SUPPORTING PATIENTS' CHOICES TO AVOID LONG HOSPITAL STAYS

Norfolk & Waveney Area Choice Policy

November 2020

in good health

The Norfolk and Waveney Health and Care Partnership

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Current Author	Kate Barlow
Author's Job Title	Senior Manager – Integrated Emergency Care
Department	Urgent and Emergency Care Strategic Commissioning Team
Approved by	Cursty Pepper
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Ratifying / Monitoring Committee	
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Owner	Victoria Braide
Owner's Job Title	Discharge Service Lead

It is the responsibility of the staff member accessing this document to ensure that they are always reading the most up to date version - this will always be the version on the intranet

Related Policies and Procedures	Admission and Discharge Policy Bed Management Policy System Wide Emergency Flow Escalation Standards

Stakeholders	Clinical Leads Clinical Directors Medical staff Patient Safety Committee Clinical Governance Committee Social Services Integrated Discharge Team Case Managers Nursing staff Operational Managers Commissioners

Version	Date	Author	Author's Job Title	Changes

V0.1	2015			National Template
V0.2	August 2019	Mandy Webb	Integrated Discharge Lead, QEHKL	Local amendments
V0.3	March 2020	Kate Barlow	Senior Manager - Integrated Emergenc y Care	National template revised for N & W system wide use
V0.4	September 2020	Kate Barlow	Senior Manager - Integrated Emergenc y Care	National template revised for N & W system wide use post COVID-19 discharge guidance updated
V0.5	September 2020	Kate Barlow	Senior Manager - Integrated Emergenc y Care	National template revised in light of feedback received
V0.6	November 2020	Kate Barlow	Senior Manager - Integrated Emergenc y Care	National template revised in light of further feedback received

Contents

1. INTRODUCTION

1.1. This policy supports people's timely, effective discharge from an NHS inpatient setting, to a setting which meets their diverse needs and is their preferred choice amongst available options. It applies to all adult inpatients in Norfolk & Waveney NHS settings, and needs to be utilised before and during admission to ensure that those who are assessed as medically optimised for discharge can leave hospital in a safe and timely way.

1.2. This policy supports existing guidance on effective discharge, such as the 2015 NICE guidance 'Transition between inpatient hospital settings and community or care home settings for adults with social care needs'[1], and is based on existing good practice.

1.3. The consequences of a patient[2] who is ready for discharge remaining in a hospital bed might include:

- Exposure to an unnecessary risk of hospital acquired infection[3];
- Physical decline and loss of mobility / muscle use[4];
- Frustration and distress to the patient and relatives due to uncertainty during any wait for a preferred choice to become available;
- Increased patient dependence, as the hospital environment is not designed to meet the needs of people who are deemed to be medically optimised for discharge[5];
- Severely ill patients being unable to access services due to beds being occupied by patients who are deemed to be medically optimised for discharge.

1.4. Patients and families can find it difficult to make decisions and/or make the practical arrangements for a range of reasons, such as:

- A lack of knowledge about the options and how services and systems work;
- Concerns about either the quality or the cost of care;
- Feeling that they have insufficient information and support;
- There is uncertainty or conflict about who will cover costs of care;
- Concerns about moving into interim accommodation and then moving again at a later stage
- The choices available do not meet the patient's preferences

1 https://www.nice.org.uk/guidance/ng27

2 The term 'patient' is used throughout this policy to refer to the individual receiving treatment

3 Hassan, M. et al, 2010. *Hospital length of stay and probability of acquiring infection.* International Journal of Pharmaceutical and Healthcare Marketing. 4(4):324-338.

4 Kortebein, P. et al (2008). *Functional impact of 10 days of bed rest in healthy older adults.* J Gerontol A Biol Sci Med Sci. 63(10):1076-81.

5 Monk, A. et al. 2006. *Towards a practical framework for managing the risks of selecting technology to support independent living*. Applied Ergonomics, Vol.37(5).

- Concerns that their existing home is unsuitable, cold or needs work done to ensure a safe environment for discharge
- Worry about expectations of what family and carers can and will do to support them.

1.5. The principles of the 6Cs[6] should be applied to this process – care, compassion, competence, communication, courage and commitment.

2. PURPOSE

2.1. The purpose of this policy is to ensure that choice is managed sensitively and consistently throughout the discharge planning process, and people are provided with effective information and support to make a choice.

2.2. This policy sets out a framework to ensure that NHS inpatient beds will be used appropriately and efficiently for those people who require inpatient care, and that a clear process is in place for when patients remain in hospital longer than is clinically required.

2.3. Where the patient lacks capacity to make[7] decisions about discharge from hospital, then the application of the policy should be adapted as explained in Appendix 2, following the Mental Capacity Act 2005.

2.4. When implemented consistently, this policy should reduce the number and length of delayed discharges and result in patients being successfully transferred to services or support arrangements where their needs for health and care support can be met. Ultimately it aims to improve outcomes for patients.

2.5. This policy includes patients with very complex care needs, who may have been in hospital for many months or years, and people at the end of life.

3. PRINCIPLES

SUPPORTING PEOPLE TO MAKE DECISIONS

3.1. Patients should not be expected to make decisions about their long-term future while in hospital; home care, reablement or intermediate care or other supportive options should be explored first, where that is appropriate to their needs.

3.2. Where it is what the patient wants and where appropriate, all possible efforts should be made to support people to return to their homes instead of residential

6 https://www.england.nhs.uk/nursingvision/compassion/

7 Due to their difficulty understanding, retaining or using information given, or in communicating their views, wishes or feelings, as a result of a disturbance or impairment in the functioning of the mind or brain, as set out in the Mental Capacity Act 2005

placements, with options around home care packages and housing adaptations considered.

3.3. People should be provided with high quality information, advice and support in a form that is accessible to them[8], as early as possible before or on admission and throughout their stay, to enable effective participation in the discharge process and in making an informed choice.

3.4. Patients should be involved in all decisions about their care, as per the NHS Constitution,
and should be provided with high quality support and information in order to participate, where possible. In the context of a discharge decision, the information relevant to the decision will include an understanding of their care needs on discharge, the process and outcome of the assessment of needs, offers of care and options available.

3.5. Where it is identified that the patient requires a needs assessment under the Care Act 2014, but would have substantial difficulty in engaging in the assessment and care planning process, the local authority must consider whether there is anyone appropriate who can support the individual to be fully involved. If there is not then the local authority must arrange for an independent Care Act advocate.

