Meeting the challenge 6

How do we plan for a successful discharge for my family member?

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This factsheet will provide you with information about planning for a family members discharge from an inpatient unit.

Words in **green** are explained in more detail in the glossary at the end of the factsheet.

Planning for discharge (leaving hospital)

A discharge plan (or 'moving on' plan) sets out the information needed to ensure that a person is discharged from an inpatient unit with the right support in place. The plan should include:

- information about the person's current needs and support, and
- what will need to be in place to enable them to live in a community setting when they leave the unit.

Meeting the persons needs set out in the plan is vital, and the right systems of support must be in place before they are discharged to ensure these needs are met and they will not be put at risk.

The Government has said that as soon as someone goes into an inpatient unit, planning for them to move back to the community should begin[1]. Your family member's care coordinator (see later in this factsheet for more) should organise the planning and development of a discharge plan, ensuring that all the professionals who are involved in your family member's care contribute. Family members and the person themselves should also be involved. The professionals from the local community that your family member is returning to should be working to put in place the right care and support services for your family member so that they can live in the community. The discharge plan should include an estimated date of when discharge is likely to be.

[1]Transforming Care: A national response to Winterbourne View Hospital, Department of Health, 2012

www.gov.uk/government/uploads/system/uploads/attachment_data/file/213215/final-report.pdf

[2]Ibid

Sometimes getting the support and housing package right for someone with behaviour that challenges can take some time – for example, if specialist housing needs to be found or adaptations to a property made. Planning from day one will help to ensure that there is no delay of discharge when the person is ready as a result of a lack of the right community-based care being in place.

Hospitals are not homes"

"Health and social care commissioners should start to plan from day one of admission to inpatient services for the move back to community"[1]

Transforming Care report [2]

Top Tip

As soon as your family member goes into an inpatient unit start asking about their discharge plan.

When should a person be discharged?

We know that people with a learning disability and behaviour that challenges should rarely need to go into an inpatient unit at all. They should be able to get the assessment and treatment they need in the community. If they do need to go in to an inpatient unit it should only need to be for a short time (see factsheet 2). The Government has been very clear that 'hospitals are not homes'. When people are detained in an inpatient unit the environment may not suit their needs leading to continued challenging behaviour. If this is the case, it is important to highlight how the environment contributes towards challenging behaviour and how a personalised service in the community could be a better option.

How and when a person can be discharged from hospital can depend on what section of the **Mental Health Act** the person has been detained under. Factsheet 4 explains some of the reasons why people with a learning disability can end up going in to an inpatient settings, for example due to a crisis because of a lack of the right support and services in the community. It also explains the different ways people can be admitted, for example, as an informal patient or as a 'detained' patient under the Mental Health Act (often known as being 'sectioned').

More Information

Read the 'planning for discharge' section in the NHS England Getting it right for people with learning disabilities: Going into hospital because of mental health difficulties or challenging behaviour:

www.nhs.uk/Livewell/Childrenwithalearningdisability/Documents/NHS-England-Getting-it-right-for-people-with-learning-disabilities-epublication.pdf

More Information

The following resources show clear commitment to good and early discharge planning for people with behaviour described as challenging:

Transforming Care: a national response to Winterbourne View (Department of Health)

www.gov.uk/government/uploads/system/uploads/attachment_data/file/213215/final-report.pdf

Inpatient services for people with learning disabilities: standards for health care professionals (Royal College of Psychiatrists)

www.rcpsych.ac.uk/pdf/LD%20standards_Pilot%20version.pdf

More Information

Find out more about the different sections under the Mental Health Act:

Mental Health Act information (Mind):

www.mind.org.uk/information-support/legal-rights/sectioning/about-sectioning/#three

Summary of the detaining sections (Mental Health Law website):

www.mentalhealthlaw.co.uk/Summary_of_the_detaining_sections

What discharge planning should address

It is important that consideration is given to all aspects of someone's life when planning for their discharge is underway. Discharge planning should always be person centred and should consider a number of key points, including:

- What is important to the person? What do they want after leaving hospital?
- Where does the person want to live and with whom (if anyone)?
- What are the person's individual needs (both health and social care) and how can they be addressed in the community? (It is important that your family member gets a needs assessment or care review when they are in hospital to help establish this.)
- What meaningful activities will the person do during the day?
- What will happen to support the person in their hobbies and interests?
- How will the person be supported to maintain relationships with friends and family?
- What money/financial support (e.g. welfare benefits) are they entitled to?
- How will the move out of hospital be managed to limit any stress and anxiety?
- It is important that the starting point is focused on the person, and that creative options are discussed. The second stage is about how these things will be delivered. Think about these questions:
- Who will provide the funding for my family member's support?
- Who will provide the day-to-day support for my family and make sure they are accessing community based activities?
- Who will provide the specialist support on behaviour or mental health to my family member (and their staff team) when they are living in the community?
- Who will train the staff team around my family member's individual needs
- Who will organise the practical issues – like claiming welfare benefits?

Top Tips

To help ensure a good transition from an inpatient unit to a new service, think about all the detail! Imagine the person's day-to-day life in the community and think about what needs to be in place to ensure they can have a good and fulfilling life.

The box on the next page includes links to guidance on discharge planning, which are useful to look at. Here are some of the things mentioned in the Beyond Limits 'Getting out of hospital' factsheet. Although the factsheet is aimed at staff in an organisation working to move people out of inpatient units, it can be useful for families too. The points below will give you an idea of some of the things that might need to be thought about and included in your family member's discharge plan, and in implementing what is outlined in the plan:

- If a person is going to live in their own home, think about the **tenancy agreement**. If the person lacks capacity, they will need either: a court appointed deputy to manage the tenancy on their behalf (an application to the Court of Protection will need to be made if the person does not already have a deputy authorised to do this) or a one-off order from the Court of Protection to sign the tenancy
- It is crucial the person themselves and their family are **involved** in recruiting their staff team
- When recruiting staff, look at what **hobbies and interests** the potential member of staff shares with the person
- Arrange for the staff who will support the person in the community to visit the person at the unit they are in and **shadow staff** there so that they can get to know the person
- If people are on certain sections of the Mental Health Act, which require the Ministry of Justice to approve discharge, then **make sure the Ministry of Justice is involved early on** in the service design (as they will only approve discharge if they are assured of safety)
- Undertake some **'community mapping'** - identify relevant health professionals in the community and make referrals where appropriate. Find out how to register with the GP (for example, will ID be needed?)
- Think about **meaningful activities** including education and jobs. Work out travel routes into the community - plan all this ahead so that there are no surprises and there are no barriers to community involvement that still need to be addressed following discharge
- Make sure a **detailed 'housing specification'** has been drawn up which explains what housing environment is needed to meet the person's needs (eg. what features are needed to help minimise triggers). Use this to search for an appropriate house. Involve an Occupational Therapist (OT) from the local community and the family
- Ensure the person and their family have **up to date information on their welfare benefit entitlements**. There are lots of different types of benefits that an individual may be entitled to on leaving an inpatient unit e.g. Housing Benefit, Employment and Support Allowance (ESA) for people who are unable to work because of a disability or illness, and Personal Independence Payment (PIP) to help with the extra costs of disability.

More Information

The following resources provide useful information and guidance about discharge planning and what should be included in the planning process:

Beyond Limits have produced a 'Getting out of hospital' factsheet for their own staff team about all of the different things to think about in the planning and transition process for people with learning disabilities and mental health needs moving out of Assessment & Treatment Units and Specialist Hospitals:

www.beyondlimits-uk.org/2013/08/news.html

United Response has produced a checklist to help those people who are involved in planning someone's move from inpatient care into the community:

www.unitedresponse.org.uk/wp-content/uploads/2014/04/Final-UR_New-CB-Service-Referral-Checklist.pdf

More Information

Further information about legal and rights issues affecting housing and support on the Housing and Support Alliance (H&SA) website:

www.housingandsupport.org.uk/rights-and-the-law

Read more about entitlements to welfare benefits when coming out of inpatient services here:

www.hft.org.uk/Supporting-people/family-carers/Resources/benefitsguide (HFT)

Turn2us is a free service that helps people in financial need to access welfare benefits, grants and other financial help. The website includes a 'grants finder' and a benefit calculator to help check what welfare benefits you and / or your family member are entitled to:

www.turn2us.org.uk/

How discharge planning should happen

Discharge planning should be centred on the person and should include input from everyone who knows the person well, including those who will support them on discharge (e.g. the relevant community-based health and social care services). This is often known as a 'multi-disciplinary' approach.

