DISCHARGE POLICY

POLICY

Reference	CPG-TW-DP		
Approving Body	Trust Management Team		
Date Approved	27th September 2023		
For publication to external SFH website	**Positive confirmation received from the approving body that the content does not risk the safety of patients or the public:**		
	YES	**NO**	**N/A**
	X		
Issue Date	25th October 2023		
Version	3.0		
Summary of Changes from Previous Version	This Policy has been updated to include additional information relating to SAFER care bundles, ward round prioritisation and additional role specific responsibilities. There is further addition of local and national discharge 'Choice Policy' letters.		
Supersedes	• Discharge Policy, version 2.0, Issued 14th June 2019 to Review Date Sept 2023 (ext[7]) • Patient Assessment for Suitability for Taxi Transport Home SOP, version 2.0, Issued 30th June 2021 to Review Date June 2024 (RO[1])		
Document Category	• Clinical		
Consultation Undertaken	- Integrated Discharge Lead, Notts (ICB) - Transfer of Care Hub (ToCH) - Integrated Discharge Assessment Team (IDAT) - Divisional Leadership Team (DLT) - Emergency Care Steering Group (ECSG) - Trust Management Team Meeting (TMT)		
Date of Completion of Equality Impact Assessment	14th April 2023		
Date of Environmental Impact Assessment (if applicable)	Not Applicable		
Legal and/or Accreditation Implications	SFH Legal team if final Choice Policy letter enacted and SFH Safeguarding		
Target Audience	All staff and clinicians working at Sherwood Forest Hospitals Trust and relevant system partners.		
Review Date	12 months (September 2024)		
Sponsor (Position)	Chief Operating Officer		
Author (Position & Name)	Associate Director of Operations - Urgent and Emergency Care, Janine Foxhall		
Lead Division/ Directorate	Corporate		
Lead Specialty/ Service/ Department	Operations		
Position of Person able to provide Further Guidance/Information	Associate Director of Operations - Urgent and Emergency Care		

Associated Documents/ Information	**Date Associated Documents/ Information was reviewed**
1. Checklist for transfer of patient in private taxi for the purpose of discharge (*documentation/ form to print from intranet for use in practice*)	1. Reviewed with policy v3.0, approved Sept 2023

2. Transfer of Care Standard Operating Procedure 3. Associated leaflets/ letters: • Planning together: leaving hospital when the time is right Fact Sheet (Leaflet A) • You are leaving hospital: returning home Choice Letter B1 • You are leaving hospital: moving or returning to, another place of care Choice Letter B2 • Final Notice Letter (Letter C) • Looking after family or friends after they leave hospital Fact Sheet (Leaflet D) • Planning together: leaving the discharge to assess bed following your period of assessment (Leaflet E) • Assessment completed: returning home (Leaflet F). • Assessment completed: moving or returning to another place of care (Leaflet G)	*2.* Currently under review 3. Reviewed/ new with policy v3.0, approved September 2023 These leaflets/ letters can be found in one document which has been published to the intranet alongside the policy for access/ printing as needed – **see this link**
Template control	June 2020

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1.0 INTRODUCTION

The aim of this policy is to set out how to plan and deliver hospital discharge for our patients; this includes the transfer of care from our hospitals to another care setting.

Sherwood Forest Hospitals NHS Foundation Trust is committed to deliver discharge to assess, home first principles. The national discharge to assess model is built on evidence that the most effective way to support people is to ensure they are discharged safely when they are clinically ready (medically safe), with timely and appropriate recovery support if needed.

This policy is to be read in conjunction with the Department of Health and Social Care Hospital Discharge and Community Support Guidance, last published on 31 March 2022.

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

2.0 POLICY STATEMENT

The policy provides guidance, sets expectations and describes underlying principles to support staff in the safe discharge and transfer of care of patients. This policy applies to all clinical and operational staff involved in the care and discharge of inpatients over the age of 18 years. There is a separate policy which relates to the discharge of children and young people.

Patients, family and patient representatives should be involved throughout the discharge planning process and provided with effective information and support during admission. Timely and appropriate patient outcomes are critical to optimise patient flow through our hospitals.

Patients, family and or patient representatives will be involved in all decisions about their care, as per the NHS Constitution. Where the patient lacks capacity to make decisions about discharge from hospital, then the application of the policy should be adapted following the Mental Capacity Act 2005.

This policy includes patients with very complex care needs, including those at the end of life.

3.0 DEFINITIONS / ABBREVIATIONS

Item	Definition
CHC	NHS Continuing Healthcare (CHC) is a package of ongoing care for an individual aged 18 or over which is arranged and funded solely by the NHS where the individual has been found to have a 'primary health need'.
Criteria to Reside	A set of medical criteria where the needs can only be addressed within an acute hospital setting. Anyone not meeting the criteria to reside can have their nursing and care needs met in a less intensive environment
D2A	Discharge to Assess (D2A) supports the discharge of people from hospital who are 'clinically stable but require further assessment to establish their ongoing health and social care needs'.