3.6. Many patients will want to involve others to support them, such as family or friends, carers or others. Where the patient has capacity to make their own decisions about confidentiality and information sharing, confidential information about the patient should only be shared with those others with the patient's consent.

3.7. Where the patient has been assessed as lacking capacity in this respect, information may be shared in his or her best interests in accordance with requirements set out in the Mental Capacity Act 2005 Code of Practice and Appendix 2 of this document.[9]

3.8. Where someone is providing care or considering providing care post-discharge, unpaid as a carer, they must be informed and invited to be involved in the discharge process and informed about their rights and sources of support. People have a choice about whether or not to provide care for other adults and people must be informed about their choices when establishing whether they are willing and able to provide care.

3.9. Carers must be offered the information, training and support they need to provide care following discharge[10], including a carer's assessment.

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8 Equality Act 2010 and Human Rights Act 1998, regarding disability and heritage languages; Accessible Information Standard to be introduced in July 2016

9 Mental Capacity Act 2005 Code of Practice available at: https://www.gov.uk/government/publications/mental-capacity-act-code-of-practice

10 Care Act 2014 s10

3.10. The process of offering choice of care provider and/or discharge destination will be followed in a fair and consistent way and there will be an audit trail of choices offered to people.

3.11. Interactions with patients will acknowledge and offer support to address any concerns.

3.12. If a patient is not willing to accept any of the available, appropriate alternatives, then it may be that they are discharged, after having had appropriate warning of the risks and consequences of doing so. This option would only be pursued following the offer and rejection of available, appropriate options of care and appropriate safeguards and risk assessments (see section 4.50). For patients who may lack capacity to make their own discharge decisions, see Appendix 2.

3.13. All persons who are homeless or at risk of homelessness on discharge should be referred by acute hospital staff to local authority homelessness/housing options teams, under the requirements of the Homelessness Reduction Act (2017). This duty to refer ensures that services are working together effectively to prevent homelessness by ensuring that peoples' housing needs are considered when they come into contact with public authorities. Further guidance on supporting homeless persons in hospital discharge can be found in the High Impact Change Model for Managing Transfers of Care.

TIMELY DISCHARGE FROM ACUTE CARE

3.14. If a patient is deemed medically optimised for discharge, it is not suitable that they remain in hospital due to the negative impact this can have on their health outcomes.

3.15. Patients do not have the right to remain in hospital longer than required[11].

3.16. Except where a patient with the relevant capacity has made an informed decision to discharge himself/herself against the advice of health or social care professionals, the discharge process must not put the patient or their carers at risk of harm or that could breach their right to respect for private life. It should not create a situation whereby the independence of the carer or the sustainability of their caring role is jeopardised.

3.17. Planning for effective transfer of care, in collaboration with the patient and/or representatives and all Multi-Disciplinary Team (MDT) members, should be commenced at or before admission, or as soon as possible after an emergency admission. The SAFER patient flow bundle[12] should be applied to support timely discharge.

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11 Barnet PCT v X [2006] EWHC 787. A patient has no right to demand / the NHS has no obligation to provide something not clinically indicated, (*R (Burke) v GMC* [2005] EWCA Civ 1003), including provision of an inpatient bed and a patient who lacks mental capacity for the relevant decisions has no greater right to demand this (*Aintree University Hospitals NHS Foundation Trust v James* [2013] UKSC 67).

12 http://www.fabnhsstuff.net/2015/08/26/the-safer-patient-flow-bundle

3.18. The process and timelines within this policy should be clearly communicated to the patient so that by the time a patient is deemed to be medically optimised for discharge they are aware of and understand the discharge process, the decisions and actions that they may need to undertake and the support they will receive.

3.19. If a patient's preferred care placement or package on discharge is not available when they become medically optimised for discharge, an available alternative which is appropriate to their health and care needs will be offered on an interim basis, whilst they await availability of their preferred choice.

FUNDING ARRANGEMENTS

3.20. This policy applies equally to people regardless of the funding arrangements and the nature of their ongoing care.

3.21. Those self-funding care will be offered the same level of advice, guidance and assistance regarding choice[13] as those fully or partly funded by their local authority or NHS Continuing Healthcare (CHC), although it is likely that some of the content will need to differ.

3.22. A full assessment for NHS CHC should only be undertaken where the longer-term needs of the individual are clear. In the majority of cases, these assessments should be conducted outside of hospital within a reasonable time frame and should not be a reason for delaying discharge to care outside of hospital. However, if (and only if) the individual has a 'rapidly deteriorating condition which may be entering a terminal phase' the NHS CHC Fast Track Pathway should be considered.

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4. OVERVIEW OF PROCESS

13 Care Act 2014 s4

STEP 1 – PROVIDING STANDARD INFORMATION AND SUPPORT

4.1. A Case Manager[14] will be identified for each patient and they will explain the discharge planning process to the patient on admission.

4.2. Factsheet and Leaflet A should be given to and discussed with the patient.

4.3. The Case Manager will ensure that the patient is aware of the circumstances in which an interim placement or package might be necessary. All communication will clearly set out the process that the hospital will follow in order to work towards the patient's safe and timely discharge when their need for inpatient treatment ends. It should be made clear that they will receive advice and support in making a decision[15].

4.4. All patients will be given an Estimated Date of Discharge (EDD) as soon as possible after admission by a consultant or senior clinician. Regular review and discussion about the EDD as part of 'board rounds'[16] will ensure all parties understand when support will be required to facilitate discharge.

4.5. Patients should be involved in all decisions about their care[17] and supported to do so, where necessary.

4.6. At this point, it should be clearly identified who else the patient wishes to be informed and/or involved in the discussions and decisions regarding discharge, and appropriate consent received (if the patient lacks capacity then other legal basis needs to be established – see Appendix 2). This can include, but is not limited to, any formal or informal carers, friends and family members.

4.7. The Case Manager will ensure that any carer(s) of the patient are identified and support through the discharge process. This includes providing information on Carer's Assessments and support services and/or referrals to the relevant support services. Ensuring the carer has adequate support in place will reduce the risk of unnecessary readmission of the patient.

