as remaining in an acute bed whilst long-term adaptations are made is not an appropriate care option. Social services are deemed liable for reimbursement for delays in the arrangements of interim social care provision in these circumstances.

39. For further advice on effective multi-disciplinary discharge planning, see the updated discharge planning workbook, *Discharge from Hospital, pathway, process and practice.*

**Assessment for NHS continuing healthcare and reimbursement**

40. Directions will be issued to the NHS during autumn 2003 requiring the NHS to assess a patient’s needs for fully funded NHS continuing care against SHA eligibility criteria before an assessment notification (section 2 notice) is issued. This new requirement responds to comments in the Ombudsman’s report on continuing care regarding assessment procedures at the point of hospital discharge.\(^{11}\)

41. The NHS body must notify the patient of the final assessment decision and record it in the patient’s notes. If assessment at this point does not indicate the need for fully funded NHS continuing care, assessment notification and discharge planning can begin. If assessment at this point does indicate the need for fully funded NHS continuing care (or other NHS services, including intermediate care) an assessment notification should not be issued because social care will not be needed. Any delays in providing assessment or services for patients in this category are not subject to reimbursement because no assessment notification will have been issued.

42. If a patient asks for a review of the decision not to provide fully funded NHS continuing care this should take place within 14 days. During this period the patient remains the responsibility of the NHS and no delay accrues to social services. If the original decision not to provide fully funded NHS continuing care is upheld, assessment notification can be made (if necessary) and discharge planning resume.

43. In cases where it is unclear following assessment that the patient needs fully funded NHS continuing care, an assessment notification should be issued where it is considered unlikely to be safe to discharge the patient.

\(^{11}\) Available at [www.doh.gov.uk/jointunit/ccc.htm](http://www.doh.gov.uk/jointunit/ccc.htm)
without the provision of community care services. The assessment notification should make it clear that the patient may be eligible for fully funded NHS continuing care in the future. If at any future point the patient is assessed as needing fully funded NHS continuing care, any notice issued should be withdrawn and the reimbursement clock stopped (see paragraph 83 on withdrawing notices).

44. The assessment for fully funded NHS continuing care should be informed by the principles of the single assessment process. Assessment should be proportionate to the presenting needs of the individual. It should make full use of the multi-disciplinary team, including social services, and adhere to any well established local protocols. The input of a consultant geriatrician should always be available and called upon whenever indicated.

45. Once it is confirmed that a patient is eligible for fully funded NHS continuing care, clinicians and commissioners should discuss with the patient and their family/carer where this care could be provided, and take these views into account when arranging services. The availability of GP prescribing, community nursing, transport and out of hours services should be considered before discharge from hospital. Fully funded NHS continuing care may be provided, subject to clinical advice, in a range of settings: a nursing home, hospice, at home or in hospital.

Carers’ assessments

46. Full involvement of patients and their carers in both assessment and care planning has long been recognised as good practice and included in guidance. In addition, carers are entitled under the Carers and Disabled Children Act 2000 to request an assessment of their needs in supporting the person they care for, including following hospital discharge of that person. It is in any case good practice that an assessment is offered to a carer who is going to be involved in providing part of the care package in order for the council to be sure that the caring relationship is sustainable.

47. Those elements of a carer’s assessment which relate to the patient’s discharge should be undertaken in the same assessment timescales laid out in the Regulations for patients. Just as assessment for discharge need not be a full community care assessment, a carer’s assessment related to a patient discharge may be only part of a full assessment which continues after the patient is discharged. Where the carer will be undertaking lifting, or other tasks that need training to ensure that the carer or patient is not put at risk, staff should ensure that appropriate training is provided.

Importance of avoiding over-referrals

48. Not everyone who is admitted to hospital will need community care services after discharge. Only those patients who are likely to need community care services should be referred to social services. Equally, there are
risks to patients’ health if they are discharged without a thorough assessment of their needs and are subsequently unable to cope when they return home. It is important that staff exercise informed judgement about when to refer patients on, in order that social services assessments and service provision is targeted effectively. A local protocol which allows NHS staff to identify those likely to need referral to social services will help streamline the process\textsuperscript{12}.

49. The same aims should apply: the scale and depth of assessment should be in proportion to people’s needs; agencies should not duplicate each others’ efforts, and processes make the most effective use of professionals’ respective expertise and resources\textsuperscript{13}.

\textit{Information sharing and patient confidentiality}

50. Staff working across different agencies will need to exchange information on patients’ needs and circumstances so as to work effectively together and avoid repeat questioning of patients and their carers. The principle of informed consent should always be adhered to and NHS staff should be sure that consent has been received before sharing confidential personal information with social services. This can helpfully be discussed with the patient and carers as part of explaining the processes of assessment and referral for services\textsuperscript{14}. The content of the assessment notification required by the Regulations is a minimum of information and does not require patient consent.


\textit{Safe to assess, safe to transfer}

52. Reimbursement focuses on the importance of finding alternatives to acute wards for patients once they are no longer in need of acute care.

