TRUST WIDE DOCUMENT

	Policy
DOCUMENT TITLE	Patient Discharge Policy
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DOCUMENT REPLACES	Version 2.5
LEAD EXECUTIVE DIRECTOR DGM	Executive Director of Integrated Care, Partnerships and Resilience
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TARGET AUDIENCE	All Trust Personnel
DOCUMENT PURPOSE	To manage the risks associated with the discharge of patients and ensure efficient access to resources/services so that appropriate discharge arrangements are made to enable patients to return to the community setting in a safe effective, timely manner, meeting individual needs.
To be read in conjunction with (identify which internal documents)	ELHT admission and discharge Bundle

SUPPORTING REFERENCES	1. The Community Care (Delayed Discharges) Act 2003 2. ELHT/C001 – Management of Procedural Documents 3. Carers and Disabled Children Act 2000 4. Carers (Recognition and Services) Act 1995 5. The National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care DOH 2007 6. ELHT/C014 Consent to Examination or Treatment Summary 7. Fair Access to Care Services (LAC(2002)13) – DoH 2002 8. Lancashire Area Child Protection Policy, Guidance and Procedures 2000 9. Transfer of Care from An Acute Hospital Bed 2003 – Cumbria and Lancashire SHA Joint Protocol 10. NHS & Community Care Act 1990 11. Delayed Transfers of Care of Acute, Non Acute and Mental Health Patients – Health Care Commission 2003/6 12. Direction of Choice (LAC(92)27 – LAC(93)18) 13. Report of the Confidential Enquiry into Homicide and Suicide by people with a Mental Illness 1999, Page 96 recommendation 21) 14. Gillick v West Norfolk and Wisbech AHA 1986 15. Every Child Matters – DoH 2003 16. ELHT Paediatric Discharge Guidelines 2006 17. Discharge from Hospital: Pathway, process and practice (DoH 2003) 18. Race Relations Amendment Act 2000 19. Disability Discrimination Act 1995 in addition to amendments made in 2005 20. Mental Capacity Act, 2005 – and the Code of Practice relating to this Act (full implementation October 2007) 21. The Health Act, 2006 – Code of Practice for the Prevention and Control of Health Care Associated Infections 22. ELHT Joint Policy Mental Capacity Act Statement and Guideline 23. ELHT/IC0015 Admission and Transfer of Suspected and/or Confirmed Infected Patients. 24. Hospital discharge and community support: policy and operating model. March 2022. 25. ELHT Admission and Discharge Bundle of care.

CONSULTATION		
	Committee/Group	**Date**
Consultation	Hospital Discharge Oversight Group	June 22
Approval Committee	Senior Leadership Group	June 22
Document ratification date	24 August 2022	
NEXT REVIEW DATE	June 2024	
AMENDMENTS	Revised to reflect Organisational reconfiguration and current practices	

1. INTRODUCTION AND OVERVIEW

POLICY STATEMENT

To manage the risks associated with the discharge of patients and ensure efficient access to resources/services so that appropriate discharge arrangements are made to enable patients to return to the community setting in a safe, effective and timely manner, meeting individual needs.

The principles of discharge planning should apply to all discharges, short stay, long stay or patients/clients who have simple or complex needs. The term discharge includes the discharge of in-patients, Day Surgery patients, Emergency Department and Urgent Care patients; and discharge to own home or carer, Care Home, Hospice, Residential rehabilitation unit, Sub acute rehabilitation unit, Continuing Care NHS hospital bed. The executive lead for discharge is the Executive Director of Integrated Care, Partnerships and Resilience

1.1 Discharges are grouped as follows:

- **Simple (Pathway 0)** - Where there is minimal disturbance to the patient's activities of daily living which does not prevent or hamper their return to their usual place of residence. They do not require input from the Hospital social work team. The Consultant and Senior Ward Sister is responsible for the discharge of patients in this group and will ensure adequate provision of information to the patient and appropriate liaison with primary care Colleagues where necessary. The lead coordinator for pathway 0 is the Head of Patient Flow clinical flow services support this operational delivery.

- **Complex (Pathway 1,2,3) -** When the patients' needs may have changed or they may require the restart of a package of care involving primary care, mental health services and /or social services. The patient does require input from the Hospital social work team; All *potential* complex discharges should be referred to the Complex Case Management Team. The lead coordinator for pathway 0 is the Head of Complex Case management/ Integrated Discharge Service operational delivery manager clinical flow services support this operational delivery.

- **Unplanned discharges –** Where a patient discharges his/herself against medical advice. Advice will be given to the patient to support an unplanned discharge against medical or multidisciplinary team advice. The patient's mental capacity to make this decision will also be assessed.

1.2 Discharge is a process and not an isolated event and should be initiated on, or before, admission or as soon as practical thereafter. It should be

discussed in the out-patient setting and in pre-operative assessment clinics. It will be planned for at the earliest opportunity across the primary, hospital and social care services, ensuring that individuals and their carer(s) understand and are able to contribute to care planning decisions as appropriate. A predicted discharge date, based upon the expected clinical pathway as decided by the parent consultant in liaison with the MDT will be given to the patient and/or carers/relatives, and on Notification to Social Services if applicable. Arrangements for outpatient follow-up will also be explained. These may include hospital, primary care, telephone or open follow-up, dependent on the Consultant's follow-up protocol. It should not be taken for granted that all patients will require a routine outpatient appointment following discharge.

1.3 Effective, patient-focused discharge planning is imperative from admission to prevent harm ensure safe personal and effective care and because poor discharge planning may result in patients/clients remaining in hospital longer than necessary or may necessitate unnecessary outpatient follow-up or readmission to hospital.

1.4 The recognition of responsibilities, engagement and active participation of the multidisciplinary team including voluntary agencies, individuals and their carer[s] as equal partners is central to the delivery of care and in the planning of a successful discharge

1.5 The discharge decision will be reached by the multi-disciplinary team, in consultation with the patient and carers, if that is not possible a suitable advocate will be used to support. The discharge to assess principles of care will be mobilised where appropriate; as set out in the national Policy on Hospital Discharge and Community support: policy and operating model October 202. Our patients will follow a pathway approach.

