Discharge and Transfer Policy and Procedure (Inpatient) (N-032)

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1. INTRODUCTION

Discharge planning is a co-ordinated, multi-professional and multi-agency process which facilitates the safe and timely discharge or transfer of an inpatient from the care of Humber Teaching NHS Foundation Trust (hereafter referred to as "the Trust"). This includes transfer to another hospital for ongoing treatment, including community hospitals or transfer to nursing or residential care homes.

The purpose of this policy is to provide an evidence-based best practice approach to facilitate the safe discharge or transfer of patients from all in patient units within the Trust.

Humber Teaching NHS Foundation Trust recognises that planning for timely discharge or transfer is an essential part of care management in any setting and must commence at the earliest opportunity. This should be where possible, a collaborative proactive process involving the patient, their families and carers, and inclusive of all agencies and disciplines as required. Arrangements must take account of all of the ongoing biopsychosocial care needs of the patient to ensure a co-ordinated package of care is in place to meet individual needs. Quality and timely communication is essential to effectively support patients using services and any ongoing care plans must be compliant with other related national or local policy requirements.

The policy and associated procedures describes the core standards to be implemented by all services in relation to discharge and transfer for patients who have been referred and accepted into the Trust in patient services.

Due to the diversity of services provided by the Trust, where there are additional service specific requirements, these will be described within the local Standard Operating Procedures, aligned to the best practice principles outlined in this policy and approved through divisional governance processes.

1.1. Background

In all in patient settings there is a drive to reduce both length of stay and delays in transfer and discharge. This requires a close working partnership with other organisations, including primary care, hospital services, Social Services, Mental health services, intermediate care services, voluntary services and the independent sector to deliver improved outcomes for patients.

The purpose of a properly planned discharge is to ensure that the patient can function appropriately and safely in their home immediately after discharge with no or minimal deterioration in their quality of life. This includes making appropriate alternative arrangements should the patient be unable to return home or requires additional support at home or end of life care.

Communication and consultation with the patient, their family and carers are of prime importance in ensuring the patient experience's care as a coherent and coordinated pathway.

The process of assessment and decision making should be patient-centred, placing the individual, their perception of their support needs and their preferred type of support at the heart of the process. Where consent of an adult cannot be obtained then decisions about their personal welfare, which includes discharge planning, should be determined in accordance with the Mental Capacity Act 2005 and the accompanying Code of Practice. This Act is designed to protect the rights of individuals and empower people.

2. SCOPE

This overarching policy applies to all staff involved in the discharge/transfer and associated care planning and care co-ordination processes for patients within the care of the Trust.

Due to the diversity of in patient service provision within the Trust, where service specific standard operating procedures/pathways/protocols are required in addition to core standards, they should

be developed and approved through the divisional governance structures (see Section 5: Procedures).

3. DEFINITIONS

For the purpose of the policy the following definitions apply

Transfer	The movement of a patient within Humber Teaching NHS Foundation inpatient clinical services to either another inpatient setting or community service
Discharge	The patient no longer requires an inpatient service and is discharged from the care of Humber Foundation NHS Trust back to their registered General practitioner with no ongoing care requirements from Trust services.
Non-Care Programme Approach (CPA)	Case managed, minimum requirement for Clusters 5, 11 and 18 – with appropriate seven-day follow-up arrangements, if within discharge planning, ongoing care needs are to be case managed (where patient has received inpatient care).
CPA	Care co-ordination for "Severe mental disorder (including personality disorder) with high degree of clinical complexity" – all other Clusters (Excluding 1-4).
Simple	The Department of Health toolkit (2004) describe these as patients who will usually return to their own home and have simple ongoing care needs which do not require complex planning and delivery.
Complex	All other discharges.

4. DUTIES AND RESPONSIBILITIES

Chief Executive
The chief executive has ultimate accountability for ensuring the provision of high quality, safe and effective services within the Trust.

Chief Operating Officer
Responsible for ensuring this policy is effectively implemented in practice and examines any associated risks identified via the corporate risk register process.

Divisional Clinical and Operational leads
Must ensure that all staff are aware and adhere to this policy and relevant appendices for their respective services to ensure quality, patient centred and effective transfer or discharge arrangements where required.

They are also responsible for ensuring that any deviation or errors arising are dealt with in the correct manner, according to the Incident Reporting Policy. They will, where appropriate and required, be responsible for formulating, implementing and reviewing where required local Standard Operating Procedures/pathways and protocols regarding transfer and/or discharge for their respective service areas to ensure best practice and revised guidance is reflected in Standard operating procedures etc.

Responsible Clinicians/Consultants
Are responsible for all aspects of the medical side of the transfer/discharge pathway and are responsible for the decision to transfer/discharge a patient. This authority may be delegated to a suitable and competent deputy.