\textsuperscript{12} A draft protocol for local adaptation is available at www.doh.gov.uk/reimbursement/pdf/notification\%20protocol29may03.pdf
\textsuperscript{13} Information on the Single Assessment Process is available at www.doh.gov.uk/scg/sap/index.htm
\textsuperscript{14} See protocol on involving patients and carers at www.doh.gov.uk/reimbursement/pdf/involvement08august.pdf
\textsuperscript{15} Available at www.doh.gov.uk/confiden/cgmcont.htm
\textsuperscript{16} Available at www.info.doh.gov.uk/doh/coin4.nsf/12d101bf4f7b73d020025693c005488a9/53dfe466285588dc00256b52002e472c\$FILE\%2lac.PDF
More general guidance on confidentiality and patient consent can be found at www.doh.gov.uk/ipu/confiden/index.htm
Remaining on an acute ward once acute care is no longer needed represents a risk of infection and a loss to independence for patients. However, no patient should be moved until they have been assessed as medically stable and safe to transfer. Furthermore, staff should be aware that repeated transfers to different environments can be distressing and confusing for patients. The decision to transfer should be one of balancing risks – the risk of remaining in an inappropriate environment, versus the risk of moving somewhere else.

53. There are particular issues relating to transferring patients with dementia. Further information and advice on good practice in this area is available from www.doh.gov.uk/changeagentteam/moving_pwd.pdf

**Specific patient categories**

**Patients near death**

54. Not all patients near death will be receiving palliative care and they may have a strong preference to return home or to be cared for in a residential setting. This choice should be the guiding principle in discharge planning for all patients nearing the end of their life and obviously community services should be put in place quickly if the person wishes to return home. Where these patients meet fully funded continuing care criteria they will continue to be the NHS’s responsibility and as such will not enter the reimbursement system. However, if they (or their carer) need a care package which includes services from social services, then social services are potentially liable for reimbursement if these are not in place by the discharge date.

**NHS-funded nursing care**

55. In making placements to care homes providing nursing care, delays are sometimes caused waiting for Registered Nursing Care Contribution (RNCC) determination or confirmation of NHS funding. If these are not finalised before the patient is ready for discharge, social services are not liable. To be liable for reimbursement, it must be social services provision and only social services provision which is not available. Once these NHS responsibilities are complete, social services become liable if the patient is ready for discharge and is not transferred to the care home. This includes instances where funding and RNCC are confirmed but there is no place available in an appropriate care home. The council remains responsible for ensuring adequate capacity of accommodation for residents. It is important that patients receive appropriate care, and delays due to lack of capacity in care homes providing nursing care indicate that PCT and social services partners need to consider how they can commission further capacity to meet the needs of individuals who need this level of care.

---

17 Further advice on ‘safe to transfer’ issues is available at www.doh.gov.uk/reimbursement/pdf/safetotransferprotocol.pdf
56. Even if the service that is not available is a jointly commissioned or provided one, it should be possible to identify which elements are provided in pursuance of NHS functions and which in pursuance of community care functions. If the only parts of the package which are not ready are the community care functions, then, regardless of the partnership arrangements in place, the council would be liable for reimbursement charges. If the NHS and the council jointly commission a care package to meet both health and social care needs, and that package is not available, then the NHS and council together will have to consider providing an alternative. The council is not responsible for the delay until all the health parts of the package are in place, so it will be up to both partners to work hard to provide an alternative. In legal terms, even where partnership arrangements are being operated, it is still possible to identify which body's function is being met by the provision of any particular service, and that body will be responsible if the lack of that service is contributing towards the delay.

57. The intention is eventually to apply the reimbursement regime to other NHS services. This reinforces the need for whole system capacity planning and commissioning.

Patients who are responsible for or will be paying for their onward care

58. All patients are entitled to an assessment for community care services, arranged and provided by the local authority ‘Fair access to care’ guidance from the Department of Health provides more information on councils’ obligations to clients.\(^\text{18}\)

59. The term ‘self-funder’ is often used to describe a range of different situations including where social services charge the client for the full cost of their care. It is therefore important to be very clear about the precise circumstances of the patient since responsibility and liability for reimbursement will vary accordingly:

\(i\) Full contributors for whom the LA has assessed and arranged care

For some people, the council will both undertake an assessment and arrange services, but the patient will be assessed as liable for paying for the full or partial cost of these services. Regardless of whether service users are required to pay for the council service, if there is a delay in assessment for or provision of that service, then reimbursement is payable.

\(ii\) Patients assessed by the LA

Some individuals receive an assessment from the council, but patients or their families then take responsibility for making and funding their own arrangements for their care. In these circumstances, councils are liable for delays in assessment only. They are liable for reimbursement if assessment is not completed by the relevant day after the assessment notification being issued or the day after the proposed date of discharge.

\(^{18}\) See www.doh.gov.uk/scg/facs/
given in the discharge notification, whichever is the later (see para. 71 on
the timing of issuing notices).

Recent changes to the means test for those who need to enter a care
home, such that the value of any property is disregarded for 12 weeks,
mean that councils are now responsible for a large proportion of patients
who need to enter a care home when they leave hospital. Also, if the
patient wishes social services to arrange care in their own home, social
services are responsible for this. They are liable for reimbursement if
services are not available within approximately 3 days of the assessment
notification being issued, or the day after the proposed date of discharge
given in the discharge notification, whichever is the later.

iii) Patients with no involvement from social services
Where individuals choose to have no involvement with social services
and go on to fund their own care, councils have no liability for reim-
bursement for delays.

iv) Patients with a “direct payment” from social services
If the delay is due to social services’ processes then councils will be
liable for reimbursement. Delays in arranging services via direct pay-
ments should not be a reason to keep the patient in an acute environ-
ment; similarly, the need to ensure prompt hospital discharge should not
be a reason to pass over the option of direct payments. It may be approp-
riate for councils to arrange an interim package of care in the short-term
to enable timely discharge from hospital, with a view to arranging direct
payments in the medium to long-term. If however social services have
fulfilled their responsibility and the delay continues for other reasons then
the council will not be liable.

v) Individuals who want to make their own social care arrangements
Such patients may want to do this without social services involvement but
the hospital considers they could benefit from social services advice. In
these circumstances the hospital staff may invite social services to pro-
vide information to support the hospital’s patient advice service in achiev-
ing timely discharge.