- ***Discharge to assess model – pathways***

Pathway 0

- ***Likely to be minimum of 50% of people discharged:***
- ***simple discharge home***
- ***no new or additional support is required to get the person home or such support constitutes only:***
    - ***informal input from support agencies***
    - ***a continuation of an existing health or social care support package that remained active while the person was in hospital***

Pathway 1

- ***Likely to be minimum of 45% of people discharged: able to return home with new, additional or a restarted package of support from health and/or social care. This includes people requiring intensive support or 24-hour care at home.***

- ***Every effort should be made to follow Home First principles, allowing people to recover, reable, rehabilitate or die in their own home.***

Pathway 2

- ***Likely to be maximum of 4% of people discharged: recovery, rehabilitation, assessment, care planning or short-term intensive support in a 24-hour bed-based setting, ideally before returning home***

Pathway 3

- ***For people who require bed-based 24-hour care: includes people discharged to a care home for the first time (likely to be a maximum of 1% of people discharged) plus existing care home residents returning to their care setting (for national data monitoring purposes, returning care home residents will count towards the 50% figure for Pathway 0).***
- ***Those discharged to a care home for the first time will have such complex needs that they are likely to require 24-hour bedded care on an ongoing basis following an assessment of their long-term care needs.***

1.6 A safe discharge is reliant upon the assessments made by a multidisciplinary team, the responsibility for which rests with the Consultant under whose care the patient is registered.

1.7 A safe personal and effective discharge requires all MDT team members to ensure that required tasks such as TTO's, referrals etc. are made in a timely way

2. TRUST RESPONSIBILITIES

2.1 The Trust's responsibilities for the effective management of risk ultimately lie with the Chief Executive. However, the formulation and dissemination of this Policy will fall upon the Departmental/Ward Manager of the specific clinical area.

2.2 The Head of Patient Flow and Head of Complex Case Management authors this policy.

2.3 The Executive Director of Integrated Care, Partnerships and Resilience is the Executive Lead for Discharge and has responsibility for the overall operational management of the Integrated Discharge Service and Community and Intermediate Care Division.

2.4 The Chief Operating Officer/Deputy Chief Operating Officer has responsibility for the overall operational management of the Acute Clinical Divisions and Patient Flow Service.

2.5 The Chief Nurse and Executive Medical Director has overall nursing and clinical responsibility for Trust services.

2.6 The Trust will:

2.6.1 ensure that each professional group, wards and departments has access to the current Discharge Policy on the ELHT intranet link for Policies and Procedures and that there is an awareness of this policy within other relevant Health and Social Care Organisations·

2.6.2 audit the policy

2.6.3 ensure any amendments are initiated as appropriate by the service/professional group responsible for highlighting those amendments by contacting the author.

2.7 The Trust has a responsibility to ensure that suitable and sufficient information, with regard to each patient's infection status and other significant healthcare risks such as the need for close supervision, falls, pressure area and VTE risk is communicated when the care of a patient is transferred from one Organisation to another.21

2.8 Throughout this document specific duties and responsibilities are identified in the relevant sections.

2.8.1 Finalising Discharge/ Providing information:

2.8.1.1 The person concluding the discharge will ensure as a minimum that appropriate follow-up information is provided if applicable, medication if applicable is given, and information in relation to medication is given to the patient or relative/carer on discharge. He/she will ensure that the discharge checklist has been completed and ensure the EPTS checklist is completed as the patient is discharged on the Electronic Patient Tracking System (EPTS) or the discharge checklist retained in the case notes. The discharge checklist is part of the admission and discharge bundle of care this is used to support the discharge policy.

2.8.1.2 A health professional will always make the necessary arrangements for community/primary health care service support and confirm that equipment/aides that are required prior to discharge are in place prior to the patient leaving hospital. Clarification of plans should be sought by the ward, if applicable, where equipment/aides are being provided after discharge.

2.8.1.3 The discharging registered nurse arranging the final stages of the discharge should make the patient aware, and/or carers/relatives if applicable, of any preventative measures to be taken after discharge relating to health care associated infections21 and other avoidable harms such as falls,

2.8.1.4 pressure area care, VTE

2.8.1.5 When discharging or transferring a patient from one Organisation to another it is the responsibility of the Nurse/Professional making arrangements to provide current and sufficient information relating to the patient. This should be given on a Transfer of Care Document following SBAR principles and the handover should be documented in the care record

2.8.1.6 A copy of the Discharge Summary is forwarded to the General Practitioner (GP) electronically. Where GPs are not on the electronic system, a copy is provided to the GP Surgery via the Pharmacy van delivery or by fax. It is the responsibility of the ward to highlight on the summary if a community nurse referral will be made for discharge. These referrals for community nursing are made by the ward staff via the ICES system to District Nursing hubs in Pennine Lancashire.

2.8.1.7 It is the responsibility of all Health and Social Service professionals to be alert to the identification of child welfare concerns.8/15

2.8.1.8 It is the Midwife's responsibility to inform community staff of a mother's transfer from hospital, or if being transferred to areas outside ELHT, communicate discharge information to the accepting Maternity Unit.

2.8.1.9 Prior to discharge, midwifery staff will ensure they discuss the legal requirements for the transportation of infants in child safety seats.

2.8.1.10 The responsibility for coordinating the discharge of a patient lies with discharging registered nurse of the specific clinical area/ward and their Patient Flow Facilitator.

2.8.1.11 The Ward/Department Manager will ensure that the necessary documentation is completed for discharge. A discharge checklist should be completed prior to discharge. As a minimum, the electronic Discharge Check List on EPTS and the electronic Discharge Summary must be completed for all patients. All relevant sections on the Discharge Summary should be completed. A copy of the Discharge Summary should be given to the patient prior to discharge.

2.8.1.12 The Nurse in charge will ensure delays in the discharge planning process are communicated to the relevant team to organise a response and plan. The ward manager/ nurse in charge is the point of escalation.

2.8.2 Complex Case Management:

2.8.2.1 will become pro-actively involved in cases where there is a communication breakdown, or where barriers to understanding and acceptance need to be overcome; to ensure all discharge options are considered and potential delays are progress chased and minimised.

2.8.2.2 Will proactively manage patients requiring pathways 1,2,3 as noted in section 1.51 of this policy.will become pro-actively involved to minimise delays in the re-housing process.

2.8.2.3 Will ensure they keep wards teams fully aware of progress and will document actions within the care record

2.8.2.4 will oversee and monitor the referral process to Social Service Organisations ensuring compliance with The Community Care (Delayed Discharge etc) Act 2003.

2.8.2.5 is responsible for monitoring, reporting and validating DOH SITREPS Delayed Transfers of Care to the Trust Information Department within reporting timescales to the Local Area Team/NHS England.