STEP 2 – ASSESSING NEED

14 The term 'discharge co-ordinator' is used throughout this policy to refer to the named individual responsible for coordinating a patient's discharge – this could be any member of the Integrated Discharge Team; a named nurse from the ward, a named social care professional from the local authority, an appropriate person from a voluntary sector organisation contracted to co-ordinate statutory services and act as patient advocate, or a named CHC health professional.

15 Care Act 2014 s4 Providing Information and Advice

16 A 'board round' is a rapid review of progress against the care plan, typically involving the consultant, the medical team, the ward manager and therapists (and sometimes a social worker). It is usually held by a wards 'at a glance' white board. The aim is to ensure that momentum is maintained and deteriorations identified and managed promptly.

17 NHS Constitution

4.8. The likelihood of the patient and any carers needing health (including mental health) care, social care, housing, or other support after discharge will be considered as soon after admission as possible.

4.9. If the patient is likely to have ongoing health, housing or social care needs after discharge, the Case Manager will ensure timely referral to these other services for assessment[18] after discharge. This should be from a holistic and patient-centred perspective of a person's needs and the care and support options may include, for example:

- Intermediate care (or step down care), either bed based or community based;
- Social care assessment;
- Community nursing services, including community matrons;
- Reablement;
- Short-term placement in a care home;
- Care at home support package;
- Financial assessment and benefits advice;
- Eligibility for NHS Continuing Healthcare or Funded Nursing Care;
- Home assessment for aids, adaptations and / or assistive technology;
- Other local health, social or voluntary service

4.10. Trusted assessors are in place to support care homes with early identification and close liaison regarding discharges

4.11. It should be made clear to the patients (and their carers, where appropriate) what the assessment in hospital is for, and what further assessments they can expect in the places they are transferred to.

4.12. Any carers of the patient should be advised of their rights to have a carers' assessment, with appropriate information and support, and referral to relevant support services.

4.13. Patients should be actively involved in the assessment process and in the development of care plans to enable full and effective assessments and support planning.

4.14. Patients should be informed of the rights they have to complain about an assessment or decisions about their need for support.

STEP 3 – PREPARING FOR DISCHARGE

4.15. Letter B (version dependent upon destination) will be prepared and given to the patient by the Case Manager. Explain the process to the patient and ensure they are aware of all timelines and steps. Leaflet B should also be provided to the patient.

18 Care Act 2014, s9 Assessment of an adult's need for care and support; NHS Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) Regulations 2012, reg 21

4.16. Tailored information should be provided to the patient about the care options available to them, including details of costs. The conditions of funding for interim, intermediate and reablement places, (and the 12 week property disregard[19] of fees for the circumstances when the patient transfers directly to a care home) should be made clear.

4.17. The patient will be referred to the relevant representative in order to receive advice and support in making an informed choice after discharge about their longer term needs, and to develop a person centred care and support plan which focuses on the individuals needs and preferences. This should include a discussion of the option of a personal budget (subject to meeting the relevant criteria) [see 4.22].

4.18. The patient should be directed to their Local Authority representative for advice and information regarding advocacy, if required.[20]

4.19. If the patient is assessed to have care needs under the Care Act after discharge, the Case Manager will advise the patient at the earliest appropriate opportunity about currently available care providers that can meet their needs and are registered with the Care Quality Commission (CQC). In some cases it is possible that there may be only one appropriate option, and the rationale for this must be explained.

4.20. If it is known that the placement / package is to be funded or provided by the NHS, the Case Manager will advise the patient of their right to look at alternatives that fall within the criteria set by the CCG, based on their individual needs.

4.21. If it is known that the placement / package is to be funded by social services, the Case Manager will advise the patient of their right to look at alternatives that fall within the criteria set by the local authority, based on their individual needs[21], and the option to top-up. Particular consideration should be given to the timings within this policy to prevent breaches of local authority duties relating to discharge[22].

4.22. If the patient is interested in taking up the offer of a personal budget (social care), personal health budget (NHS) or integrated personal budget, the relevant organisations representative will advise them where to get information, who to contact locally and refer them to the lead locally.

4.23. Self-funders should be provided with the same level of information, advice and support as people whose care is being funded by the NHS or the local authority[23].

19 Certain circumstances where the local authority should disregard a property from means testing for the first 12 weeks of being a permanent resident in a care home, when it is providing assistance with the placement

20 Care Act 2014, s67 Involvement in Assessment, Plans etc

21 Care Act 2014 s4 and s30; Care and Support and After-care (Choice of Accommodation) Regulations 2014

22 Care Act 2014 s3, and Care and Support (Discharge of Hospital Patients) Regulations 2014, SI 2014/2823

23 Care Act 2014

4.24. The Case Manager or support service should discuss discharge plans with the patient regularly, in some cases this may be as often as daily conversations. The Case Manager will endeavour to meet the patient's wishes regarding specific concerns about the appropriateness of a temporary arrangement, if concerns are brought to their attention.

4.25. Patients should be informed of the rights they have to complain and provided with details of how to do so.

4.26. In order to minimise the need for patients to have recourse to formal complaints procedures, statutory agencies should make every effort to ensure that patients are involved in all stages of decisions that affect them, and that their agreement to such decisions is obtained.

STEP 4 – DAY WINDOW

4.27. Once step 3 is completed by giving appropriate information on packages of care or placements, resolving any disputes and giving Letter and Leaflet B to the patient, the expectation should be that the patient makes a decision about discharge within 7 consecutive days, and either discharge has happened or arrangements are in place to do so. The Family and friends leaflet should be given to the patient.

4.28. If there are particular circumstances, such as an out of area transfer or safeguarding concerns, when it is unreasonable to expect a decision to be made within seven days, a longer period may be agreed for an individual.

4.29. Step 3 should be completed well in advance of the EDD, where possible, to prevent avoidable delays to discharge occurring, and in these circumstances more than 7 days can be given as a timescale to people to make arrangements. This is particularly the case with people whose care will be funded by the local authority to prevent breaches of their responsibilities for discharge[24].

4.30. Patients do not have the right to remain in hospital longer than required[25]. However, they do have the right to respect for private life and not to be treated in an inhuman or degrading way. Therefore it is crucial for the hospital to ensure that the proposed transfer is appropriate and in line with human rights legislation.[26]

4.31. The Case Manager will advise the patient that the hospital will expect discharge to be achieved within the agreed timescale.