Modern Matrons/Senior Professionals
Will ensure systems are in place to support this policy in their areas of responsibility and that they are regularly reviewed. Support teams in the planning for discharge/transfer of complex patients. Ensure that best clinical care is paramount during patient transfers and/or discharge.

Charge Nurses/Ward Sisters/Team Leaders
Will ensure that effective discharge/transfer planning processes are in place and operate effectively.
Ensure effective and timely communication between services.
Ensure that staff within their area of responsibility have access to and attend appropriate training.
Ensure that best clinical care is carried out during patient transfers and/or discharge.

Other Staff
All staff, both clinical and non-clinical are responsible for applying the principles contained within the overarching policy and any relevant service specific Standard Operational Procedures/pathways and protocols.

They have a responsibility to escalate concerns through operational/clinical structures where they are unable to meet requirements identifying any barriers in order to explore solutions to these issues to achieving good quality effective discharge/transfer.

5. PROCEDURES

5.1. Core Standards
These apply to, and must be followed by all services (unless otherwise stated).

Any services formulating local checklists/SOPs should refer to and consider the content of this policy and Appendix 1: Best Practice Standards, taken from the literature review for this policy.

Patients are admitted to our services where it has been established they meet relevant criteria for admission or service provision through identified triage or gatekeeping procedures.

The receiving ward/unit must be fully aware of the transfer/admission, a bed has been identified as being available and where applicable the senior medical officer has agreed to the transfer/admission.

Planning discharge/transfer for those patients who have been in receipt of a service from the Trust will be commenced at the earliest opportunity.

For patients assessed as lacking mental capacity to consent to discharge/transfer arrangements, best interest decision making process should be followed with collaboration with relevant others. See Consent Policy

Any potential for Deprivation of Liberty in relation to planned admission and associated care and treatment must be recognised and associated procedures followed.

* For end of life patients staff should be clear about the aims and objectives of the admission, use compassion and sensitivity and also discretion when making a decision about applying elements of this policy that are not appropriate in particular situations such as identifying an Expected Date of Discharge (EDD) if a patient has elected to come into hospital as their preferred place of death.

Patients should be assessed on their ability and competency to take their medications correctly as part of the on-going discharge assessment.

5.1.1. Expected Date of Discharge
An initial Expected Date of Discharge (EDD) should be agreed where possible with patients/carers within **24 hours** of arrival for those discharges which have been anticipated as being ‘Simple’ and communicated to staff in contact with the patient.

An initial EDD should be agreed where possible with patients/carers within **48 hours** of arrival for those discharges which have been anticipated as being ‘Complex’ and communicated to staff in

contact with the patient. For patients in receipt of in patient mental health services an EDD should be identified within 48 hours in line with complex admissions.

Daily clinical discussions with effective clinical leadership should consider ongoing patient needs and related care/treatment plan, and proactive management of discharge planning including achievement of EDD.

Related patient information leaflet about 'Your discharge' should be given to the patient and where appropriate carer.

5.1.2. Ongoing Discharge Planning

a) Review care plans/management plans at regular intervals within multi-disciplinary team (MDT) forums/clinical meetings/recovery meetings etc. to ensure proactive actions are taken regularly to progress to safe and appropriate patient discharge.
b) The **EDD and progress against this should be regularly reviewed** in such meetings and any changes to this should be made where possible in collaboration with the patient and carer.
c) Where a transfer to another care setting is required, where possible this should be discussed and agreed with the patient and the carers.
d) Patients and carers should be involved in making informed decisions and choices that deliver a personalised care pathway and maximise recovery and independence.
e) Planning for discharge should include all appropriate statutory and voluntary agencies necessary to meet the patient's needs to avoid unnecessary readmissions through the effective co-ordination and delivery of services.
f) Local authorities should be involved in the discharge process where appropriate and where applicable. Ensure relevant notifications are made to them in a timely way to progress any assessment and discharge arrangements.
g) Carers should be offered an assessment to identify any services they may need to support them in their caring role if appropriate.
h) Where appropriate, a patient's eligibility for NHS continuing healthcare must be assessed in a timely fashion, or any extra contractual funding requests/exceptional treatments must be identified and negotiated through identified local arrangements.
i) Make decisions to facilitate planned discharge and transfers over seven days where it is possible to ensure continuity of care delivery can be provided to meet patients care needs on discharge.

5.1.3. Delayed Transfer or Discharge

A delayed transfer or discharge of care occurs when a patient is ready to depart from such care and is still occupying a bed.