If the council has been involved in providing advice only, delays in such
cases should not count towards a reimbursement liability. The intention
of the Act is not to introduce perverse incentives to disrupt flexible local
arrangements which facilitate timely discharge. Hospitals may however
want to consider strengthening their patient advice/PALS services around
discharge planning. Meanwhile staff should explain to patients that even
if they have taken responsibility for arranging or providing care after hos-
pital discharge, if at any time their care arrangements break down, they
can contact the council for help.
Assessment notifications

Content of notices

60. Section 2 of the Act requires an NHS body to notify social services of a patient’s likely need for community care services after discharge. A notification of need to assess may be issued up to eight days before the day of admission, when known, if it is anticipated that the patient will need community care services after discharge.

61. The information contained in an assessment notification is intended to be minimal, both to reflect patient confidentiality requirements and to minimise bureaucracy – it is only the trigger for assessment and care planning. Local development of the Single Assessment Process and agreements on information sharing means that local protocols can be developed to share more information at this point in order to streamline processes.

62. Assessment notifications must be reproducible in a written form so that in cases of dispute there is no doubt about whether or not a notice was issued. However, while it important to establish an audit trail, the systems which NHS bodies and councils set up around issuing notices should not impede good working practice. Where hospitals and councils are already operating joint discharge teams which are often co-located in the same office with access to a shared database, an update to the database may be all that is required.

63. Local partners will need to give some consideration to the best way of establishing regular and effective communication\(^\text{19}\).

64. It should be noted that it is the content of the notices that is important, not the format. As long as the required information as set out in the Regulations is provided with a clear statement that it is being issued under section 2 or 5, any format may be used which allows for a written record to be produced\(^\text{20}\).

Identifying ordinary residence

65. One of the new NHS responsibilities covered in the Act is a duty to identify the patient’s responsible council, so that assessments and service provision can be arranged promptly and charges, where due, are invoiced to the correct council. Notices should be issued to the council in which it appears to the NHS body that the patient is ordinarily resident at the time (for patients of no fixed abode, see paragraph 33). The NHS body is not required to undertake lengthy investigations to establish with

\(^{19}\) A checklist on establishing a notification protocol is available at www.doh.gov.uk/reimbursement/pdf/notification%20protocol29may03.pdf

\(^{20}\) Further information on the contents of the notices, including sample assessment and discharge notifications which may be copied or amended, is available at www.doh.gov.uk/reimbursement/notification.htm
certainty which council this is, but it must make reasonable efforts to identify which council is responsible, and then serve notice to it. If an NHS body has to withdraw a notice which was issued to the wrong council and then reissue a notice to the correct one, it risks causing a delay in the patient’s discharge, as the time allowed for the assessment and care planning process starts again for the new council (see paragraph 87 on withdrawing notices).

66. A mapping tool to identify the relevant council for any given postcode in England is available on the STEIS information system and is also available on the reimbursement website\(^{21}\). This will usually indicate the relevant council, apart from circumstances where the patient has been placed in a care home by another council, or has given a temporary address.

67. If a council receives an assessment notification in respect of a patient who it believes is ordinarily resident elsewhere, it should inform the issuing NHS body, which should withdraw the notice if it agrees with the council’s opinion. If the NHS body does not agree and the matter cannot be resolved locally and informally, the council receiving the assessment notification must proceed with assessment and care planning as if it were the responsible authority, as set out in the existing guidelines covering ordinary residence.

68. Local authority circular LAC(93)7, *Ordinary Residence*, contains guidance on ordinary residence issues\(^{22}\). The Department of Health will be updating this circular in 2004. This will clarify a number of issues, but will not change the underlying position with regard to the requirement that a local authority must take responsibility for providing care to a person while a dispute about ordinary residence is ongoing.

69. If it becomes clear after social services have already started the assessment and planning process that the wrong council has been informed, again it is the responsibility of the hospital to withdraw the assessment notification and reissue to the correct council. If ordinary residence is not resolved until after services have been provided or reimbursement has been paid, the council which has been dealing with the case is entitled to reclaim the costs incurred in providing services or any reimbursement payments, if made, from the correct council.

70. Where an ordinary residence dispute involves a Welsh council and an English council, it is the country in which the patient is located which will indicate who has responsibility for determining ordinary residence. If the individual is physically present in England, the Secretary of State will make the determination. If the individual is in Wales, the National Assembly for Wales will be responsible. The Department of Health will

\(^{21}\) Available at [www.doh.gov.uk/reimbursement/links.htm#la](http://www.doh.gov.uk/reimbursement/links.htm#la)

\(^{22}\) Available at [www.info.doh.gov.uk/doh/coin4.nsf/12d101b4f7b73d020025693c005488a9/4f8d980824ea8b4000256ab200500f80/$FILE/LAC(93)7.pdf](http://www.info.doh.gov.uk/doh/coin4.nsf/12d101b4f7b73d020025693c005488a9/4f8d980824ea8b4000256ab200500f80/$FILE/LAC(93)7.pdf)
be publishing more detailed information on this issue. This will be available on the reimbursement website.

**Timing of issuing assessment notices**

71. For assessment notifications, the Regulations require that notices issued after 2pm are to be treated as having been issued on the following day.