2.8.2.6 Oversee and maintain the centralised referral system for discharge planning and Home First, Discharge to Assess recovery beds, End of Life care, rehabilitation pathways; monitors time scales of referral, assessment and transfer/discharge to health and social care provision.

2.8.2.7 will identify trends in the discharge planning process; progress chasing referral and assessment activity and address issues arising with internal departments/teams and with external partners as necessary.

2.8.2.8 Oversee the Discharge to Assess pathways/ Continuing Healthcare Assessment process, including the administration relating to the coordination of these pathways in liaison with the Commissioning Support Unit and Local Authority partners. The Complex Case Management Team will also support the post MDT discharge planning process as required.

2.8.2.9 Will monitor and report on delays in transfers to ELHT rehabilitation beds at Clitheroe Community Hospital, Burnley General Hospital and Pendle Community Hospital.

2.8.2.10 Co-ordinate the process of step out for identified patients into block contracted or spot purchased beds in liaison with the Clinical Commissioning Group and Social Care colleagues.

2.8.2.11 Will support and enable the 'Home First' and 'Discharge to Assess' pathways with support in identifying appropriate patients from the ward multi-disciplinary teams.

2.8.3 Provision of Information

As a minimum the following information provision is required to be considered on discharge. Whether given or not or not relevant will need to be recorded.

Information provided		To who	Where recorded
Discharge Summary/Letter		Patient	• EPTS checklist or health
		GP	• ICE or in health record
		Receiving health professional *	• ICE or in health record
Information re discharge medication (if applicable)	Patient	• EPTS checklist or health records	
	GP	• Discharge Summary on ICE	
	Receiving health *	• Via Discharge Summary on ICE	
Information re follow up arrangements (if applicable)	Patient	• EPTS checklist or health records	
	GP	• Discharge Summary on ICE	
	Receiving health *	• Discharge Summary on ICE	
Specific Discharge instructions and action required by GP	Patient	• EPTS checklist or health record	

*Community services have access to GP systems and ICE via Trust Systems
On EPTS the four key requirements are included. The discharging officer cannot remove or discharge a patient from the system without these questions being answered. For the purpose of the records “No” and “N/R” may be used in circumstances when provision of information is not applicable. Free text is not mandated, but if used supports Health Records.

3. KEY PRINCIPLES

3.1 The Discharge bundle will be completed from admission and follow the patient journey to enable a continual focus on discharge planning.

3.2 All patients for discharge on the RBTH site are to be transferred to the Discharge Lounge prior to 08:00 hours on the morning of discharge unless there is a valid clinical exception. All clinical exceptions must be escalated to the Clinical Site Manager on bleep 087.

3.3 Proactive preparation for discharge should commence on admission and continue to be refined throughout the patient journey. It should also be discussed in out-patient or pre-op assessment clinics. Progress on the discharge planning process must be documented, by the relevant professionals, in the patient/client records.

3.4 Page 2 of the in-patient Generic Admission Document (GAD) should be completed and added to at admission and throughout the admission to take a baseline social assessment and to monitor referrals made to other professionals and agencies

3.5 A predicted date of discharge will be given to the patient and/or carer/relatives on admission, or, if not appropriate, as soon as practically possible after admission. This will also be provided to Social Services via the Trusted Assessment Document should input be required for discharge.

3.6 Patients should be encouraged to send valuables home with relatives. However, if this is not possible, property can be handed over for safe-keeping with Patient Affairs/Patient Services and on request will be returned upon discharge during office hours. Out of hours and weekend, however, this may be the following working day or a request can be made to the Duty Matron or Clinical Site Manager to place valuables in the 'Night Safe'..

3.7 All staff will work within a process of Multi-Disciplinary and Multi-Agency Team working. The ward should ensure that multi-professionals involved in this process are made aware/updated to the patients predicted discharge date.

3.8 Patients and their relatives and carers, with the patient's consent, will be involved in the planning and decision-making process so that the agreed plan is sensitive to wishes, abilities and needs.

3.9 Eligibility for Criteria led discharge should be considered as an option or all patients by the named consultant Clearly identified Criteria should be documented within the case notes and agreed with the patient, relative/carer.

3.10 For patients who are undergoing a period of rehabilitation in a sub-acute bed, patient focused goal plans should be agreed prior to transfer and documented within the rehabilitation/care plan for that patient within the rehabilitation setting. There should be a clear understanding of what rehabilitation is to achieve. The Discharge letter including TTO section should be commenced prior to transfer to an in-patient intermediate care bed.

3.11 Patients/clients who are vulnerable, or who have complex needs and require assistance from community services, should not normally be discharged without confirmed arrangements being made by the multi-disciplinary professionals involved in the discharge planning process,

3.12 Patients have the right to refuse to be discharged from NHS care into a care home. In such cases, health and social service professionals will work with the patient/family to find a suitable alternative .The Complex Case Management Team will become pro-actively involved in cases where there is a communication breakdown, or where barriers to understanding and acceptance need to be overcome to ensure all discharge options are considered and potential delays are minimised.

3.13 A person must be assumed to have capacity for decision-making unless it is established that he/she lacks capacity.(See section 4.1). The Trust Safeguarding team and advocacy service should be contacted where a best interest decision is required. Out of hours the Clinical Site Manager is the point of contact.

3.14 A decision made for or on behalf of a person who lacks capacity to do so, must be done, or made, in his/her best interest. (See section 4.1)

3.15 Good record keeping is essential for a safe and effective discharge planning process. All information must be legible and completed in full, ensuring that the information is current and accurate at the point of discharge. All discharge plans will be discussed with the patient/carer. Ward staff will ensure that the necessary documentation is completed in full for discharge. Individual Wards and Departments may augment discharge processes by basic discharge information leaflets providing aftercare and advice to patient/carer. Any leaflets should go through the correct governance channels within the Trust prior to being introduced

3.15.1 A Trust approved discharge checklist should be completed prior to discharge. As a minimum all wards will complete the discharge checklist on EPTS.

3.15.2 The discharging nurse will ensure that the appropriate follow-up arrangements (see section 1.2) are initiated, and take-home medication (if applicable) is given to the patient or relatives/carer on discharge.

3.15.3 A copy of the Discharge Summary is given to all patients. If applicable, a copy of a District Nurse referral will also be given. Should follow up be required post discharge by the Integrated Community Nursing Services, a referral is made via the ICES system. The relevant section should be completed on the Discharge Summary to ensure a copy is made available from Pharmacy.

3.15.4 Pharmacy will forward the Discharge Summary to the patients G.P electronically; or by pharmacy delivery van or fax if for GP's who are not on the electronic system. Where the summary indicates Community Nursing input is being requested post discharge, a referral is made vis the ICES system.