The national definition for this situation is as follows:

A patient is ready for transfer/discharge when:

a) A clinical decision has been made that patient is ready for transfer **and**
b) A multi-disciplinary team decision has been made that patient is ready for transfer **and**
c) The patient is safe to discharge/transfer.

A multi-disciplinary team in this context includes nursing and other health and care and support professionals, caring for that patient.

Once the patient meets the definition above and is ready for discharge/transfer, it is from this date onwards that their discharge/transfer is considered to be delayed.

5.1.4. Prior to Discharge (24-48 hours prior to EDD)

It is critical to use effective communication prior to a patient discharges to ensure timely support and care arrangements are in place to meet assessed need. Reference should be made to the service specific information sharing protocols regarding the sharing of information with other agencies.

Inpatient teams and community based services must ensure a comprehensive handover and exchange of pertinent clinical information through a combination of verbal, written and face to face information exchange. This must be recorded as per defensible documentation requirements

Wherever possible patients/family and/or carers will be given at least **24 hours**' notice of discharge.

Clinical staff must be assured the patient is both physically and psychologically prepared for discharge from hospital and appropriate support is available as described in the appropriate discharge care plan or equivalent which must be in place outlining any ongoing arrangements for care and treatment.

A summary of their discharge care plan and where applicable risk and relapse plan/long-term safety plan **and** Initial Discharge Letter (IDL)/discharge summary pro forma will be shared with the patient's GP and all relevant clinicians or clinical teams, who will be involved in the patient's care on discharge. This will always include details of the current medication prescribed and any physical health needs.

The patient's key worker/named nurse or other identified person as directed by the charge nurse within inpatient areas will ensure that this is completed, sent and details regarding its completion entered in the clinical records.

Additionally where relevant this information will be shared with all other appropriate and relevant healthcare/local authority professionals securely on the day of discharge. The patient's key worker/named nurse or other identified person as directed by the charge nurse within inpatient areas will ensure that this is completed, sent and details regarding its completion entered in the clinical records.

When patients are discharged from inpatient services staff are to follow the Procedures for Safe and Secure Handling of Medicines, to ensure patients leave with the correct medication and are competent in self-administration or if not alternative support for administration of medicines is in place.

The Initial Discharge Letter (IDL) should be sent to the general practitioner on discharge and a copy offered to patients/carers for their information.

All patients will be offered a copy of their care plan/discharge plan/Initial Discharge Letter (whichever is appropriate to care setting) and where applicable.

Their current risk and relapse plan/long-term safety plan. This should include personalised signs and symptoms of relapse and contact numbers for in-hours/out of hours where assistance may be obtained.

All information shared with healthcare professionals, patients/carers will be documented in patient records for audit purposes.

Additional information required by the patient with regard to any further treatment or ongoing condition is provided along with any appropriate information leaflets.

Where appropriate, and where consent is gained/carers/significant others should be involved in the discharge process and receive a copy of the above documents. This will be documented in the patient record.

5.1.5. Transfer/Discharge of an Infectious Patient

The Trust has a duty to ensure that all patients who are undergoing any treatment or intervention in an inpatient or outpatients setting are protected from the potential and actual acquisition of Healthcare Associated Infections (HCAI). It is therefore important that there effective communication between the Trust and any other healthcare provider when care is being transferred from one care facility to another to prevent the spread of a communicable disease.

In accordance with the Infection Prevention and Control Admission, Transfer and Discharge Policy a risk assessment must be undertaken on all infectious patients transferred or discharged from the trust to determine the potential risk of a patient contracting or spreading infection. See the IPC Admission/Transfer and Discharge Policy.

The nurse in charge of the unit or nominated deputy should ensure that the area that is receiving the patient has received verbal communication and information regarding the patient's infective status prior to transfer.

If the patient is being discharged home the general practitioner should be informed if any patient requires any continuing care or treatment, such as wound management or a physical care package, then the appropriate healthcare professional needs to be informed prior to the patient's discharge, e.g. district nurse/therapist. Any verbal communication needs to be recorded in the patient's notes.

5.2. Mental Health and Learning Disability

Specific standards to be followed in addition to Core standards

All patients in receipt of inpatient care will have care co-ordinated within the CPA framework whilst they remain an inpatient.

Discharge planning must also be co-ordinated within the associated requirements of the CPA framework/Section 117 requirements (for further information regarding associated requirements see Trust guidance on delivery of the CPA pathway).

Prior to discharge from inpatient services, the clinical team responsible for the patient will undertake an assessment/revise the existing assessment of clinical risk using the agreed pro forma in relation to returning to the community which will inform the decision for timescales for follow-up.