72. If a notice is treated as having been issued on the following day, and that day is excluded under special arrangements for Sundays and public holidays in place until 31 March 2005, the notice will count as having been issued on the next non-excluded day (see paragraph 82 on weekends and public holidays).

73. In legal terms, a notice counts from the time it is received at the intended recipient’s address. In some cases this may be earlier than the time it is actually seen by the recipient. This means that NHS bodies and social services will need to make sure that notices are sent by rapid means such as e-mail or fax. They will also need to consider ways of making sure that notices can be collected regularly by the recipient, i.e. that faxes and e-mail accounts are checked frequently and arrangements are in place when the usual member of staff who receives e-mails is absent.

74. However, to avoid disputes around whether a notice was received before or after the cut-off time, the NHS body should consider making sure that notices are sent well in advance. In this way, social services has the maximum amount of advance warning to perform assessments and arrange services, and it is more likely that patients will leave NHS care without delays.

75. The NHS body may still wish to inform social services verbally of a patient’s need for community care services, and in hospitals where there are joint discharge teams this will obviously be the most sensible way to proceed. However, a formal record must be kept to show that the assessment notification has been passed to social services.

**Minimum interval for assessment**

76. The Act refers to a minimum interval after an assessment notification has been issued. This is the minimum period provided for a council to assess a patient and arrange services and is set at 2 days. A council cannot be charged for a delay before the minimum interval has elapsed.

77. However, there are actually very few patients for whom a payment would be liable immediately after the minimum interval, since the majority of patients likely to need services upon discharge are older people and will remain in hospital for longer than three days. Assessment and planning

*For further guidance on timelines for reimbursement, including the minimal interval, see the paper at [www.doh.gov.uk/reimbursement/pdf/notificationissuing.pdf](http://www.doh.gov.uk/reimbursement/pdf/notificationissuing.pdf), which includes a weekly planning chart.*
can take place throughout the patient’s hospital stay. Where it is obvious that the hospital stay may be lengthy, the NHS body should use its judgement about the timing of issuing an assessment notification, so that social services can make a meaningful assessment of the individual’s needs after discharge.

78. Because the Act requires assessment notifications issued after 2pm to be counted from the following day, this 2 day period is extended by a certain number of hours, depending on the time at which the assessment notification was issued. The Regulations also provide that charging does not start until 11am on the day following the proposed day of discharge and social services have until this time to put services in place for the patient or carer.

79. If the NHS body issues a discharge notification (see paragraph 108) with a proposed discharge date which falls inside this minimum period, charging will not start until the minimum period has elapsed with the patient still remaining in acute care. The charge will therefore apply from 11am on the day after the proposed discharge date identified by the NHS in the discharge notification, or three days after social services have been given an assessment notification of a patient’s likely need for community care services, whichever is later. Both assessment and discharge notifications must be in force for charging to start. If services are not in place after 11am, the full daily charge will apply for that day and onward.

80. There may be individuals with complex community care needs whose care plan cannot be drawn up quickly and yet who are medically safe for discharge within the minimum interval or soon after. However, an acute ward is still not the correct place for patients to remain whilst their onward care plan is arranged. Health and social care partners should consider transferring the patient to some form of interim or step down care whilst the care planning is completed (see section 104 on alternative forms of care).

81. Those elements of the carer’s assessment which relate to the patient’s discharge should be undertaken in the same assessment timescales laid out for patients.

Saturdays, Sundays and public holidays

82. Both the NHS and social services should be moving towards 7-day, extended hour services and patients should not have to remain in hospital over the weekend due to the unavailability of either NHS or social services assessment or provision. However, it is recognised that this cannot happen instantly.

83. Under special arrangements in place until at least 31 March 2005, the Act provides that Sundays and public holidays do not count as part of the minimum interval. In addition, the Regulations provide that Sundays and
public holidays are excluded for the purposes of issuing notices, and do not count as the first day of the delay.

84. This means that if a notice is issued on a Sunday or public holiday, it will count as having been issued on the next non-excluded day. Similarly, if the day after the proposed discharge date is a Sunday or public holiday the delay will not count for charging purposes unless services continue not to be in place by 11am on the next non-excluded day.

85. However, from implementation of the Act onwards, Sundays and public holidays are not excluded from charging for a delay which has already started. There are no special arrangements under the Act for Saturdays, unless Christmas Day falls on a Saturday.

86. Further information on the minimum intervals and the earliest time at which charging can start when an assessment notification is issued on any given day is available at www.doh.gov.uk/reimbursement/pdf/notificationissuing.pdf

Withdrawing notices

87. There may be occasions when it is necessary to withdraw the assessment or discharge notifications. Health and social care partners should agree on a process for this – to minimise bureaucracy, a phone call backed up by a brief written record may be all that is required.

88. For assessment notifications, the Regulations require the NHS body to withdraw the notice in certain circumstances. This is to make sure that social services do not continue needlessly to arrange a care package when the NHS body is aware of changes. Of course in many cases it will actually be social services who are aware of these changes and inform the NHS, who then must withdraw the notice. These circumstances could be that the patient has made arrangements of their own, is actually resident in a different council, or will not be admitted to hospital at the expected time. Alternatively, for one reason or another, the package of care arranged by social services may be inadequate for the safe discharge of the patient and further care planning may be necessary. The NHS body may also decide that, contrary to what it originally thought when issuing the assessment notification, the patient actually requires NHS continuing health care (see paragraphs 40-45 on continuing care).