4.32. The Case Manager will proactively support the patient during this process and will offer advice and support regardless of how the placement is to be funded. Regular

24 Care Act 2014 s3, and Care and Support (Discharge of Hospital Patients) Regulations 2014, SI 2014/2823

25 Barnet PCT v X [2006] EWHC 787. Case law 'R (Burke) v GMC [2005] EWCA Civ 1003' states that patients have no right to insist on particular treatment which is not clinically indicated. This includes provision of an acute inpatient bed when medically optimised for discharge.

26 Human Rights Act 1998

communication will be maintained throughout this period by the Case Manager and the support service.

4.33. Implementation of this policy does not impact on the measurement of delayed transfers of care, which should continue to be reported against the guidance laid out by NHS England[27].

STEP 5 – INTERIM PACKAGES AND PLACEMENTS

4.34. An interim package of care or placement will be offered to a patient where a decision has not been made within seven days of completion of step 3, available options have been declined, or where a decision has been made but the specific package, placement, or adaptation is not yet available. Patients do not have the right to remain in hospital to wait for their preferred option to become available.

4.35. The interim package or placement is distinct from intermediate care or reablement.

4.36. Where decision and/or discharge is not achieved within seven consecutive days of completion of step 3, members of the MDT will liaise within two working days. The MDT will discuss and seek to agree the recommended interim package or placement with the patient. Consideration of interim arrangements must be accompanied by a risk assessment, including impact on any carers.

4.37. The MDT may then advise the patient that an interim package or placement, which meets their assessed needs, is being offered, the reasons why the offer is appropriate, and a proposed date for transfer.

4.38. The interim package or placement will be confirmed with Letter C (version dependent upon funding arrangements). Letter C will be prepared and given to the patient by a hospital representative. It is important that the letter is addressed to the patient, is personalised to reflect their circumstances and that the process is also discussed with the patient.

4.39. The interim package / placement will allow further time for the choice of package / placement to be resolved outside of hospital. This interim option would normally be in one of the initial packages / placements offered, if still available.

4.40. Interim placements will be funded by the appropriate organisation, informed by the discharge pathway for a maximum of 6 weeks[28] and this timescale will be clearly communicated to the patient from the outset. Where a placement has been made by the Local Authority, the person must be made aware that they may be charged to contribute towards the care retrospectively, if the placement is not funded under the new NHSE Covid 6 week funding.

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27 https://www.england.nhs.uk/statistics/wp-content/uploads/sites/2/2015/10/mnth-Sitreps-def-dtoc-v1.09.pdf

28 Local organisations that have supported the development of this template policy recommend an interim funded placement of 6 weeks in order to ensure the policy works in practice and can be implemented easily by staff. This prevents multiple transfers in quick succession and enables time for full assessments to be completed well. This timescale is specifically for interim placements not intermediate care or reablement pathways.

4.41. Discussions regarding permanent options will continue throughout the interim placement with a designated person from the relevant organisation.

4.42. Self-funders will be required to fund their care for the interim package / placement beyond the 6 week[29] funded period, if a permanent decision has not yet been made or if the chosen package / placement is not yet available. The exception to this is where the 12 week property disregard applies.

4.43. Where the need for a discharge onto a health pathway (NHS CHC assessment) has been identified on hospital discharge, the individual should not be charged for their care during the period it takes to complete the NHS CHC assessment.

4.44. The relevant statutory organisation is responsible for arranging the interim placement beyond the 6 week period if the ongoing placement/package is not yet available. Patients and their families should be made aware that all Local Authority placements are subject to financial assessment (beyond the interim placement) and are potentially chargeable from the commencement of the placement.

STEP 6 – ESCALATION PROCESS

4.45. If no agreement has been reached regarding discharge arrangements after steps 1-5, and transfer arrangements are challenged by the patient, the local director or senior manager / clinician in the hospital will support the Case Manager to continue plans for transfer to an interim package or placement.

4.46. The patient will be provided with details of complaints and appeals procedures throughout the process.

4.47. The Case Manager and director or senior manager / clinician will arrange a formal meeting with the patient. The formal meeting enables all parties to discuss concerns and seek to agree transfer to the most appropriate care provider, at least as an interim option.

4.48. The Case Manager will send letter D following the formal meeting, summarising the discussion, including discussions around risks, and next steps.

4.49. Letter D should also be sent if the patient does not engage in the formal meeting, including details of the reasons why the patient did not engage.

4.50. The Case Manager will continue to work with the patient throughout this process to try and understand and address barriers to a decision being made.

4.51. If the patient declines NHS treatment and a care or support package, they may be discharged from hospital[30]. In those circumstances they will be advised in advance

29 Local organisations that have supported the development of this template policy recommend an interim funded placement of 6 weeks in order to ensure the policy works in practice and can be implemented easily by staff. This prevents multiple transfers in quick succession and enables time for full assessments to be completed well. This timescale is specifically for interim placements not intermediate care or reablement pathways.

of any discharge on the further NHS or social care support they may be able to access in the community and warned of the risks if they refuse such support.

4.52. The Case Manager, supported by the local director or senior manager in the hospital, will consult local legal advisors and escalate as required to ensure discharge from hospital, in order to safeguard the health and wellbeing of the patient and other patients.

5. MENTAL CAPACITY

5.1. All patients should be assumed to have mental capacity to make a decision about their ongoing care, including as regards discharge. A capacity assessment should be undertaken at any point during the process if their capacity, in relation to the discussions and decisions on discharge, is in doubt.

5.2. Appendix 2 sets out in detail how the application of this policy should be adapted for cases where the patient may lack capacity to make the relevant decisions at the appropriate time.

6. CONSULTATION AND APPROVAL PROCESS

6.1. This policy was developed nationally by a collaboration of partners with input from people working across the system, both locally and nationally.

6.2. This Policy has been reviewed and approved system wide through agreement at each locality System Operational, Resilience and Transformation (SORT) meeting and the STP wide Urgent and Emergency Care Transformation Steering Group

7. REVIEW, REVISION

7.1. This policy will be reviewed at least every 3 years lead by the Strategic Commissioning Team within NHS Norfolk and Waveney Clinical Commissioning Group, in collaboration with the locality teams, their providers and partner organisations

8. MONITORING COMPLIANCE AND EFFECTIVENESS

8.1. Monitoring will take place by the NHS Norfolk and Waveney CCG locality teams.

8.2. Monitoring in each hospital will be undertaken on a biannual basis, facilitated by the local manager or lead nurse for discharge services.