Where any medication is prescribed on discharge, the clinical team should use information available to them and decide based on the updated risk assessment whether they will limit the amount of medication given to the patient on discharge and provide less than the standard seven days discharge prescription (i.e. provide medicines daily, or only two or three days' worth). Should limited supply of medicines be given in response to presenting risks, the rationale for this and any recommendations about future prescribing should be communicated within the Initial Discharge Letter ensuring continuity of measures to reduce assessed risk.

Clinical teams will hold a discharge planning meeting involving the patient/carer and relevant others for all patients prior to planned discharge. Those still in receipt of care and treatment will receive follow up within a maximum of seven days of discharge or sooner (within 24-48 hours) if the clinical risk assessment identifies particular vulnerabilities. Where additional vulnerabilities have been identified, and the contact is arranged within two days following discharge, this must where possible be face to face. If a face to face visit is unable to be conducted, the reason for this must be recorded in the clinical notes, and discussed within the MDT at the earliest opportunity.

Other follow-up contacts should be face to face, but could take place over the telephone if judged appropriate by the clinical team in line with the patient's clinical risk assessment, individual profile of the patient, and the patient's wishes.

Discharge care plans for people who are at high risk of suicide will require more intensive support following discharge from inpatient care.

A small number of people following assessment will be identified as requiring no further mental health treatment/care. They will be discharged from services and therefore will not require ongoing care within the CPA or case management frameworks, however where appropriate as part of discharge planning, the MDT will consider the need to provide one follow-up contact – face-to-face or telephone depending on risk profile and rationale for level of provision will be documented in patients notes.

Every patient discharged from inpatient care who continues to receive secondary mental health services will have an individualised package of care in line with requirements within CPA and relevant care cluster. This will take into account any issues relating to equality and ongoing biopsychosocial needs of the patient.

A review of the patient's cluster will take place prior to discharge facilitated by the care co-ordinator.

Integrated records should be made available to the community teams within five working days allowing for the completion of comprehensive discharge letter. Any relevant working documents should be photocopied at the point of discharge and given to the accepting community mental health/learning disability team to inform their continued care and treatment of the patient.

5.3. Patient Transfers

5.3.1. Mental Health and Learning Disability Services

All patients transferred internally between mental health/learning disabilities wards will be reviewed medically and clinically by a member of the medical team on the receiving wards within two working days. This can be either by the Consultant Psychiatrist or their nominated deputy. This review will be documented in the clinical records.

Where required a Section 17 form would need to be completed, or in the case of an emergency, at the earliest opportunity.

When existing inpatients are transferred between teams or out of area, the care co-ordinator will provide the receiving care professional with copies of relevant documentation (following where appropriate CPA guidance and any Service specific Standard Operating Procedures/pathways/ protocols). The most appropriate practitioner should liaise with the receiving team. As a minimum a verbal handover should be given and the details of the handover should be documented in the patient's records. With more complex handover information is necessary, the SBARD communication tool should be used to focus and aid this exchange.

5.3.2. Medium Secure Forensic Units

Please follow relevant divisional Standard Operating Procedures and guidance.

5.3.3. Community units

A referral is made via internal mechanisms, and the rationale for the change of clinical area is documented on the referral/transfer form.

As a minimum a verbal handover should be given and the details of the handover should be documented in the patient's record.

Existing care plans/medication charts should be reviewed and shared with the receiving ward, and where appropriate patient/carers.

5.4. Transfer of the Deteriorating Patient to Acute Services

Any patient in hospital may become acutely ill. This might require them being conveyed to an acute hospital ward or unit. The occurrence might be in-hours or out of hours. The core standards for staff to follow do not change, the order might change in an emergency.

All inpatients must have a clear care plan that sets out the frequency of monitoring of the patients' physical observations and should be reviewed following any signs of clinical change/deterioration. Responses to change should be in line with the graded responses that support the NEWS2 and care escalated as appropriate. The attending healthcare professional can override the NEWS2 if they consider it necessary to escalate care, NEWS2 should be used to aid decision making in relation to transfer of a patient.

If a patient needs to be transferred into the acute care setting staff should communicate using the SBARD framework to ensure accurate and relevant information is relayed to the accepting healthcare professional. See Physical-health-and-care-of-the-deteriorating-patient-policy-and-procedure

Where a member of medical staff works with or to the service area, all patients transferred into the acute trust will have a letter from the responsible consultant or a doctor working to them to the receiving doctor within the acute trust, as per the Physical Health Policy.

If a patient deteriorates to an extent that transfer/Admission to another unit is required then certain principles need to be followed. Information needs to be shared using the SBARD format along with the score from the NEWS2. This would ensure that all key stakeholders are aware of the patient's immediate needs.

Where a medical emergency arises for patients on community units, it is common practice to seek advice if possible from the general practitioner who may direct staff to summon an emergency ambulance. If these circumstances arise, the minimum information of drug card and medical history must be photocopied if possible and be sent with the patient. A verbal handover can also take place between clinical staff and attending paramedic/ambulance technicians.