89. If a patient dies or discharges themself after the assessment notification has been issued, the notice ceases to have effect at that time. Any days of delay which have accrued will also stop from this point. The NHS body should inform social services that a patient has died or left hospital.

90. The NHS body may later issue a fresh assessment notification if the patient’s circumstances make this necessary. Reissue of an assessment notification restarts the assessment process from the beginning with a fresh minimum interval.
91. If a notice is withdrawn and has not been reissued, a council will not be liable for any days of delay.

92. Withdrawing notices should be done as simply as possible while still ensuring effective communication.
Patient and Carer Involvement

Consent

93. The Act requires the NHS body to consult the patient before making a referral to social services. Many patients will want this as a matter of course. However, the patient may be clear that they do not wish to be referred to social services or may state they do not need social services’ involvement because their family will look after them. But before deciding not to issue a notice, the NHS body should establish whether a patient who says they can manage alone will be safe to discharge without social services’ support or whether the patient’s carer(s) are genuinely able and willing to provide all the support required e.g. checking with the patient’s family or GP that support is available to the patient once at home. The NHS body should issue an assessment notification if this is not the case and will need to explain further to the patient and carer(s) their concerns. The situation might be helped by explaining that they could find it useful to discuss the options with social services and do not have to accept any services which are offered.

94. If the patient is clear that they do not want the involvement of social services and that they will not accept the services put in place for them, at this stage the patient becomes responsible for arranging their own onward care. Up to that point, following an assessment notification, social services should make all reasonable efforts to perform an assessment and prepare a care plan, however limited that might be. If they then offer those services and these are unreasonably rejected, they have fulfilled their responsibility and are not liable for reimbursement charges after that point.

95. If the patient still refuses any help from social services, then the NHS will need to consider providing NHS services to help the patient go home safely. If the reason for the delay continues to be the non-cooperation of the patient, then as long as community care services are available, albeit refused, the council cannot be charged.

96. Full involvement of patients and their carers in both assessment and care planning has long been recognised as good practice and included in guidance. Where the patient lacks the capacity to be fully involved both NHS and social services are expected to act in the patients’ best interests. Obviously they should be informed and consulted about future care arrangements and all reasonable efforts made to take their wishes and concerns into account. If they are unhappy with the outcome of their assessment or care plan, they should have access to the appropriate complaints procedure. In the meantime, patients do not have the right to stay in an acute hospital bed if they no longer need that type of care and the NHS and social services will need to consider providing suitable non-
acute care (see para.104 on alternative care arrangements)\textsuperscript{24}. See Annex A on the issues around reasonableness and adequacy of care plan arrangements.

\textit{Direction on Choice}

97. The provisions of the Direction on Choice continue to apply to patients leaving hospital for a place in a care home. Health and social care systems should put in place locally agreed protocols on patient information incorporating how the issue of patient choice will be dealt with. These should make it clear that an acute bed is not an appropriate place to wait and the alternatives that will be offered. Where social services are responsible for providing services and a person’s preferred home of choice is not immediately available, they should offer an interim package of care. All interim arrangements should be based solely on the patients assessed needs and sustain or improve their level of independence. If no alternative is provided which can meet the patient’s needs, social services are liable for reimbursement.

98. Social services should take all reasonable steps to gain a patient’s agreement to a care package, that is to provide a care package which the patient can be reassured will meet the needs identified and agreed in the care plan. In doing this social services must ascertain all relevant facts and take into account all the circumstances relevant to the person, and ensure that the patient (and family, carers or advocate) understands the consequences of failing to come to an agreement.

99. If the patient continues to unreasonably refuse the care package offered by social services they cannot stay in a hospital bed indefinitely and will need to make their own arrangements so that they can be discharged safely. If at a later date further contact is made with social services regarding the patient, the council should re-open the care planning process, if it is satisfied that the patient’s needs remain such to justify the provision of services and there is no longer reason to think that the patient will persist in refusing such services unreasonably. Councils may wish to take their own legal advice in such circumstances.

100. Where appropriate alternative services, which take account of the patient’s views, have been offered, and active encouragement given to the patient to transfer, but they unreasonably refuse to move to the alternative, social services will not be held responsible. See Annex A on issues around reasonableness. It is important to ensure that patient and carers (where appropriate) have been involved throughout, their views taken into account, and that they understand the consequences of continuing to refuse services.

\textsuperscript{24} Further information on issues around patient and carer consultation, consent and involvement is available at \url{www.doh.gov.uk/reimbursement/qandabill.htm}

102. A protocol checklist dealing with patient communication in relation to discharge arrangements and choice is available at [www.doh.gov.uk/reimbursement/pdf/involvement08august.pdf](http://www.doh.gov.uk/reimbursement/pdf/involvement08august.pdf)

103. The Department of Health is currently consulting on new guidance on the Direction on Choice\(^{27}\). This clarifies a number of issues, but does not change the underlying position.

**Using alternative forms of care**

104. In many cases where patients cannot immediately move on from acute care, whether they are waiting for a place in a care home, for family members, carers or an advocate to visit and be involved in any decisions, or for home adaptations to be completed, NHS and social care staff should take a joint approach to providing interim arrangements which allow the patient to move from the acute bed. This interim care could be a period of intermediate care, NHS step-down care provided in a non-acute bed, or extra support in the person’s own home. For patients who require care in a care home, it is established good practice that where possible people should not move directly from a hospital to a care home for the first time, but should have a period of time to make personal arrangements and adjust.