3.15.5 No patient/client should be discharged from hospital until:

3.15.6 The health professional responsible has written in the patient's records that the patient/client is medically optimised for discharge

3.15.7 Where necessary, a multi-disciplinary care plan has been agreed and the discharge date has been confirmed with the patient, carers and disciplines involved to meet identified needs.

3.16 Patients who are discharged from the Surgical Day Case Units will be given a contact telephone number in case of any concerns or queries regarding their post- operative recovery. Depending on the surgical procedure undertaken, patients will receive a follow up telephone call the following day.

3.17 The assessment for, and delivery of, the Discharge to Assess pathways, continuing health and social care is organised so that individuals understand the continuum of health and social care services. Patients and carers should be made aware of their rights and should receive the advice and information they need to make informed choices. Referring to appropriate agencies/services, if necessary, will enable them to make informed decisions about their future care. Carers have the right to an assessment of their needs and, with their consent, will be referred to Social Services.

3.18 Patients/clients who have primary health needs and who may fulfil the eligibility criteria for Fully Funded Continuing Health Care (CHC) or Funded Nursing Care for long term care placement will be considered for discharge via the discharge to assess pathways utilising the Pennine Lancashire agreed Trusted Assessment document, this considers the historical CHC Checklist and a 6 Domains test is completed, assessed and discharged with reference to The CHC National Framework.

3.19 Good practice indicates that where possible planned discharges should take place before 10.00am however patient safety remains paramount. The trust operates a system whereby discharge is prioritised and patients for discharge are classed as golden patients and specifically managed by ward teams and clinical flow to ensure the patients discharge is operated in a safe and effective manner. To achieve a safe early discharge requires good planning in the days prior to discharge including early completion of Discharge letters and To Take Home medication prescriptions.

3.20 It is expected that proactive discharge will be supported by daily consultant ward rounds on acute wards, proactive medical plans and completion of medical aspects of discharge such as TTO's discharge letters and referrals. In community ward settings ward multidisciplinary meetings and Consultant review take place on Monday to Friday.

3.21 The responsibility of coordinating the discharge lies with the manager of the specific clinical area/ward. The manager may delegate appropriately within the nursing team to refer to specific disciplines to commence the discharge planning process enabling timely and effective discharges to take place.

3.22 A health professional will always make the necessary arrangements for community/primary health care service support and confirm that equipment/aides that are required prior to discharge, are in place prior to the patient leaving hospital. Clarification of plans should be sought by the ward, if applicable, where equipment/aides are being provided after discharge and these should be documented in the patient case notes.

The Ward Nurse arranging the final stages of the discharge should make the patient aware, and/or carers/relatives if applicable, of any preventative measures to be taken after discharge relating to health care associated infections and other significant healthcare risks such as the need for close supervision, falls, pressure area care and VTE risk.

3.23 It is the responsibility of the nurse arranging the discharge or transfer of a patient, from one Organisation to another, to provide current and sufficient information on the infection status of the patient so that any risks to the patient and others may be minimised.

All patients/clients due for discharge should:

3.23.1 have their legal position considered if unable to give informed consent.

3.23.2 have access to a range of health and social care services in the Community, to support identified needs, subject to the relevant eligibility criteria.

3.23.3 be enabled, with appropriate support, to live in their own home and to remain there as long as possible.

3.24 The individual needs of babies and children must be considered by all those involved in their care. Particular attention must be given to those considered at risk of abuse, with a long-term disability, or who have required special or intensive care. It is the responsibility of Health and Social Service professionals in all areas where children access, to be alert to the identification of child welfare concerns.

3.25 Consideration must be given to the needs of patients/clients with a continuing disability, including those with a mental illness or learning disabilities, in order that any special arrangements to ensure their continued well-being in the community can be made. Information should be offered to patients/carers to enable them to network specialist charitable or support groups where appropriate.

3.26 Patients/clients have the right to obtain the services of an independent advocate via the East Lancashire Advocacy Service

3.27 Good practice and Legislation indicate, independent interpreters will be contacted where a patient has a sensory impairment and/or there is a need to overcome a language/communication barrier. Policy on Interpreting Services is available on intranet, (Policy HR26)

3.28 All patients should be suitably attired prior to discharge with consideration of weather conditions and dignity. Staff should encourage carers including other organisations such as nursing homes to bring the patient's own attire to go home in. This will further promote comfort and dignity but also reduce the loss of linen from the Trust

3.29 Staff should firstly encourage patients/carers to make their own transport arrangements for discharge, via relatives, friends or other means. Ambulance transportation must only be booked on the basis of clinical need.

3.30 Any delays in the discharge process should be communicated to the directorate Matron, Patient Flow Team and Complex Case Management teams for resolution as soon as possible.

3.31 Where there is a change to processes and working practice out of hours, this is identified throughout this policy in the relevant section.

4. DISCHARGE ARRANGEMENTS

4.1 Discharge of patients aged over 16 who may not have the capacity to make their own decisions about discharge arrangements

4.1.1. The Mental Capacity Act 2005 Principles

Section 1 of the Mental Capacity Act 2005 sets out 5 key principles designed to emphasise the fundamental concepts and underlying 'ethos' of the Act and to provide a 'benchmark' for decision makers and carers.

Staff will adhere to and implement the following five fundamental 'statutory principles' that underpin the legal requirements of the mental Capacity Act:

When assessing capacity:

- Every adult has the right to make his/her own decisions and must be assumed to have capacity to do so unless it is proved otherwise.
- People must be given all practicable help and support to make their own decisions before anyone concludes that they cannot make their own decisions and lack capacity
- People must retain the right to make what might be seen as unwise or eccentric decisions.
- When acting or making decisions on behalf of someone lacking capacity – anything done on behalf of people without capacity must be in the person's best interests.
- Anything done for or on behalf of people without capacity should be the least restrictive of their basic rights and freedoms.

Mental capacity can only be assessed in relation to a particular matter/decision at the time the decision needs to be made.

4.1.2 Unless all practical steps have been taken without success, a person is not to be regarded as unable to understand information relevant to a decision. If he/she is able to understand a general explanation given to him/her in a way that is appropriate to his/her circumstances, i.e. the use of simple language, interpreters, visual aids etc., or any other means of communication that gives the patient every opportunity of being able to understand or access information necessary to make the decision, then he/she should be regarded as being able to make the decision.