When a medical emergency arises for patients detained under the Mental Health Act, an emergency Section 17 leave form may already be in place and have been anticipated, where this isn't already available, a Section 17 form must be requested at the earliest opportunity.

The information given to the admitting unit would take the form of a verbal/written handover dependant on the situation. Best practice would indicate that the handover is undertaken by the medical practitioner to medical practitioner using the SBARD. The doctor should ensure that a letter is sent detailing the information and a copy should be placed in the patients' notes. Information governance requirements and information sharing protocols must be adhered to.

In an emergency situation out of normal hours, the most appropriate practitioner should liaise with the admitting unit and a verbal handover should be given. The details of the handover should be documented in the patient's records. Photocopies of significant medical records to support safe and seamless continuity of care should be transferred with the patient.

Where appropriate all information should be shared via electronic records.

The following minimum information should be documented (same requirements for paper records):

1. Clear rationale as to why the transfer of the patient was felt appropriate.
2. The views of the patient and carers/relatives and those clinicians involved in the care of the patient.

3. Concerns that may be highlighted as a result of the transfer.

Arranging suitable transport for the patient is the responsibility of the transferring ward or unit.

The **medical** records (not to be confused with integrated mental health records) should be traced out and follow the patient from team to team, and be sent within three working days. Copies of any relevant Humber documentation, such as care plans, risk assessments and physical health needs. If this is not possible a note should be put into the clinical records as to why this was not achieved. This will reduce the risk of delays in treatment or the wrong interventions been followed. The same principles will apply for transfer of teams within and external to the Trust.

All patients with Learning Disabilities will use the Patient Passport when using services within the acute trust.

5.5. Transfer to Out of Area

When existing community or inpatients are transferred between teams or out of area, the care co-ordinator will provide the receiving care professional with copies of all relevant documentation to ensure continuity of care.

The most appropriate practitioner should liaise with the receiving team and a verbal handover should be given. The details of the handover should be documented in the patient's records. Photocopies of significant medical records to support safe and seamless continuity of care should be transferred with the patient. The following documentation should be shared as a minimum with the receiving team:

- Care plans
- Risk and relapse plan/long-term safety plan, where applicable
- Risk assessment, where applicable
- Physical health needs

Where applicable, CPA responsibilities for provision of continued care co-ordination should be provided in line with national policy and local guidance.

5.6. Patients wishing to take their Own Discharge

There may be occasions where discharge is not clinically appropriate or supported by the multi-disciplinary team. In these circumstances the following principles need to be followed:

- Where a patient insists on taking own discharge, request that the patient signs a Self-Discharge Form (Form Z10 – intranet under Mental Health Act forms).
- Once completed this is to be filed in the patient's notes/upload onto Lorenzo or SystmOne as per local arrangements.

5.6.1. Mental Health/learning Disability Service

If the patient has informal status the request to take self-discharge should be considered/assessed by the registered clinician on duty, where possible in discussion with others. If the outcome of the discussion/assessment determines no risk or low risk to self or others that can be mitigated or plans put in place to manage the discharge request should be supported. All information regarding potential risks of self-discharge and the benefits of continuing with their hospital care must be explained to the patient to allow them to make an informed decision, ensuring the principles of the CPA or equivalent are followed regarding the safe discharge to an appropriate place, with follow-up arrangements put in place.

All discussions with the patient must be documented accurately in the patient's nursing records. Ensure all appropriate members of the multi-disciplinary team involved in the patient's care are informed as soon as possible.

Ensure that the patient's own GP is informed as soon as possible, and where possible inform the GP verbally of the situation. Complete the discharge letter stating the patient discharged against professional advice.

If appropriate, obtain the patient's consent to inform their next of kin of patient's self-discharge. Ensure that the circumstances surrounding the self-discharge process and the actions taken are fully documented in the patient's records. If the patient continues to take their own discharge despite having full explanations of the consequences, they must arrange their own transport by which to leave the hospital.

Medical advice must be sought for any patient who is wishing to take their own discharge if the staff member believes that the patient lacks capacity to make the decision and that by taking their own discharge they would be putting themselves at significant risk. Should the patient leave the premises before this advice can be obtained consideration must be given to informing the next of kin and/or the Police. All discussions and decisions must be documented in the patient's notes.