105. Options for interim care should be considered and offered based on assessed needs, with a full explanation to the patient of the terms of the interim package, including any charges which may apply. Councils should take all reasonable steps to gain an individual’s agreement to an interim care package, that is, to provide a care package with which the individual is satisfied. As with a permanent care package, if an individual continues to unreasonably refuse an interim care package which the council has offered, having taken the patient’s circumstances into account, the council is entitled to consider that it has fulfilled its statutory duty to assess and offer services, and may then inform the individual they will need to make their own arrangements.

\(^{25}\) Available at [www.info.doh.gov.uk/doh/coin4.nsf/12d101b4f7b73d020025693c005488a9/ab0dd25da1478a3800256a11003e1442/$FILE/lac(92)27.pdf](http://www.info.doh.gov.uk/doh/coin4.nsf/12d101b4f7b73d020025693c005488a9/ab0dd25da1478a3800256a11003e1442/$FILE/lac(92)27.pdf)


\(^{27}\) See [www.doh.gov.uk/directiononchoice/index.htm](http://www.doh.gov.uk/directiononchoice/index.htm)
106. If a council arranges a period of residential care for a patient, care charges are governed by regulations\textsuperscript{28}. Where this is intermediate care, regulations under Part 2 of this Act exclude charging for the first six weeks. For temporary residential care councils have discretion on charging for the first 8 weeks of the stay. If a council arranges a non-residential community-based service, for example a period of intensive support in the person’s own home, councils have discretion whether or not to charge. If necessary, this initial period after discharge can be used to ensure that an assessment is completed and any further services are arranged.

107. If a patient is discharged from hospital or intermediate care to a home care package, whether that is an interim measure or on a long-term basis, social services should check the adequacy of the care package within at most two weeks of discharge. This should ensure the patients are suitably cared for and are not, for example, unable to cope and at risk of a deterioration in their condition or readmission to hospital.

\textsuperscript{28} Available at www.legislation.hmso.gov.uk/si/si1992/Uksi_19922977_en_1.htm. See also the associated Charging for Residential Accommodation Guide (CRAG), available at www.info.doh.gov.uk/doh/point.nsf/66b6f04bdca6defc0025693b0051ada0/f2a99ee868e72be380256cfa00491afc/$FILE/cragmar03.pdf
**Notification of discharge date**

108. Section 5 of the Act requires the NHS body to notify social services of the proposed date of the patient’s discharge. Patients and carers should be informed of the discharge date at the same time as, or before, social services. In addition hospital staff may give social services an early indication of when discharge is likely to be to help with planning, but a formal discharge notification must be issued to give confirmation of the intended date.

109. The Regulations require that notices issued after 2pm on Fridays, and 5pm on other days, are to be treated as having been issued on the following day. To ensure that a council receives fair advance warning of the discharge, the NHS body must issue the discharge notification at least one day before the proposed discharge date given in the notice, i.e. by 5pm on Thursday if the discharge date is the Friday, or by 2pm on Friday if the discharge date is the Saturday. Obviously the NHS body can issue the discharge notification with a much longer period of advance warning, but it will need to consider the likelihood of such a date being inaccurate and then needing to withdraw and reissue the discharge notification. Both assessment and discharge notifications must be in force for charging to start. If services are not in place after 11am, the full daily charge will apply for that day and onward. If the day after the proposed discharge date is a Sunday or public holiday the delay will not count for charging purposes unless services are not in place on the next non-excluded day (see paragraphs 82-86 on weekends and public holidays).

110. Regulations specify that the hospital is required to inform the social services department of changes in circumstances affecting the discharge date, for instance if the patient dies or their condition fluctuates meaning they are no longer ready for discharge. This is another area where clear protocols and agreement between hospital and social services on the format and means of exchanging information and withdrawing notices are strongly advised. This requirement also applies to patients who are already delayed but whose state of health deteriorates while they are waiting for community care services to be put in place. In such cases, the council remains liable for any charges which have accrued up to the time of the notice being withdrawn. But withdrawal always ‘stops the clock’, so there is no liability to pay from that point onwards. Social services should be informed as soon as possible that the notice has been withdrawn, as well as the patient and family.

111. Discharge notifications must be reissued in line with the requirement to give advance warning of discharge to social services. As an example, in the case of a patient who was already delayed when the notice was withdrawn, Friday is the earliest date that can be given in a fresh discharge notification reissued before 5pm on Thursday. The council’s liability for the delay will restart from Saturday if services are not in place by 11am.
112. Withdrawing notices should be done as simply as possible while still ensuring effective communication. Where a withdrawal can be combined with a new notice, it should be: the reissued notice could state, for example, that the discharge is no longer Monday but will be Wednesday. This is likely to be the simplest way of proceeding if there is only a short-term break in the patient’s readiness for discharge.

113. If either assessment or discharge notice is withdrawn and has not been reissued, a council will be liable for any days of delay which have already accrued, but the withdrawn notice must be reissued for the process to restart and any further delay to be charged for. Both notices must be in force for a delay to count for charging purposes.

114. Arrangements should be made for the adequacy of any home care package to be checked within two weeks. How and when this is done should be appropriate to the care needed, e.g. a person returning home to live alone may need this in the first few days after discharge.
Partnership working

Whole systems investing and planning in the context of reimbursement

115. The NHS and councils are bound by a duty to work in partnership (Health Act 1999) and this will be essential in fulfilling the requirements of this legislation in a way which improves services and benefits patients. The overriding objective of the introduction of reimbursement is to provide financial incentives to invest in a wider range of community services and a sustained reduction of delayed transfers of care. Whole system planning needs to involve independent sector providers of both health and social care. Poor partnership working at both strategic and operational levels can be a major cause of delayed transfers.