4.1.3 A lack of capacity cannot be established merely by reference to a person's age or appearance or a condition of his/her, or an aspect of his/her behaviour, which might lead others to make unjustified assumptions about his/her capacity, or what his/her best interests might be.

4.1.4 When determining whether a patient is unable to make the decision, other family members, services or relevant others should be consulted. Staff should make every effort, as far as possible, to determine whether there is an Enduring or Lasting Power of Attorney, or Court of Protection order etc in force, with regard to past and present feelings, wishes, beliefs and values.

4.1.5 Windows of opportunity for assessment of capacity must be considered where a patient's capacity appears to fluctuate or there may be some improvement to enable the patient to make the decision which may influence the discharge plan.

4.1.6 The question of capacity must be decided on the balance of probabilities

4.1.7 A person is unable to make a decision for himself/herself if he/she is unable:

a) to understand the information relevant to the decision to be made
b) to retain the information long enough to be able to make the decision
c) to use or weigh that information as part of the process of making the decision
d) to communicate the decision (this may be talking, using sign language, visual aids or any other means of communication)
e) All steps taken to determine mental capacity to make the decision, must be rationalised and fully documented in the patient's notes structured from points in 4.1.11

Please refer also to:-
The Capacity Assessment Proforma Document attached to ELHT/C82: How to Implement the Mental Capacity Act 2005 and the supporting Code of Practice.

4.2 Discharge of patients requiring Social Service support

4.2.1 Referral to Social Services from professionals in all agencies should be made to the agreed initial contact point**.** In-patient referrals for adults are to be made via the Trusted Assessment documents.

4.2.2 Copies of the Trusted Assessment Documents should be retained in the current care record

4.2.3 The ward team must put on the discharge status screen of EPTS when referral is made to the Integrated Discharge service.

4.2.4 Unnecessary admissions are avoided, and effective discharge is facilitated by a 'whole system approach' to assessment processes and the commissioning and delivery of services.

4.2.5 The process of discharge planning should be coordinated by the appropriate health/social care professional who has the responsibility for coordinating all stages of the 'patient journey'. This may involve liaison with the pre-admission case coordinator in the community at the earliest opportunity and the transfer of those responsibilities on discharge.

4.2.6 Effective use is made of transitional and intermediate care services, so that existing acute hospital capacity is used appropriately, and individuals achieve their optimum outcome.

4.2.7 The assessment for, and delivery of, continuing health and social care is organised so that individuals understand the continuum of health and social care services, their rights, and receive advice and information to enable them to make informed decisions about their future care. This is all considered whilst a patient is an in patients however the patient is discharged by the discharge to assess principles of care and formal assessments take place out of a hospital bed base. This does not mean our patients are discharged without consideration of their needs this is clearly documented on the Trusted Assessment document which is used to plan onward community care. The Discharge to Assess pathways used follow the principles of care set out in the national policy Hospital discharge and community support policy and operating model. October 2021.

4.2.8 Any patient/client receiving hospital or community health services, or their carer has the right to request an assessment of their need for community care services from the Social Services Department. Anyone who is providing or intending to provide substantial amount of care to a person needing community care services on a regular basis may also request or be offered an assessment of their own needs. Carers have the right, under the Carers (Recognition and Services) Act 1995 to ask for a Carers Assessment

4.2.9 Social Services Departments have a duty to ensure that community care services are provided to adults assessed as needing them.The purpose of the assessment is to work with the person, their carers and relevant health colleagues to identify social care needs, support networks and risks.

4.2.10 Services provided by the Social Services Department are subject to financial assessment and may result in a contribution to the cost of the assessed care needs. These assessments are now completed out of hospital as discharge to assess pathways are funded for **up to** 28 days after discharge with no financial burden for our patients until formal assessments take place.

4.2.11 Emergency out of hours referral to Social Services is made to the Emergency Duty Team.

4.2.12 Where a patient has a need for Fully Funded Continuing Health Care as identified by the Eligibility Criteria, then the necessary services will be organised through the appropriate Agencies. This is completed via the discharge to assess model of care and with negotiation of support between the Integrated Discharge Service/ Complex Case Management clinical support units and the local authorities Mental Health service and Learning disability teams.

4.2.13 Where the multi-disciplinary team has identified a need for rehabilitation provision, an assessment of their needs will be

carried out by the relevant health/social service professional.

4.2.14 Admission to a Social Services funded care home will not be considered until all rehabilitation options have been explored.

4.2.15 The Ward Manager has responsibility for ensuring an assessment takes place, where needs have been identified which indicate the patient may be eligible for Funded Nursing Care patients will be discharge via discharge to assess for further community assessments. A Trusted Assessment and 6 Domains Test should be completed to support the identification of the patients' current needs and to support onward community assessments. The outcome of this consideration will support the discharge pathway that is operated and that the patient is discharged to the relevant setting to meet their needs.

4.2.16 A patient assessed as needing placement in a care home funded by Health/Social Services has the right to choose, within the Health/Social Services limits on cost, and subject to assessed needs, which home he/she moves into. Where a place in the home chosen by the patient is not available when the patient is considered to be ready for discharge from NHS in-patient care, and such a place is unlikely to be available to facilitate discharge it will be necessary for the patient to be discharged to an alternative home until such a place becomes available.

4.2.17 A copy of the Trusted Assessment Document will be provided a copy of to the service providers in preparation for a patients transfer/discharge. The service providers will indicate whether they can support the patients needs this will be done to discharge.

4.3 Discharge of patients with Mental Health problems

4.3.1 Prior to discharge, any concerns with a patient's immediate mental health needs should be referred to the appropriate Mental Health Liaison Service for assessment. The Liaison Service will identify any further input required from the Mental Health Trust. While awaiting assessment by MHLT the relevant risk assessment and care plans must be implemented. Staff must escalate any delays in assessment to the Matron for the area.

4.3.2 All patients who have attempted suicide are referred for an assessment by an appropriate Health Professional prior to discharge. Based on this assessment, patients may be transferred to an Acute Mental Health bed within Lancashire Care NHS Foundation Trust, once medically stable.

If admission to the unit is not assessed as being required follow up care in the community will be arranged by the Mental Health Service.

4.3.3 A child/young person who has self-harmed will be referred to and reviewed by the ELCAS Team before they are discharged from Paediatrics with a follow-up plan in place. Should admission be needed to the Mental Health Service for young people aged 16 and under, liaison with other organisations and Health Care Providers will be carried out to facilitate an appropriate admission and transfer to an appropriate provision which may be out of area. N.B. Young people aged over 16 who require a Mental Health bed, are under the care of Lancashire Care NHS Foundation Trust.