Ensure form Z10 – Self discharge is completed, copy given to patient and placed in note.
Z10 form

If informal but judged to be a danger or risk to self or others – Consider the use of the holding powers described in the Mental Health Act (2007) and its Code of Practice (2008) if appropriate persuasion does not prove effective. A full record must be made of the discussion and rationale for the use of holding powers in the patient's records. Any interventions used to prevent the patient leaving hospital must also be documented in the clinical records as well as any appropriate documentation. If holding powers are used then a full review of the patient must be held with the appropriate professionals in line with the time frames specified within the Mental Health Act.

5.6.2. Community (Inpatient) Services

All information regarding potential risks of self-discharge and the benefits of continuing with their hospital care must be explained to the patient to allow them to make an informed decision. All discussions with the patient must be documented accurately in the patient's nursing records.

Ensure all appropriate members of the multi-disciplinary team involved in the patient's care are informed as soon as possible. Where the patient insists on taking own discharge, request that the patient signs the relevant self-discharge form. Where the patient lacks mental capacity in relation to the decision to take self-discharge staff must ensure they follow procedures and consult where practicable with relevant others, as described to Mental Capacity Act and best interests process to establish if authorisation to detain someone under Deprivation of Liberty Safeguards.

Medical advice must be sought for any patient who is wishing to take their own discharge if the staff believe that the patient lacks capacity to make the decision and that by taking their own discharge they would be putting themselves at significant risk. Should the patient leave the premises before this advice can be obtained consideration must be given to safeguarding responsibilities informing relevant others including statutory agencies as required.

Ensure that the patient's own GP is informed as soon as possible and where possible inform the GP verbally of the situation. Complete the discharge letter stating the patient discharged against professional advice.

If appropriate, obtain the patient's consent to inform their next of kin of patient's self-discharge. Ensure that the circumstances surrounding the self-discharge process and the actions taken are fully documented in the patient's records. If the patient continues to take their own discharge despite having full explanations of the consequences, they must arrange their own transport by which to leave the hospital.

Ensure form Z10 – Self discharge is completed, copy given to patient and placed in notes.
Z10 form

5.7. Homeless People

The health and wellbeing of people who experience homelessness is poorer than that of the general population. They often experience the most significant health inequalities. The longer a person experiences homelessness, the more likely their health and wellbeing will be at risk.

The Homelessness Reduction Act 2017 places duties on local housing authorities to take reasonable steps to prevent and relieve an eligible applicant's homelessness.

The Act has introduced a new 'duty to refer', from October 2018, requiring specified public authorities (including all inpatient services) in England to notify Local Housing Authorities of individuals they think may be homeless or threatened with becoming homeless in 56 days.

A person is considered homeless if:

- They do not have any accommodation which is available for them which they have a legal right to occupy; or
- It is not reasonable for the person to occupy their current accommodation, for example, because they would be at risk of domestic abuse.

Actions to be taken

Consider the patient's social circumstances and identify whether the patient is homeless or at risk of homelessness at the earliest opportunity (via CPA/ward rounds/medical reviews/assessments).

Discuss and gain consent with the patient to refer to the housing authority of their choice. The duty allows service users to choose which local housing authority they are referred to. However, when discussing the referral and offering guidance to the service user, it is important to be aware that local housing authorities owe more duties towards homeless applicants who have a local connection with their area.

Referral to a housing authority is via the 'Duty to Refer' form. There is a generic form which can be emailed to the appropriate housing authority (please see the link below for the referral form and email contacts for housing authorities) https://www.gov.uk/government/publications/homelessness-duty-to-refer.

In partnership with Hull City Housing there is a referral pathway and a specific referral form for mental health services to Hull Housing please access the safeguarding Intranet page for a copy of this form. This ensures multi-agency working. For example; following a referral, housing services could attend CPA meetings and hold hostel beds for patients until discharge.

When arranging a discharge for a homeless patient to the community staff should make a referral to housing and not rely on the patient making the referral themselves.

5.8. Discharging Patients who Disengage from Services

Every effort should be made to understand why a patient is not readily engaging with services, where consent is given this should include conversations with patient's carer.

All efforts made in relation to this should be documented in the patient's records.

Consideration should be given to the patient's mental capacity and the ability to consent to proposed care and treatment and to understand the consequences and implications of not engaging.

Clinicians should consider if there are any safeguarding considerations or actions required, this may include undertaking responsibilities around self-neglect as outlined in the Care Act (2015), or

initiating the Vulnerable Adults Risk Management Meeting (VARM) process. Advice and support is available from the Trust's Safeguarding Team.

Where appropriate, assessment can be sought under the Mental Health Act to establish if nature of concerns and presentation of patient would meet threshold for detention and treatment.

Otherwise, having taken reasonable steps to engage the patient and have dialogue around implications, and having discussed the circumstances within either an MDT forum (or with GP and relevant others in community service settings), the decision to discharge the patient from the care of Humber Teaching NHS Foundation Trust can be made and associated procedures followed through.