It is important to note that local authorities (social services) have ongoing responsibility for individuals, even where they are in NHS-funded acute or mental health services, so they should remain involved. They should be working with the person, their family and all relevant health and social care professionals to develop and work towards delivering a discharge plan.

Individuals and their families have a critical role to play in successful planning and discharge arrangements. However, it is not their responsibility to manage and oversee the planning and discharge process, or to organise the care and living arrangements of their family member on their discharge from hospital.

The Government is clear that every person in an inpatient setting should have a care coordinator from their local area. This is usually a health (e.g. nurse) or social work (e.g. social worker) professional from a community learning disability or mental health team. They should work to support the individual through their hospital admission, as well as with their return home. They should lead on developing the discharge.

Top Tip

NHS England has said that all inpatients should have a care coordinator. Ask who your family member's care coordinator is if you don't know. If they haven't got one – ask for one!

Making sure the person's needs are met after discharge

Your family member should have had a needs assessment or care review in the unit. This should identify all their needs and set out how these will be met.

It is important that this process includes looking at what led to them being admitted to an inpatient unit in the first place (e.g. were their needs properly understood? Did staff have the right skills?). It is also important that adequate funding has been agreed. There is more about assessments, what good support looks like and how packages of care are funded in Factsheet 2.

Note - certain patients who have been detained under the Mental Health Act have a right to aftercare under Section 117 of the Act. This imposes a duty on health and social care services to provide free aftercare services for as long as the patient is in need of such services. (Your family member's care co-ordinator will be able to tell you if this applies).

What if discharge isn't happening?

Unfortunately we know that too many people are remaining stuck unnecessarily in inpatient units, often under the Mental Health Act.

Sometimes there can be delays in people moving on from a hospital setting. This can be for different reasons, including:

- Funding disputes: sometimes there can be disagreement over who (e.g. health or social care or which local authority) is responsible for funding an individual's package of care on leaving hospital. This might be between health and social services within the same local area or between localities. Sometimes disputes between localities are known as **ordinary residence** disputes.
- No appropriate service to go to: sometimes there can be a delay in discharge for someone as a result of a lack of appropriate provision for the individual. But this should not be an excuse. This should spur people on to think in a more personalised and innovative way to create an appropriate package around the person.
- No focus on discharge: some people have become stuck - sometimes for many years and this is not acceptable. Some families describe little or no planning for discharge for their family member, and/or lack of clarity about relevant professionals who should be involved.

See the 'When will my family get out?' section in **factsheet 4** for information about challenging a detention. The Top Tip at the end of this section highlights that being able to access legal representation can be important to help challenge unnecessary detentions.

See **Meeting the challenge: Frequently asked questions about the law** written by Irwin Mitchell Solicitors for more information about your family member's legal rights: **www.irwinmitchell.com/meetingthechallenge**

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Glossary

The Mental Health Act (1983) is the law which sets out when someone can be admitted, detained and treated in hospital against their wishes. This is only done if the person is putting their own safety or someone else's at risk and they have a "mental disorder". A "mental disorder" is described in the Act as "any disorder or disability of the mind" and includes a wide range of condition including things like personality disorders, depression and schizophrenia. The definition includes learning disability, but the Act states that someone with a learning disability and no other form of mental disorder may not be detained for treatment unless their learning disability is accompanied by abnormally aggressive or seriously irresponsible behaviour.

Ministry of Justice - under the Mental Health Act, some inpatients are detained in inpatient units (e.g. secure hospitals) having been diverted from the criminal justice system (e.g. the courts). Some of these people are 'restricted patients' which means they are subject to ongoing case-management by the Mental Health Casework Section of the Ministry of Justice, including decisions relating to their discharge. The Ministry of Justice is the Government department responsible for things like public protection.

Ordinary residence – this is the term used to refer to a person's 'usual' place of living and therefore to establish the authority responsible for the funding and / or provision of that person's care and support. Sometimes, a person's 'ordinary residence' status can be difficult to work out, which leads to disputes about the responsible authority.

For more information visit
www.mencap.org.uk/meetingthechallenge

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