4.4 Discharge of patients requiring Ambulance Transport for discharge

4.4.1 Ambulance transportation must only be booked based on clinical need. Patients should firstly be encouraged to make their own arrangements, via relatives, friends or other means.

The ambulance service must be informed of any infection issues when the booking is made.

4.4.2 Regarding vulnerable patients who do not meet the criteria for ambulance transport and have no other means of transport for discharge, arrangements may be made via the hospital Transport Service; this will be charged to your budget. Out of hours, the Clinical Site Manager should be contacted for authorisation.

4.4.3 Every attempt will be made to give a period of 48 hours' notice when booking transport to ensure vehicle availability, under the terms of the Ambulance transport contract with East Lancashire Hospitals NHS Trust.

4.4.4 Essential booking information should always be provided when booking transport for discharge with reference to the Ambulance Service flow chart.

4.4.5 Every attempt will be made to ensure all patients are suitably attired prior to discharge with consideration of weather conditions and dignity. Staff should encourage carers including other organisations such as nursing homes to bring the patient's own attire to go home in. This will further promote comfort and dignity but also reduce the loss of linen from the Trust.

4.4.6 Patients should be encouraged to ask relatives to take belongings home wherever possible prior to discharge, For safety reasons electrical equipment, televisions, glass items or plants cannot be carried on board ambulance vehicles.

4.4.7 For health and safety reasons, any luggage being transported by ambulance should not contain sharp or breakable objects and should be limited to two small bags.

4.4.8 All take home medications, belongings, and follow up instructions, where applicable, should be provided/communicated to the patient and ready to take with them, to prevent delays which may result in ambulances being cancelled or re-scheduled.

4.4.9 Ambulance Liaison will provide a list of transport bookings on request to Bed Management or the Head of Clinical Flow.

4.4.10 All fast track and bariatric transport must be booked 24 hours in advance to guarantee availability.

4.5 Discharge of patients from Emergency Department

4.5.1 All patients will be discharged from Emergency Department by a Doctor or Emergency Nurse Practitioner (ENP) following consultation in the department. Allied Health Professionals e.g., OT, or Specialist Nurses e.g., Respiratory Nurses will be involved in the decision where applicable.

4.5.2 Every patient will have an electronically generated discharge letter, in a standard format, including a summary of attendance forwarded to their GP. In urgent and/or complex cases, where more information is required, the GP will be contacted directly.

4.5.3 Patient's property can be handed over for safe keeping. This is returned by the following day, wherever possible.

4.5.4 In the first instance, and wherever possible, transport home should be arranged by the patient or their relatives/carers. Ambulance transport will be arranged based on clinical need.

4.5.5 Where medication is required, Patients will be given a hospital outpatient's prescription for dispensing on site. Out of hours, this will be dispensed the following day. Where necessary, an overnight supply will be provided from the Emergency department.

4.5.6 Out of hours, patients will be provided with appropriate appliances, e.g., crutches, by the physiotherapy department or nursing staff.

4.5.7 Where it is deemed necessary for follow-up care to be in the secondary care setting, appointments will be made in the appropriate clinic. These may be given to the patient on discharge from the Department or forwarded in the post.

4.5.8 All patients will be given appropriate advice upon discharge supplemented with advice cards to take home, if applicable.

4.5.9 Patients who attend the department and behave inappropriately will be asked to leave. The police will be called where required.

4.5.10 Social/Special needs

- When there is no acute medical need for a patient to be admitted to an acute or sub-acute rehabilitation bed, nursing staff may refer to other health and social service professionals. This would be with the consent of the patient, and/or carers/relatives if applicable, and/or where there is a need for community-based rehabilitation, Health or Social Service support in the community.
  e.g:
  - Occupational Therapist/Physiotherapist
  - Social Workers
  - Community Nurses
  - Complex Case Manager
  - Intensive Home Support Services
  - Specialist Nurses
  - Senior Bed Managers
  - Primary Care Single Point of Access Teams, i.e.
  - RATs and ICAT
  - COPD Respiratory Team
  - Patient's G.P.
  - Treatment Rooms
  - Clinics Voluntary Agencies
  -

NB. Out of Hours contact will be made with Social Services Emergency Duty Team or if necessary, by the Duty Matron or Clinical Site Manager.

- Good practice indicates, where possible, independent interpreters will be contacted where a patient has sensory impairment and/or there is a need to overcome a communication barrier. (See section 3.25)
- In cases where a patient is homeless, contact will be made with the appropriate Housing Department during working hours. Out of hours, referral will be made to the Out of Hours Duty Housing Officer, or Social Services Emergency Duty Team if appropriate.
- Patients who require assessment of their mental health status will be referred to the on-call psychiatrist or a member of the Mental Health Liaison Team.
- If there is a medical/mental health need to do so, when a patient absconds from the Emergency department, the police will be contacted in order to find the patient and return them to the department, or advise them to return to Emergency Department.

4.5.11 **Older People**

- Referrals to Intermediate Care Services can be made via the appropriate single point of access points.
- All patients 60 years and over will be offered an assessment by Age Concern. This may take place in the department prior to discharge or telephone contact will be made within 24 hours.

Children

- Parents/guardians of children under the age of 16 years will be contacted with the permission of the child, or in cases when it is deemed the child is not Gillick competent.
- All children under the age of 5 years are automatically referred to the Health Visitor. Staff will make additional referrals as appropriate. All children attending school aged between 5 – 16 years are automatically referred to the School Nurse. Additional referrals will be made as appropriate.
- Children 10 years and under are referred to the Paediatric Liaison Team, where further referrals may be made as appropriate.
- Any child assessed to be at risk will be referred as a matter of urgency to Social Services as per departmental policy.

4.6 Discharge of patients from Maternity Services

4.6.1 In order to avoid the unnecessary hospitalisation of an expectant mother who self-refers with suspected onset of labour, a practicing midwife may transfer a mother home when labour has been excluded and the criteria listed in the Delivery Suite Protocol have been met.

4.6.2 It is the midwife's responsibility to inform community staff of the mother's transfer from hospital.

4.6.3 Where expectant mothers must be transferred to areas outside the East Lancashire Hospitals NHS Trust, the midwife is responsible for communicating discharge information to the accepting maternity unit.

4.6.4 The midwife assumes full responsibility for the transfer home of women and infants following normal childbirth. Women who have had complicated pregnancies or births will be assessed by an appropriately trained practitioner prior to transfer home. Newborn infants will be fully examined by an appropriately trained practitioner. Where this is not possible, arrangements will be made for the GP to complete a full examination of the newborn.