116. At a strategic level, councils need to work with acute trusts and PCTs to identify the causes of delay, and assess the appropriate intervention and investment needed to tackle them.

117. The new duties on both the NHS and social care should help to ensure that effective information-sharing and joint planning take place at the frontline to enable the smooth transfer from an acute ward into the community.

118. It is entirely desirable for partners to act to minimise reimbursement or indeed avoid it altogether. The aim of the policy is to incentivise the provision of appropriate services so that people can leave acute care for an appropriate setting as soon as they are fit to do so.

119. Joint capacity planning will be vital in minimising reimbursement. Partners need to work together to identify the causes of delay in their local system, and to decide where best to invest to find solutions. Managing reimbursement and the new funding will be a process of risk management for both NHS and councils. Working together, partners should decide how much money they might realistically need to put aside for paying charges in the short- and medium-term, as new investments and ways of working bed in. They should then agree the priorities for investment. Formal modelling tools may help health and local government partners to help identify where investment would make the most impact on delays in the system.

120. For more help and information on using modelling contact the reimbursement implementation team.

121. Pooling funds using the Health Act 1999 flexibilities is one option for managing the financial flows resulting from reimbursement. Partners may combine the Delayed Discharges Grant, the Access and Systems Capacity Grant, any funds from reimbursement and perhaps an agreed sum from individual partner budgets to set up a budget focussed on improving community care services with the aim of reducing delayed transfers. This option enables partners to combine their funds in one
single ‘pot’, following a legal partnership agreement setting out the objectives of the fund, who is authorised to spend it, agreed contributions from partners etc. Once in the pooled fund, money can be spent on any jointly agreed objective, without the restrictions of individual budget headings. This means that partners, who must include the hospital, could agree to reinvest any funds from reimbursement charges in older people’s services\(^{29}\).

\(^{29}\) For more detail on financial flows from reimbursement, see [www.doh.gov.uk/reimbursement/systems.htm](http://www.doh.gov.uk/reimbursement/systems.htm)
For more guidance on pooled funds, see [www.doh.gov.uk/jointunit/s31guidance.htm](http://www.doh.gov.uk/jointunit/s31guidance.htm)
Resolving disagreements

116. Local partners need to stay focused on the purpose of the Act, which is to achieve a sustained reduction in the number of delayed transfers of care from acute beds. The system’s energy and activity should be directed to that aim rather than be diverted into the management of disputes. Recourse to a formal disputes process should be viewed as a measure of failure in collaboration. However it has to be recognised that this is a complex, high-risk area of activity for all the parties and that there may well be issues of disagreement and difference, particularly in the early months of implementation. It is therefore crucial that strategic managers take steps to strengthen joint activity and agreement and prevent conflict

Cross-boundary disputes

117. Health and social care partners will need to agree arrangements for discharge of patients whose treatment and care arrangements cross council or hospital catchment areas. Even if a patient is treated far from home, the council in which they are resident remains responsible in law for their assessment and provision of services. Councils will wish to consider the potential for establishing protocols with neighbouring councils to provide assessments for their residents in hospitals based in the other council’s area.

118. In particular, partners will need to understand and share the details of patient flows – of both patients using ‘out of area’ hospitals and ‘out of area’ patients using local hospitals including those providing tertiary services. They will also need to consider the implications of the NHS Patient Choice initiative which offers alternative treatment locations for patients waiting over a defined time.

119. Regardless of where a patient is treated and how far this is from their home, both NHS and council partners remain bound by their duties of notification for assessment and discharge, provision of services, and where necessary, payment of charges for delays.

Details of dispute panels

120. The Regulations require each Strategic Health Authority to establish and maintain lists of persons from which panels can be appointed to assist in the resolution of disputes between two or more public authorities (defined as NHS bodies or social services authorities). The panel may be used either for disputes about individual patient delays, or issues of broader

---

30 For further guidance on handling disagreements, a protocol on resolving disputes is available at [www.doh.gov.uk/reimbursement/pdf/disputesprotocol.pdf](http://www.doh.gov.uk/reimbursement/pdf/disputesprotocol.pdf)

31 Further advice on establishing cross-boundary protocols is available at [www.doh.gov.uk/reimbursement/protocols.htm](http://www.doh.gov.uk/reimbursement/protocols.htm)
disagreement between partner organisations in relation to the management of reimbursement provisions.

121. The function of each panel is to consider and make recommendations back to the relevant bodies on the resolution of disputes which concern either determination of the need for community care services on discharge, or liability for delayed discharge payments where these cannot be resolved by informal means. Although advisory, it is expected that panel recommendations be accepted in most cases and a council or NHS body should be cautious about rejecting the recommendations of the panel. Furthermore, the Regulations prevent the social services authority or NHS body from bringing legal proceedings without first having attempted resolution via a panel.
**Interface with other legislation**

122. This guidance does not override any other legislation or guidance around NHS and councils’ responsibility for provision of services; the importance of patients, users and carers being consulted and involved in care; promoting independence and choice; and the right of patients and users to complain to the agency which is providing the service.

123. Councils are responsible for carrying out community care assessments under Section 47(1) of the NHS and Community Care Act 1990 and the Community Care (Delayed Discharges etc.) Act makes it clear that any assessment required for discharge is part of this existing responsibility. A Direction to be made (Autumn 2003) under Section 47 will reinforce the accepted good practice that section 47 assessments should:

- involve the patient (and carers if any) in the assessment;
- involve consulting the patient before a decision is made about which services to provide;
- take all reasonable steps to gain agreement to the care plan;
- provide information about any costs to the patient of that care plan;
- ensure that the patient’s best interests have been duly considered where they lack mental capacity.