30 The duty on Trusts and Foundation Trusts to carry out their functions "effectively, efficiently and economically" under NHS Act 2006 (as amended) s26, 63; Criminal Justice and Immigration Act 2008, ss119-121, if the patient is no longer in need of inpatient treatment and their behaviour constitutes a nuisance or disturbance and NHS protect guidance on this provision

8.3. Local monitoring will include an audit of:

- Staff training to check that training courses are relevant to the policy and ensure training is undertaken;
- Policy effectiveness;
- Review of when choice information is provided;
- Patient and/or representative feedback and complaints;
- Number of Delayed Transfers of Care;
- Length of Delayed Transfers of Care;
- Equality monitoring.

13 APPENDIX 1: GLOSSARY

Advocacy: a service to help people be involved in decisions, explore choices and options, defend their rights & responsibilities, and speak out about issues that matter to them.

CHC: NHS Continuing Healthcare is defined as a package of ongoing care for an individual aged 18 or over which is arranged and funded solely by the NHS where the individual has been found to have a 'primary health need'.

Deprivation of liberty: when an individual without mental capacity to consent is under continuous supervision and control and is not free to leave, and this is imputable to the state. See Appendix 2.

Case Manager: the named individual responsible for coordinating a patient's discharge. This could be a named nurse from the ward, a named social care professional from the local authority, an appropriate person from a voluntary sector organisation contracted to co-ordinate statutory services and act as patient advocate, or a named CHC health professional.

EDD: Estimated or expected date of discharge. This means when the patient is clinically assessed as ready for discharge. The EDD is initially based on average length-of-stay data and may change several times in response to the patient's specific needs.

Independent Mental Capacity Advocate (IMCA): will represent patients assessed as lacking capacity under the Mental Capacity Act 2005 to make important decisions, such as change of accommodation, and who have no family and friends to consult.

Interim care: A provisional placement that is suitable and able to meet the patient's assessed needs whilst they wait for their preferred option.

Intermediate care: Short-term care provided free of charge by the NHS for people who no longer need to be in hospital but may need extra support to help them recover. It lasts for a maximum of six weeks and can be in the patient's home or in a residential setting.

MDT: Multidisciplinary team of health and social care professionals involved in the care and assessment of patients.

Medically optimised for discharge: Further inpatient medical care or treatment is no longer necessary, appropriate or offered. Any further care needs can more appropriately be met in other settings, without the need for an acute inpatient hospital bed.

Mental capacity: Being able to make a specific decision at a specific time (see Appendix 2).

Patient: The individual receiving treatment in hospital.

Reablement: Reablement services are meant to help people adapt to a recent illness or disability by learning or relearning the skills necessary for independent daily living at home. Reablement should be provided free of charge by the local authority for up to six weeks. It can be extended at the local authority's discretion.

Self-funder: A person who financially meets the full cost of their social care needs (apart from reablement care and the 12 week property disregard), because their financial capital exceeds the threshold for adult services funding, their level of need is not deemed to be high enough for local authority funding, or because they or a representative choose to pay for their care.

14 APPENDIX 2: HOSPITAL DISCHARGE AND MENTAL CAPACITY ISSUES

All staff must follow the five guiding principles of the Mental Capacity Act 2005 ("MCA"). This means:

- Presume that adults from 16 are mentally capable of making their own decisions;
- Do not determine the person lacks capacity until all practicable steps to support them have been taken without success;
- Do not consider someone to lack capacity because they make a decision we consider to be unwise;
- When the patient is assessed to lack capacity we must act in their best interests;
- Before taking any action or decision on their behalf we must consider if it can be achieved in a less restrictive way.

Capacity is specific to the decision that must be made, at the relevant time, and so it is possible that a patient who has been assessed as having capacity to consent to or refuse the treatment they have had as an inpatient may lack capacity to make decisions around discharge and care planning (and vice versa). Where there is a reason to doubt capacity for a particular decision, it must be specifically assessed, in accordance with the MCA, the MCA Code of Practice and relevant case law and documented appropriately.

All practicable steps must be taken to support the patient to make the decision before concluding that they are unable to make it themselves. This might involve taking a number of steps such as a providing information in a different format or breaking information down into smaller chunks.

If a person is assessed to lack capacity this means that staff have tested whether they can:

- Understand the information relevant to the decision,
- Retain the information long enough to make a decision,
- Use and weigh the information as part of the decision making process and
- Communicate the decision they want to make.

In the context of a discharge decision, the information relevant to the decision will include an understanding of their care needs on discharge, the process and outcome of the assessment of needs, offers of care and options available, with the person being given concrete information to consider, not starting with a blank sheet approach.

Options which are not available (e.g. placements which are not available, care which is not considered clinically appropriate, or care which will not be funded) should not be considered in either capacity assessments or in best interest decision-making. A patient with capacity cannot insist on staying in hospital after they are deemed as medically optimised for discharge and so neither is it an option for a patient who lacks capacity for the discharge decision.

Where a patient, despite all reasonable efforts to support them, lacks capacity for discharge decisions, the decision must be made in their best interests (see MCA s4).

It is important to identify who the decision maker is as it could be a number of different people. The decision maker may be an attorney (if a health and welfare Lasting Power of Attorney has been granted, and is valid, applicable and registered) or a Deputy (if a health and welfare Deputy has been appointed by the Court). If neither of these are appointed then it will be the health or care professional who needs to make the decision in question. The wishes and feelings of the patient are paramount, but this does not mean they will always get what they want, anymore than a patient with capacity would.

“Best interests” is interpreted widely, and goes beyond medical risk and benefit to include social, psychological and emotional factors. Before making a best interests decision, it should be tested by asking whether the patient’s best interests can be achieved in a way which is less restrictive of their rights and freedoms.

A patient is entitled to an Independent Mental Capacity Advocate (IMCA) where it is proposed that an NHS body or a local authority provides accommodation in a care home for 8 weeks or longer unless there is someone to consult about their best interests other than a paid professional (MCA s38-39).

If the proposed placement or care package on discharge puts a patient without capacity to consent to it at risk of being deprived of liberty (Article 5, European Convention of Human Rights), currently as interpreted by the Supreme Court in Cheshire West [2014] UKSC 19 to mean “under continuous supervision and control and not free to leave” then additional safeguards are required to ensure that the deprivation is lawful.