4.6.5 Prior to discharge, midwifery staff will ensure they discuss the legal requirements for the transportation of infants in child safety seats.

4.6.6 Prior to discharge, midwifery staff will ensure that appropriate information, medication and appointments are given, and the necessary documentation is completed, and copies distributed

to the GP and Health Visiting Service.

4.6.7 For those mothers and/or babies with complex needs, it will sometimes be necessary to instigate a multi-disciplinary discharge planning meeting. Where this is not necessary, the midwife will ensure that requests for services are made with all the relevant agencies.

4.6.8 Where, as a result of a child protection conference, an emergency protection order, or where the baby is under the care of Social Services, the baby will not be transferred home with the mother, in accordance and referring to the relevant Local Authority Child Protection Guidance.

4.7 Discharge of patients from the Paediatric Services

4.7.1 Health/social service professionals involved in the discharge planning of children should refer to Paediatric Discharge GuidelinesP.

4.7.2 The child's named nurse will instigate the discharge plan and involve the parent/guardian in the assessment/planning process.

4.7.3 Appropriate arrangements for support in the community will be initiated at the earliest opportunity.

4.7.4 Where special arrangements are required for meeting the continuing health needs of the child/family, a multidisciplinary discharge planning meeting, involving the family must take place and the appropriate arrangements made.

4.7.5 All discharge documentation should be fully completed and signed for by those disciplines involved and placed in the patient's records prior to discharge.

4.7.6 A child should only be discharged into the care of his/her parent/guardian unless special arrangements have been agreed, in person, with the relevant services.

4.7.7 Information regarding the continuing care of the child on discharge and any follow up instructions should be given in such a way that the family understand, for example, written, pictorial.

4.7.8 Where patients/carers take children home against medical advice, medical staff must be informed, and the situation documented fully in the medical records. Appropriate support services and follow up care should be arranged as for a planned discharge. (See section 4.8)

4.7.9 Staff in the Paediatric Directorate are in a key position to identify child welfare concerns. Prior to discharge, if concerns are identified the Multi-Agency Policy, Guidance and Procedures as set out by the Lancashire Area Child Protection Committee should be followed

A child/young person who has self-harmed will be referred to and reviewed by the CAMHS Team before they are discharged from Paediatrics with a follow-up plan in place. Should admission be needed to the Mental Health Service for young people aged 16 and under, liaison with other

Organisations and Health Care Providers will be carried out to facilitate an appropriate admission and transfer to an appropriate provision which may be out of area.

N.B. Young people aged over 16 who require a Mental Health bed, are under the care of Lancashire Care NHS Foundation Trust.

4.8 Patients/Parents/Carers taking responsibility for discharge of patients against medical advice

4.8.1 Should a patient choose to self-discharge, or a parent/carer take a child/relative home against medical advice, wherever possible every effort should be made to counsel the patient/parent/carer regarding their intended actions by the Doctor and Registered Nurse on duty. The advice given and discussion held with the patient/parent/carer must be fully documented by both professionals present. An incident form should be completed regarding the discharge and the matron informed

4.8.2 Should a patient self-discharge prior to being seen by a Doctor, then the Registered Nurse must fully document any advice given and details of any discussion with the patient. If possible, two members of staff should be present and both sign in the notes.

4.8.3 Any referrals to other health and social service professionals must be made, if required, as per discharge arrangements for all patients. In addition, attempts should be made to provide all appropriate support as though it was a planned discharge.

4.8.4 The patient's own GP should be made aware of the self-discharge at the earliest opportunity.

4.8.5 Where there is an informal carer or family member, it is important to make them aware of the situation, with the patient's consent. Where patients are identified as being at risk/vulnerable every effort will be made to contact the relevant services or in some cases the police. All actions taken must be clearly documented in the patient records. Where deemed appropriate and necessary a referral should be made to safeguarding

4.8.6 Advice to the patient must include what the patient might need to do next if they need further medical help. Patients must be given the option of returning to the hospital within 24 hours should they become unwell. This would be as an emergency attendee or as a GP referral.

4.8.7 Should a patient arrive on a ward after self-discharging, they should be directed to Emergency department, or alternatively, the ward should contact the Duty Bed Manager for advice on the appropriate pathway.

NB: The above does not apply to patients who are legally detained under the Mental Health Act, Child Protection Orders or legal custody.

The principles of The Mental Capacity Act 2005 will potentially apply to any patient over the age of 16 (see 4.1.1 above). Guidance on undertaking capacity assessments and subsequent Best Interest Decision making where a patient is deemed to lack capacity is provided in ELHT/C82: How to Implement the Mental Capacity Act 2005 and the Supporting Code of Practice.

4.9 Discharge of individuals who have been identified as homeless/ needing e- housing

4.9.1 Patient choice is considered as extremely important. However, patients who have been assessed as not requiring NHS continuing in- patient care; do not have the right to occupy, indefinitely, a hospital.

4.9.2 The housing situation of patients wherever possible, should be identified on admission, or at the earliest opportunity, to ensure that patients are not discharged to inappropriate places or become homeless as a result of their hospital stay or disability arising from a patients' acute episode.

4.9.3 Timely referral for multi-professional assessment is vital to enable effective liaison between health and social services and the local housing needs department, to ensure acute facilities are not used appropriately.

4.9.4 Referrals to appropriate multi-disciplinary professionals, in particular Occupational Therapy and Social Services, should be made at the earliest opportunity, where it is identified that patients are likely to require re-housing as a result of disability arising from the acute episode of care. The needs of these patients are likely to be complex, which will require assessments to be carried out in a timely manner to identify the pathway and/or initiate an application for appropriate re- housing and/or adaptations. Complex Case Management will become pro-actively involved to minimise delays in the re-housing process and will liaise with housing needs and allocated social workers, as required.

4.9.5 The Complex Case Management Team should be contacted at the earliest opportunity when patients declare themselves as homeless, for reasons other than in section 4.9.4. Arrangements will be made with the responsible Housing Department, to provide an interview on discharge with Housing Needs Officers for advice; or if eligible, liaison will take place between Housing Needs Officers and Complex Case Management, to arrange temporary accommodation.

Out of Hours arrangements are provided by the Housing Needs Out of Hours Service, or if applicable, the Social Services Emergency Duty Team.