124. The use of the Single Assessment Process to inform discharge planning and to continue assessment in the setting to which the patient moves from the acute ward will support the intentions of the legislation to ensure good communication and planning. This will ensure that decisions are made using maximum information and that the patient and their family are fully involved without receiving duplicate requests for information. The local information sharing protocol put in place as part of the Single Assessment Process will enable local exchanges of information during the discharge process to be tailored to local requirements beyond the minimum stated in Regulations.

125. The Act puts in place a number of steps to ensure that carers:

- are involved in discharge planning,
- can ask for an assessment (under the Carers and Disabled Children Act 2000) of any services they need to support the discharge of the person they care for,
- are given such an assessment if they are already receiving carers’ services or have had a carers’ assessment in the previous 12 months,
- and receive the services, or direct payments for the services, they need to support the safe discharge of the person they care for within the same timeframe as any community care services which are provided to the person being cared for.
Useful links and references

The main source of information on the Community Care (Delayed Discharges etc.) Act is the reimbursement website [www.doh.gov.uk/reimbursement/index.htm](http://www.doh.gov.uk/reimbursement/index.htm)

The site contains links to the legislation and Regulations, a set of frequently asked questions and answers, checklists for the NHS and councils to use in preparing for reimbursement and a number of draft protocols for health and social care partners to adapt and incorporate within discharge planning processes locally.

General guidance on good practice around hospital discharge is provided in *Discharge from hospital: pathway, process and practice*. This is available to read or order at [www.doh.gov.uk/hospitaldischarge/index.htm](http://www.doh.gov.uk/hospitaldischarge/index.htm)

Alternatively, this and other documents published by the Department of Health can be ordered in hard copy from:

Prolog,  
Department of Health,  
PO Box 777,  
London SE1 6XH  
doh@prolog.uk.com  
fax 01623 724524

A Department of Health support team is assisting the implementation of reimbursement, including producing training material, highlighting good practice and supporting local briefing events. It includes nominees from the Association of Directors of Social Services and the NHS Confederation.

To contact the Reimbursement team please send an e-mail via the Joint Unit mailbox at the Department of Health: Mb-hsd-scju@doh.gsi.gov.uk
Annex A

Reasonableness and adequacy of care plan arrangements

This annexe addresses the question of what constitutes a ‘reasonable effort’ to perform an assessment and prepare a care plan that meets the client’s needs on discharge from hospital.

Paragraph 94 of the guidance states:

If the patient is clear that they do not want the involvement of social services and that they will not accept the services put in place for them, at this stage the patient becomes responsible for arranging their own onward care. Up to that point, following an assessment notification, social services should make all reasonable efforts to perform an assessment and prepare a care plan, however limited that might be. If they then offer those services and these are unreasonably rejected, they have fulfilled their responsibility and are not liable for reimbursement charges after that point.

This annexe addresses the question of what constitutes a ‘reasonable effort’, however councils should still consider seeking legal advice. Consideration of judgements where this has been tested sheds some light on what the courts have considered reasonable.

There are several key judgements looking at the question of reasonableness around the refusal of services. These show that reasonableness is a rigorous test and rests on the notion that for the local authority to be able to treat its duty as discharged by reasonable conduct requires "manifestation of persistent and unequivocal refusal, rather than a single transgression". This quote is taken from the judgement in Kujtim [1999] 4 All ER 161, and it is on this judgement that several other cases have rested.

Two such judgements are Batantu (2000) unreported and Khana (2002) LGR 15. In one case the patient was deemed to act unreasonably and the other reasonably. It is the passages reproduced here, from the judgement in Kujtim [1999] 4 All ER161, that have been pivotal when establishing the reasonableness of care plans. Whilst these can not be used as a checklist they can offer guidance with regard to commissioning and planning strategies. For example an option which a London council considered and decided was unreasonable was the placing of frail older people in a care home on the South Coast, unless they actively chose such a move.

Once an individual is assessed and need is established “the local authority is under a duty to provide accommodation on a continuing basis so long as the need of the applicant remains as originally assessed, and if, for whatever reason, the accommodation, once provided, is withdrawn or otherwise becomes unavailable to the applicant, then (subject to any negative reassessment of the applicants needs) the local authority has a continuing duty to provide further accommodation. That said, however, the duty of the local authority is not absolute in the sense that it has a duty willy-nilly to provide such accommodation regardless of the applicant's willingness to take advantage of it."
“… there are two realities to be recognised. First the duty to provide accommodation is predicted upon the co-operation of the applicant in the sense of his willingness to occupy it on such terms and in accordance with such requirements as the local authority may reasonably impose in relation to its occupation. The second, and connected, reality is that the resources of the local authority are finite … in relation to which it will be reasonable for the local authority to lay down certain requirements as to the use of such accommodation…”

“...if an applicant assessed as in need of Part 3 accommodation either unreasonably refuses to accept the accommodation provided or if, following its provision, by his conduct he manifests a persistent and unequivocal refusal to observe the reasonable requirements of the local authority in relation to the occupation of such accommodation, then the local authority is entitled to treat its duty as discharged and to refuse to provide further accommodation. That will remain the position unless or until, upon some subsequent application, the applicant can satisfy the local authority that his needs remain such as to justify provision of Part 3 accommodation and that there is no longer reason to think that he will persist in his refusal to observe the reasonable requirements of the local authority..."