Where the proposed deprivation of liberty is in a hospital or a registered care home, a referral must be made for a standard authorisation under the Deprivation of Liberty Safeguards (DoLS). However, DoLS do not extend to other placements, such as supported living or domiciliary care and so any proposed deprivation of liberty there can only be authorised by the Court of Protection. [In either case, case law has found that it is preferable for any proposed deprivation of liberty to be authorised in advance by a prior referral to DoLS or Court application – see for example Re AJ (DoLS) [2015] EWCOP 5, or Re AG [2015] EWCOP 78]

[It may be appropriate to seek legal advice on cases where deprivation of liberty after discharge appears to be an issue.]

15 APPENDIX 3: SUMMARY OF LEGAL RESPONSIBILITIES AND RIGHTS

This appendix includes a brief summary of selected key legal responsibilities held by participating organisations and the rights that patients have in relation to the specific topic of this policy, with references to specific legislation and case law.

This list does not cover all of the legal complexities in relation to this issue – it is only provided as a guide to the people reading this policy and should not be used in place of legal advice.

	Responsibility or right in relation to choice at discharge	Relevant legislation / case law
Hospital (NHS Trust)	No clinician or Trust is obliged to offer anything which is not clinically indicated. This includes provision of an acute inpatient bed.	R (Burke) v GMC [2005] EWCA Civ 1003; Aintree University Hospitals NHS FT v James [2013] UKSC 67
	A Trust is obliged to carry out its functions "effectively, efficiently and economically", which is not consistent with prolonged occupation of inpatient beds by patients who are deemed to be medically optimised for discharge	NHS Act 2006 (as amended) s26, 63
	In some cases, where the patient's refusal to leave hospital when deemed medically optimised for discharge constitutes a nuisance or disturbance, an offence may be committed and there is a power to remove the patient	Criminal Justice and Immigration Act 2008, ss119-121 [and see NHS Protect guidance]
	Alternatively, other remedies may be available to Trusts under property law	Barnet PCT v X [2006] EWHC 787
	Where appropriate, where the Trust considers it will not be safe to discharge a patient unless arrangements for care and support are in place it must give notice to local authority, including provision in some circumstances for a financial remedy against the local authority where discharge is delayed as a result of failure to meet needs	Care Act 2014, Schedule 3, Care and Support (Discharge of Hospital Patients) Regulations 2012, and Delayed Discharge (Continuing Healthcare) Directions 2013
	Responsibility to seek authorisation for any deprivation of liberty occurring in the hospital	MCA Schedule A1, paras 1-3 , 24 and 76
	Acute hospital staff should refer all persons who are homeless or at risk of	Homelessness Reduction Act (2017)

	homelessness on discharge to local authority homelessness/housing options teams	
Local Authority	Responsibility to assess a patient's needs for care and support where it appears to the local authority that the patient may have such needs	Care Act 2014 s9
	Responsibility to assess a carer's needs for support and choice about caring	Care Act 2014 s10
	Responsibility to provide patient's choice of accommodation in care home / shared lives / supported living, where this is to be arranged by the local authority, in some circumstances	Care Act 2014 s30, Care and Support and After-care (Choice of Accommodation) Regulations 2014
	Responsibility to provide information and support on choices	Care Act 2014 s4
	Responsibility to offer choices / involve the patient in preparation of a care and support plan	Care Act 2014 s25
	Responsibility to provide a Care Act advocate if a patient would experience substantial difficulty in participating in the assessment of need or care planning process unless there is another (unpaid) appropriate person to fill this role	Care Act 2014, s67 MCA Schedule A1 paras 21, 50
	Responsibility to authorise deprivation of liberty in care homes and hospitals	Homelessness Reduction Act (2017)
	Local Authority homelessness/housing options teams staff should accept all referrals from acute hospital staff for persons who are homeless or at risk of homelessness on discharge	
Clinical Commissioning Group [and NHS England]	Responsibility to ensure an assessment for eligibility for NHS funded Continuing Healthcare where it appears that there may be a need for such care. [This is the responsibility for NHS England for military personnel and prisoners]	NHS Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) Regulations 2012, reg 21
Patient	Right to assessment for care and support by local authority and for NHS Continuing Healthcare as appropriate	Care Act 2014, s9 and NHS Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) Regulations 2012, reg 21

	No right to insist on particular treatment which is not clinically indicated, including provision of an acute inpatient bed when deemed medically optimised for discharge Right to be involved in decision making about care Right to choice of accommodation in care home / shared lives / supported living, where this is to be arranged by the local authority, in some circumstances (but no right to remain in hospital when deemed medically optimised for discharge while preferred choice is awaited) Right to respect for family life and to not be treated in an 'inhuman or degrading' way	Barnet PCT v X [2006] EWHC 787; R (Burke) v GMC [2005] EWCA Civ 1003 NHS Constitution Care Act 2014 s30, Care and Support and After-care (Choice of Accommodation) Regulations 2014 Human Rights Act 1998 s6 in relation to Articles 3 and 8 of the European Convention of Human Rights
Carer	Right to carer's assessment / support and choice about caring i.e. willingness to provide care	Care Act 2014 s10

16 APPENDIX 4: SUPPORTING TEMPLATE FACTSHEET AND LETTERS

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21 FACTSHEET A: The Assessment and Discharge Process

We want to give you the support you need to get home as quickly as possible. Following a hospital admission, most patients are able to return home, sometimes with a care package or adaptations made to their home. However, some patients are unable to return home and need the added support only available in a care home.

We will involve you in all decisions about your care, treatment and discharge, and give you all the information and support you need to make the best decisions

What can you expect to happen?

- We will tell you when your treatment is due to end and when you would be considered well enough to leave hospital (this is called an expected discharge date) – we aim to tell you this within 48 hours of you being admitted and will discuss with you if this changes.

- We will provide you with a named staff member who will support you throughout your time in hospital and make sure that things happen when they are supposed to.

- We will tell you how to access information, advice and support to help you make your discharge decision. This will include helping you to understand your care needs, the process of assessing your needs and the care options available to you.

- With your permission, we will request assessment(s) to find out what needs you have and the services you might need to be safely discharged from hospital. The assessments could be for social care, home assessment for any adaptations, eligibility for NHS continuing healthcare, etc.