In these circumstances, it is important to give written information where possible to the patient/carer, advising should they choose to at a future date, how they can make contact and re-engage with our services.

5.9. Service-Specific Standard Operating Procedures

- Adult Mental Health Inpatient Procedure for admission, transfer and discharge
- Older People's Mental Health Inpatient Procedure for admission, transfer and discharge
- Community Inpatient Procedure for admission, transfer and discharge
- Learning Disability Inpatient Procedure for admission, transfer and discharge
- CAMHS Inpatient Procedure for admission, transfer and discharge
- Specialist Services

6. IMPLEMENTATION AND MONITORING

This policy will be disseminated by the method described in the Document Control Policy

Additionally, there will be a resource implication in undertaking identified monitoring and associated actions to continually seek to improve discharge/transfer planning and implementation.

Divisions should determine frequency and number of audits to be completed to provide assurance of compliance with best practice requirements as described within the policy to give assurance around patient experience and safe and effective care.

Other existing mechanisms for monitoring are as follows:

1. Reporting of delayed discharges via monthly spreadsheet (or inputted directly into Lorenzo) and discussion with chief operating officer/relevant staff to understand extent of delayed discharges and barriers.
2. Adult inpatient service discharge care pathway.
3. Community services hospital admission/discharge pathway.
4. Local discharge checklists.
5. Datix systems to highlight 'Transfer of care concerns' – where concerns are identified pertaining to the transfer of a patient from acute area/transfer of care concerns form agreed within local health community for use to highlight associated concerns for investigation.

7. TRAINING AND SUPPORT

This policy will require local training resources to ensure knowledge and competencies associated with best practice and discharge planning in line with the local standard operating procedures.

8. REFERENCES

Department of Health (2008) Refocusing the Care Programme Approach – Policy and positive practice guidance

Care Quality Commission (2009) 'National report: Managing patients' medicines after discharge from hospital'

Department of Health (2010) –Ready to go: Planning the discharge and transfer of patients from hospital and intermediate care

National Institute for Health and Clinical Excellence (NICE) 2011 clinical guidance 136 *Service user experience in adult mental health: improving the experience of care for people using adult NHS mental health services*

British Medical Association (2014) 'Hospital discharge; the patient, carer, doctor perspective'

Healthwatch (2015) – Safely home: what happens when people leave hospital and care settings?

Releasing time to care – productive series admission/discharge planning

Care Quality Commission (2015) – The fundamental standards

National Health Service act (2006) – The Delayed discharges (continuing care) directions 2013

Department of Health (2015) NHS Continuing Healthcare Checklist November 2012 – revised

9. RELEVANT POLICIES/PROCEDURES/PROTOCOLS/GUIDELINES

CPA Policy and Procedural Guidance

Clinical Risk Assessment, Management and Training Policy

Multi-Agency Policy and Procedure for conveying a patient to hospital under the Mental Health Act

Entry and Exit for Non-Secure Mental Health and Learning Disability Inpatient Units Policy

Infection, prevention and control Admission, Transfer and Discharge Policy

Medicines Reconciliation Guideline

Patients' Property Procedure

Physical Health Policy

Deteriorating Patient Policy

Risk Management Strategy

Section 117 Aftercare Protocol

Safe and Secure Handling of Medicines Procedures

Appendix 1: Best Practice Standards

Key considerations to inform content of local Standard Operating Procedures and checklist

- Must meet defensible documentation requirements
- Patient/carer information leaflets related to discharge/transfer given
- Equipment required to facilitate discharge in place
- Referrals to other agencies/services have been completed as required
- Transport arrangements
- Discharge to a safe environment
- Return of patient property
- Medical certificates issued where required
- Patients and carers are kept fully informed of progress towards discharge and any barriers to this
- Given or offered any other patient/carer information at point of discharge
- Carers needs considered, have the patients care needs changed and can the carer still meet these needs
- Medication provision, arrangements for timely communication re: medicines and any changes in prescribing. Ensure adequate information is given to patients/carers as appropriate re: changes in medicines
- Funding requirements for accommodation/ongoing care and treatment where applicable resolved and agreed
- Ensure effective communication systems between statutory/voluntary agencies and discharging team
- Mental Capacity Act and best interest requirements in relation to proposed care and treatment
- Deprivation of Liberty requirements in relation to proposed care and treatment
- Discharge care plan taking into consideration ongoing biopsychosocial ongoing care needs and how these will be addressed, including consideration as to how this is formulated and shared with patient taking account of their needs, preferences and strengths (NICE CG136) and carer where appropriate
- Risk and relapse plan/long-term safety plan where appropriate, to include personalised signs and symptoms of relapse and information for who to contact if help is required after discharge. Where required to include specific contact details including consideration as to how this is formulated and shared with the patient and carer where appropriate
- Clearly defined staff roles in relation to discharge/transfer process and associated responsibilities
- Staff training and competency requirements
- Decision making frameworks allowing clearly agreed individual parameters for discharge, to enable nurse led discharge across seven days
- Updated risk assessment
- Requirements for the patient under the Mental Health Act, including Section 117 eligibility and Care programme approach requirements
- Follow-up arrangements including any outpatient appointments, tests or treatments required
- Discharge/summary letter
- DNACPR status
- Out of hours discharge process
- Effective handover between care settings, associated procedures/joint working protocols
- Out of hours handover process
- Relationships/networks within partner care providers/agencies, fostering effective relationships and how to address barriers to discharge/transfer including representation and engagement at local relevant multi-agency/disciplinary forums
- Managing delayed discharge
- Out of area transfer procedure