5. MONITORING TOOL

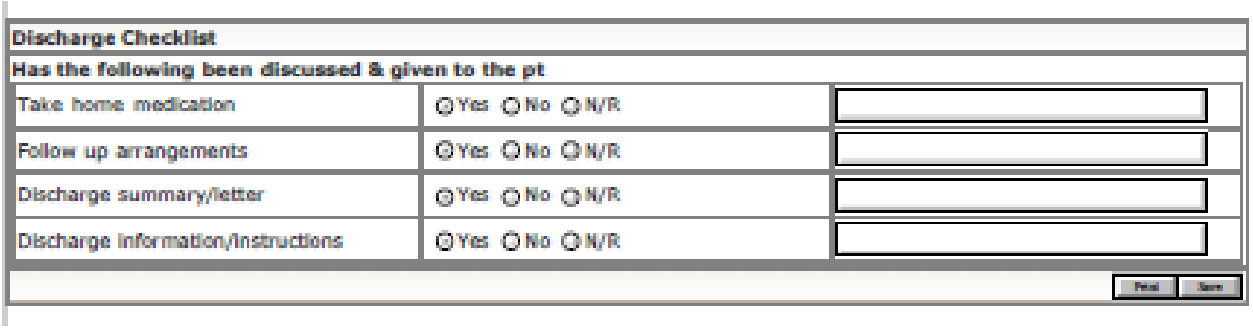
Measuring and monitoring compliance with the effective implementation of this procedural document is best practice and a key strand of its successful delivery. Hence, the author(s) of this procedural document has/have clearly set out how compliance with its appropriate implementation will be measured or monitored. This also includes the timescale, tool(s)/methodology and frequency as well as the responsible committee/group for monitoring its compliance and gaining assurance.

Aspect of compliance being measured or monitored.	Individual responsible for the monitoring	Tool and method of monitoring	Frequency of monitoring	Responsible Group or Committee for monitoring
The recording of provision of information to health professionals and patients will be audited at least once each calendar year. At least 50 patients will be chosen, at random, to establish where the minimum requirements were met.	Head of Complex case	At least 50 patients will be chosen, at random, to establish where the minimum requirements were met via audit. Monitoring of EPTS & ICE.	Annually	The audit will report to the Patient Safety Group (PSG) and any remedial action will address the identified issues arising through action planning.
The Head of Complex Case oversee and ensure monitoring processes are in place for the referral and process to Social Service	Head of Complex case	Delays in discharge are proactively monitored and reported weekly by the Complex Case Team Manager to the Trust Information	Weekly Delayed Transfers of Care to NHS England within required	Delayed Transfers of Care to NHS England within required timescales for reporting.

Organisations; ensuring compliance with The Community Care (Delayed Discharge etc.) Act 2003. Reimbursement monies are claimed for delays, if applicable.		Department for submission of SITREPS	timescales for reporting.	
Same day late afternoon bookings to ambulance transport for discharge and delays affecting transport capacity is provided to the Ambulance Liaison Meetings This enables trends to be identified and initiates action to change working practices to minimise delays.	Head of patient Flow	Booking systems. Logs detailing delays and actions taken.	Head of Flow meets with ERS DOO bi-monthly and attends NWAS meetings monthly.	Emergency Care Improvement Programme (ECIP)
Social Services identify cases to the Complex Case Management Team Manager where there are crisis calls/problems arising within one week of discharge from hospital. Complex Case Managers identify any breakdown in the discharge planning process and address the issues within the relevant teams/systems or with Ward Managers, Matrons, Heads of Departments, if applicable.	Head of Complex Case	Trigger list and in-patient DPTL.	Ongoing	

APPENDIX 1 Discharge Checklist

A = Discharge Check List now included on EPTS discharge screen



On EPTS the four key requirements are included. The discharging officer cannot remove or discharge a patient from the system without these questions being answered. For the purpose of the records “No” and “N/R” may be used in circumstances when provision of information is not applicable. Free text is not mandated, but if used supports Health Records.

APPENDIX 2 DELAYED TRANSFERS

When a patient is medically stable and deemed by the MDT as safe to transfer from acute care but is unable to transfer due to waits for issues such as provision of services, equipment or suitable accommodation then this patient is determined as a ‘delayed transfer’.

Under national SitRep guidance, a discharge may only be defined as delayed when all three criteria listed below have been met and the patient has not left the acute care setting.

a) The patient has been declared medically fit for discharge.

b) A multidisciplinary team assessment that includes social services, where appropriate, has been completed.

c) It is safe for patient to be discharged.

Appendix 3 Equality Impact Assessment

Department/Function	Clinical Flow Team/CIC			
Lead Assessor	S Reid/A Isherwood			
What is being assessed?	Impact to equality groups regarding discharge process.			
Date of assessment	June 2022			
What groups have you consulted with? Include details of involvement in the Equality Impact Assessment process.	Staff Inclusion Network/s	☐	Staff Side Colleagues	☐
	Service Users	☐	Other (Inc. external orgs)	☐
	Please give details: Hospital Discharge oversight group.			

1) What is the impact on the following equality groups?		
Positive: ➢ Advance Equality of opportunity ➢ Foster good relations between different groups ➢ Address explicit needs of Equality target groups	**Negative:** ➢ Unlawful discrimination, harassment and victimisation ➢ Failure to address explicit needs of Equality target groups	**Neutral:** ➢ It is quite acceptable for the assessment to come out as Neutral Impact. ➢ Be sure you can justify this decision with clear reasons and evidence if you are challenged

Equality Groups	**Impact** (Positive / Negative / Neutral)	**Comments** ➢ Provide brief description of the positive / negative impact identified benefits to the equality group. ➢ Is any impact identified intended or legal?
Race (All ethnic groups)	Neutral	
Disability (Including physical and mental impairments)	Neutral	
Sex	Neutral	
Gender reassignment	Neutral	
Religion or Belief	Neutral	
Sexual orientation	Neutral	
Age	Neutral	
Marriage and Civil Partnership	Neutral	
Pregnancy and maternity	Neutral	
Other (e.g. caring, human rights)	Neutral	

2) In what ways does any impact identified contribute to or hinder promoting equality and diversity across the organisation?	n/a

3) If your assessment identifies a negative impact on Equality Groups you must develop an action plan **to avoid discrimination and ensure opportunities for promoting equality diversity and inclusion are maximised.** ➢ This should include where it has been identified that further work will be undertaken to further explore ➢ the impact on equality groups ➢ This should be reviewed annually.		
Action Plan Summary		
Action	**Lead**	**Timescale**
n/a		