- It may also be necessary to assess how any ongoing care will be funded, although in most circumstances to avoid any delay this will be carried out after you have been discharged. It is important to note that whilst NHS care is free to everyone, social care is not. Speak with your named staff member to find out what the time limits are for free care and what this might mean for you.

- It is expected that the option/s provided to you for free funded care, will be accepted by you/your family to facilitate a timely discharge from the hospital.

- Once you have received information about the discharge choices that are available to you, we request that you make a decision within 7 days. You may wish to arrange for yourself or a family member to meet with the care providers

during this time. We will do our best to help make this possible for you and you will be able to speak with your named staff member about these choices.

- If your preferred choice is not available when you are ready for discharge, an alternative option can be arranged for you temporarily. It is not possible for you to wait in this hospital, once you no longer need hospital care.

- If you wish to make a complaint or appeal against any part of the discharge process then contact the Patient Advice and Liaison Service at any point.

If you would like a copy of this factsheet to be given to someone else or you have any questions, please speak to one of the nurses on your ward or any member of the team caring for you.

Please do not hesitate to ask questions about your discharge at any time during your hospital stay.

With best wishes,

[*insert NHS Trust Chief Executive signature*]

22 CHOICE LETTER B1

Date: ……

Dear <*Name*>

You now need to choose a care package at home

We request that you make your decision within 7 days of receiving this letter {or insert a longer timeframe if letter is sent more than 7 days before the EDD}. We will arrange for a temporary package of care or accommodation to be made available to you if you need longer than 7 days to make your decision, or need to wait for your preferred care provider.

Additional information to help you with your decision
The recent assessment looked at your care needs and wellbeing and showed that you will need a care package at home following discharge on {*insert estimated discharge date*}.

We want to help you leave this hospital as soon as possible because home is the best place for you to recuperate, and will give you more independence than being on a hospital ward.

To support you at this time we will ensure that:

- You now have all of the information about the choices currently available to you, including details of any costs, and you have spoken about this with a member of the team;
- You have access to further high quality information, advice and support to make your decisions [*include details of where this can be accessed*];
- This includes [*include details of support service*] and the option to involve your family, friends and carers to support you, as you wish.
- You can make a complaint or appeal at any stage of the discharge process by contacting [*insert details of local complaints and appeals procedures*].

Please do not hesitate to ask one of the nurses on your ward, or to any member of the team caring for you, if you have any questions or if you would like a copy of this letter to be given to someone else.

Yours sincerely,

[*letter to be signed by senior clinician*]**CHOICE LETTER B2**

Date: ……

Dear <Name>

You now need to choose a care home.

We request that you make this decision within 7 days of receiving this letter {or insert a longer timeframe if letter is sent more than 7 days before the EDD}. We will arrange for temporary accommodation to be made available to you if you need longer than 7 days to make your decision, or need to wait for your preferred choice if it has no current vacancies.

Additional information to help you with your decision

The recent assessment looked at your needs and wellbeing and showed that you will need to be discharged to a care home {insert for how long if a temporary placement} on {insert estimated discharge date}.

We want to help you leave this hospital as soon as possible because a care home is the best place for you to recuperate, and will give you more independence than being on a hospital ward.

To support you at this time we will ensure that:

- You now have all of the information about the choices currently available to you including details of any costs, and you have spoken about this with a member of the team;
- You have access to further high quality information, advice and support to make your decisions [include details of where this can be accessed];
- This includes [include details of support service] and the option to involve your family, friends and carers to support you, as you wish.
- You are able to make a complaint or appeal at any stage of the discharge process by contacting [insert details of local complaints and appeals procedures].

Please do not hesitate to ask one of the nurses on your ward, or to any member of the team caring for you, if you have any questions or if you would like a copy of this letter to be given to someone else.

Yours sincerely,
[letter to be signed by senior clinician]

23 CHOICE LETTER B3

Date: ……

Dear <Name>

You now need to choose an available housing option.

We request that you make this decision within 7 days of receiving this letter {or insert a longer timeframe if letter is sent more than 7 days before the EDD}. We will arrange for temporary accommodation to be made available to you if you need longer than 7 days to make your decision, or need to wait for your preferred choice if it has no current vacancies.

Additional information to help you with your decision
Your recent assessment looked at your care needs and wellbeing. It showed that you will need support from housing support services before being discharged on {insert estimated discharge date}.

We want to help you leave this hospital as soon as possible because supported housing is the best place for you to recuperate, and will give you more independence than being on a hospital ward.

To support you at this time we will ensure that:

- You now have all of the information about the choices currently available to you, including details of any costs, and you have spoken about this with a member of the team;
- You have access to further high quality information, advice and support to make your decisions [include details of where this can be accessed];
- This includes [include details of support service] and the option to involve your family, friends and carers to support you, as you wish.
- You are able to make a complaint or appeal at any stage of the discharge process by contacting [insert details of local complaints and appeals procedures].

Please do not hesitate to ask one of the nurses on your ward, or to any member of the team caring for you, if you have any questions or if you would like a copy of this letter to be given to someone else.

Yours sincerely,
[letter to be signed by senior clinician]

24 CHOICE LETTER C1

Date: ……

Dear <Name>

Notification of plan to transfer to interim care whilst waiting for a preferred home

We understand that you are well enough to leave hospital and move to a care home, but <you have not yet found one that you like> OR <the one you prefer is not able to offer you a room at this time>.

We do not wish to cause you or your family anxiety, but unfortunately you will not be able to stay at this hospital whilst you continue to <search> OR <wait> for a care home.

- Staying in a care home will allow you to recuperate and give you more independence than being on a hospital ward;
- A care home is the best place for you to continue your recovery once your acute illness is over;
- Severely ill patients may be unable to access services, if beds in this hospital are occupied with patients who are medically optimised for discharge.

As it has taken longer than 7 days to organise your discharge, we are now offering to transfer you to temporary accommodation in the following location, which has been assessed as suitable to meet your short-term needs because <insert reason for decision>. This will be funded by <insert organisation(s)> for <x> weeks[31]. Beyond <x> weeks the costs of this care will need to be met by <insert responsible organisation or by you>.

Discharge destination:	<Name of location>
Address:	<Address of location>
Tel number:	<Phone number of location>
Proposed date of transfer/discharge:	<Discharge date>

You will be offered further support there with any decisions you need to make and you can wait there until transfer to a preferred home can be arranged.

Please discuss discharge plans with <insert name and contact details>. You will need to either transfer to the temporary accommodation outlined above or inform us of an alternative arrangement to leave the hospital without further delay.