Appendix 2: Document Control Sheet

This document control sheet must be completed in full to provide assurance to the approving committee.

Document Type	Inpatient Discharge and Transfer Policy and Procedure (N-032)		
Document Purpose	The purpose of this policy is to provide an evidence-based best practice approach to facilitate the safe discharge or transfer of patients from all in patient units within the Trust.		
Consultation/Peer Review:	Date:	Group/Individual	
List in right hand columns consultation groups and dates		Triumvirate – clinical, medical, operational leads, modern matrons representative across all services	
Approving Committee:	QPaS	Date of Approval:	
Ratified at:		Date of Ratification:	
Training Needs Analysis: *(please indicate training required and the timescale for providing assurance to the approving committee that this has been delivered)*		Financial Resource Impact	
Equality Impact Assessment undertaken?	Yes [ ]	No [ ]	N/A [ ] Rationale:
Publication and Dissemination	Intranet [✓]	Internet [ ]	Staff Email [✓]
Master version held by:	Author [ ]	HealthAssure [✓]	
Implementation:	*Describe implementation plans below - to be delivered by the Author:*		
	• This policy will be disseminated by the method described in the Policy and Procedural Documents Development and Management Policy. • This policy may require additional local training resource to ensure knowledge and competencies associated with best practice and discharge planning. • Additionally, there will be a resource implication in undertaking identified monitoring and associated actions to continually seek to improve discharge/transfer planning and implementation.		
Monitoring and Compliance:	An organisational audit tool (Appendix 3) has been developed to further understand compliance against agreed quality standards around discharge planning. Divisions should determine frequency and number of audits to be completed to provide assurance of compliance with best practice requirements as described within the policy to give assurance around patient experience and safe and effective care. The Audit tool is based upon best practice as described within: Department of Health (2008) Refocusing the Care Programme Approach – Policy and positive practice guidance Department of Health (2010) – Ready to go: Planning the discharge and transfer of patients from hospital and intermediate care		

	Health watch (2015) – Safely home: what happens when people leave hospital and care settings? Care Quality commission (2015) Community services key lines of enquiry (KLOE)

Document Change History: (please copy from the current version of the document and update with the changes from your latest version)			
Version number/name of procedural document this supersedes	*Type of change, e.g. review/legislation*	*Date*	*Details of change and approving group or executive lead (if done outside of the formal revision process)*
2.02	Review	April 2011	Reviewed
3.00	Review	July 2012	Reviewed and harmonised with ERYPCT Legacy policy CP26
3.01	Amendments	December 2012	Amendments to Section 5.1 and 5.2 following NHSLA assessors visit
3.02	Amendments	December 2013	Amended to reflect NEWS and SBARD
3.03	Minor amendments	April 14	Minor changes made following SI to Section 5.1 regarding all patients transferred internally within mental health/learning disability wards to be reviewed medically and clinically be a member of the admitting wards medical team within two working days. Added patient complaints in the monitoring section. Minor changes to incorporate wider principles of Supreme Court ruling and revised 'Acid test' in relation to Deprivation of Liberty Safeguards (DOLs)
3.04	Minor amendments	November 2014	Minor changes to incorporate wider principles of Supreme Court ruling and revised 'Acid test' in relation to Deprivation of Liberty Safeguards (DOLs)
4.00	Review	Dec 15	Reviewed in line with related national policy, consideration given to Homeless, Refugees and Prisoners in line with national policy requirements. Audit tool developed to be used to evaluate adherence of policy implementation and self-discharge form revised
4.01	Minor amendments	April 16	Minor changes following consultation
5.00	Review	May 19	Removed information in relation to admission criteria. Added section 2 – Background. Changed responsibilities section to show the chief operating officer as responsible or the implementation of the policy. Removed z10 Appendix as current form available on the intranet.