If you would like a copy of this letter to be given to someone else or you have any questions please speak to one of the people below or any member of the team caring for you.

31 *Local organisations that have supported the development of this template policy recommend a funded placement of 3 weeks in order to ensure the policy works in practice and can be implemented easily by staff. This prevents multiple transfers in quick succession and enables time for full assessments to be completed well.*

If you would like to make a complaint or appeal against this decision then please [insert details of local complaints and appeals procedures].

Please do not hesitate to ask if you have any questions.

Yours sincerely, [letter to be signed by senior clinician]

25 CHOICE LETTER C2

Date: ……

Dear <Name>

Notification of plan to transfer to interim care whilst waiting for preferred care at home services

We understand that you are well enough to leave hospital with care at home but <you have not yet found a care service that you like> OR <the care service you prefer is not able to accommodate you at this time>.

We do not wish to cause you or your family anxiety but unfortunately you will not be able to stay at this hospital whilst you continue to <search> OR <wait> for a care at home package.

- Leaving hospital will allow you to recuperate and give you more independence than being on a ward;
- Severely ill patients may be unable to access services, if beds in this hospital are occupied with patients who are medically optimised for discharge.

As it has taken longer than 7 days to organise your discharge, we are now offering to transfer you to temporary accommodation in the following location, which has been assessed as suitable to meet your short-term needs because <insert reason for decision>. This will be funded by <insert organisation(s)> for <x> weeks[32]. Beyond <x> weeks the costs of this care will need to be met by <insert responsible organisation or by you>.

Discharge destination:	<Name of location>
Address:	<Address of location>
Tel number:	<Phone number of location>
Proposed date of transfer/discharge:	<Discharge date>

You will be offered further support there with any decisions you need to make and you can wait there until your preferred care at home package can begin.

Please discuss discharge plans with <insert name and contact details>. You will need to either transfer to the temporary accommodation outlined above or inform us of an alternative arrangement to leave the hospital without further delay.

If you would like a copy of this letter to be given to someone else or you have any questions please speak to one of the people below or any member of the team caring for you.

If you would like to make a complaint or appeal against this decision then please [insert details of local complaints and appeals procedures].

Please do not hesitate to ask if you have any questions.

32 *Local organisations that have supported the development of this template policy recommend a funded placement of 3 weeks in order to ensure the policy works in practice and can be implemented easily by staff. This prevents multiple transfers in quick succession and enables time for full assessments to be completed well.*

Yours sincerely,
[Letter to be signed by senior clinician]

26 CHOICE LETTER C3

Date: ……

Dear <*Name*>

Notification of plan to transfer to interim care whilst waiting for housing support services

We understand that you are now well enough to leave hospital but require housing support services <*that are not yet completed*> *OR* <*that you have not yet decided upon*>*.*

- We do not wish to cause you or your family anxiety but unfortunately you will not be able to stay at this hospital whilst you continue to <*wait*> *OR* <*decide*> upon housing support services.
- Leaving hospital will allow you to recuperate and give you more independence than being on a ward;
- Severely ill patients may be unable to access services, if beds in this hospital are occupied with patients who are medically optimised for discharge.

As it has taken longer than 7 days to organise your discharge, we are now offering to transfer you to temporary accommodation in the following location, which has been assessed as suitable to meet your short-term needs because <*insert reason for decision*>. This will be funded by <*insert organisation(s)*> for <x> weeks[33]. Beyond <x> weeks the costs of this care will need to be met by <insert responsible organisation or by you>.

Discharge destination:	*<Name of location>*
Address:	*<Address of location>*
Tel number:	*<Phone number of location>*
Proposed date of transfer/discharge:	*<Discharge date>*

You will be offered further support there with any decisions you need to make and you can wait there until the housing support services <*are completed*> *OR* <*are available*>*.*

Please discuss discharge plans with <*insert name and contact details*>*.* You will need to either transfer to the temporary accommodation outlined above or inform us of an alternative arrangement to leave the hospital without further delay.

If you would like a copy of this letter to be given to someone else or you have any questions please speak to one of the people below or any member of the team caring for you.

33 *Local organisations that have supported the development of this template policy recommend an interim funded placement of 3 weeks in order to ensure the policy works in practice and can be implemented easily by staff. This prevents multiple transfers in quick succession and enables time for full assessments to be completed well. This timescale is specifically for interim placements not intermediate care or reablement pathways.*

If you would like to make a complaint or appeal then please [*insert details of local complaints and appeals procedures*].

Please do not hesitate to ask if you have any questions.

Yours sincerely, [*letter to be signed by senior clinician*]

27 CHOICE LETTER D

Date: ……

Dear <Name>

Confirmation of discharge plans following formal meeting

Thank you for meeting with us on <insert date> to discuss your discharge arrangements from this hospital and on-going care requirements.
OR
{Dr ??} and the discharge team met in your absence on <insert date> to discuss your discharge arrangements from this hospital and on-going care requirements.

Discharge options discussion
We want to help you leave this hospital as soon as possible now you no longer need hospital care. A hospital ward is not the best place for you to continue your recovery and other types of services are now better equipped to support your needs. In addition we have a responsibility to make sure that beds on our wards are available for people who need treatment that can only be provided in a hospital.

At the meeting we discussed the following points:
<insert summary discussion here>.
We discussed the following options to enable the discharge process to proceed:
<insert options provided here>.

Discharge plan discussion
The following discharge plan was agreed:
<insert agreed next steps here>.
OR
We noted the reasons why you are unwilling to engage with this process:
<insert reasons here>.

The risks of you refusing the care options provided after being discharged from NHS hospital care were also discussed and identified:
<insert risks identified here>.

We will continue to work with you to try to come to a mutually agreeable solution. However, in the meantime the hospital will now need to consult our legal advisers about your situation and how we can arrange for you to be safely discharged from this hospital as soon as possible. We have a responsibility to consider and to ensure your health and wellbeing throughout this process. You also have the right to consult with your own legal advisers.

If you would like a copy of this letter to be given to someone else or you have any questions please speak to one of the people below or any member of the team caring for you.

If you would like to make a complaint or appeal against any part of the discharge process then please [insert details of local complaints and appeals procedures].

Please do not hesitate to ask if you have any questions.

Yours sincerely, [letter to be signed by senior clinician]