FIT	Frailty Intervention Team (FIT).
IDAT	Integrated Discharge Advisory Team (IDAT)
IMCA	An Independent Mental Capacity Advocate (IMCA) will represent patients assessed as lacking capacity under the Mental Capacity Act 2005 to make important decisions, such as change of accommodation, and who have no family and friends to consult.
Interim Care	Residential placement commissioned and funded by Adult Social Care, where a package of care cannot be sourced within 48 hours of the patient being deemed discharge ready.
Intermediate Care	Short-term care provided free of charge by the NHS for people who no longer need to be in hospital but may need extra support to help them recover. It lasts for a maximum of six weeks and can be in the patient's home or in a residential setting.
LLOS Meeting	Long Length of Stay meeting to address barriers to discharge
MCA	Mental Capacity Act (MCA)
MDT	Multi-Disciplinary Team (MDT) of health and social care professionals involved in the care and assessment of patients
MSFT	Medically safe for transfer. When inpatient medical care or treatment is no longer required, and the patient is deemed to be medically optimised.
EDD	Estimated Date of Discharge. This is the predicted date that a patient no longer needs hospital acute care. Any ongoing assessments, rehabilitation and /or recuperation could continue in a less acute environment. The EDD is initially based on average length-of-stay data and may change several times in response to the patient's specific needs.
Reablement	The Reablement service, is provided by Nottinghamshire County Council Short-Term Assessment and Reablement Team (START). Reablement is a service provided in the person's own home or care home. It is a goal-focused intervention that involves intensive, time-limited assessment and therapeutic work for up to a few weeks. Ongoing care and support needs will be assessed during this period.
ToCH	Transfer of Care Hub
TTO	To Take Out (Medicines)
SAFER	Senior Review, All patients, Flow, Early Discharge, Review. Five key elements of best practice in safe and timely discharge of patients.

4.0 ROLES AND RESPONSIBILITIES

Role	Responsibilities
Chief Operating Officer	• Overall accountability for ensuring the safe and timely discharge of all patients.
Executive Team, Divisional Leadership Teams, Specialty Triumvirates	• To ensure suitably competent staff are on shift to discharge patients safely and that they are aware of, have access to and implement the policy. • To Act upon incidents arising from patient discharge. • To be a point of escalation for concerns/issues relating to discharge.
Matrons/Head of Discharge/ToCH Manager	• To monitor the safe discharge and action any improvements required to address areas of concern. • To review and develop learning from unsafe or inappropriate discharges • To be a point of escalation for supported discharge delays/complex discharges. • To monitor staff compliance with using and updating electronic patient records • To attend board rounds to support and identify the reasons behind stays of seven days or more and take appropriate actions
Flow Room, Duty Nurse Managers	• To manage and support flow through the organisation in a timely way. • To liaise with ward staff, IDAT team and the Transfer of Care Hub as necessary, to maximise safe and efficient discharge thus relieving pressure at the front door of the hospital. • To participate in 5 x daily flow meetings, overseeing discharge numbers, delays and bed waiters.
Ward Leaders Therapy Team Leaders Registered Nurses	• To ensure discharge planning is started within 24 hours of admission for all patients setting expectations around Home First • To ensure patients who need support for discharge are flagged for IDAT review at least 24 hours ahead of the patients MSFT date. • To present cases through the long length of stay meeting (LLOS) • To ensure staff have an appropriate understanding of discharge procedures and are aware of this policy. • To communicate with patients, relatives and external partners on matters linked to patient discharge planning. • Where discharge planning is proving to be difficult ward leaders should work with the IDAT team to make decisions and communicate them to patients and carers. • To provide patients with adequate information pre-discharge and contact details in case of difficulties post-discharge. • To complete discharge planning documentation. • To make patients ready ensuring TTOs, equipment and transport are prepared/booked in advance.

Consultants Medical Teams	• Consultants will adhere to the to the Safer Care Flow Bundle, documents which can be found on the Intranet. • To lead twice daily board rounds (morning board round to start no later than 9am) and subsequent ward rounds for all Acute beds. • To confirm patients are Medically safe for transfer (MSFT) and ensure clinical systems are updated. • To ensure all members of the MDT have a voice and are involved in EDD setting. • To escalate discharge delays to senior operational team in division. • To ensure all delays within the control of the ward team are addressed i.e., TTO's, electronic discharge letter, etc • Assess the patient's Criteria to Reside, ensure clinical systems are updated, and take appropriate action. • Once the MDT has deemed that a patient no longer meets the Criteria to Reside, the ward team will be responsible for discharging patients.
Head of Service-Discharge	• Continuous service improvement, with emphasis on embedding the 'home first' approach in line with the Discharge to Assess model. • Ensuring high quality and timely completion of D2A documentation by IDAT. • To be a point of escalation for supported discharge delays/complex discharges or delayed discharges. • To further escalate unresolved discharge issues.
Integrated Discharge advisory team (IDAT) **IDAT Nurses** **Case Managers** **IDAT Admin**	• To maintain an overview of all patients identified as requiring a supported discharge. • To complete the D2A referral, ensuring that information is accurate and up to date. • To ensure relevant supported discharge information is updated on the appropriate clinical systems. • To ensure the timely triage of all complex patients within the ToCH • To be a point of support for multi-agencies with the discharge of complex cases where needed. • Escalate discharge related concerns to the Head of Discharge/ToCH Manager as appropriate. • To attend daily flow meetings as required.
Pharmacy Staff	• To dispense TTO's in a timely manner in accordance with the Medicines Management Policy. • Work with wards/flow team to prioritise TTOs. • Escalate TTO delays to the Capacity & Flow team. • Ensure that appropriate and sufficient medication has been dispensed on discharge to allow time for the patient or carers to obtain further supplies from their GP. • Ensure medicine and dispensing information is up to date on the appropriate clinical systems. • If TTOs have not been issued and are posing a risk to delayed discharge it is possible that a person may be discharged and their TTOs either arranged to follow in a taxi or if in agreement that family will collect them. If this decision is made then all decisions

	will be recorded on the relevant clinical Systems, SystemOne and Nervecentre, to ensure that the discharge is safe and that the medication arrives with the patient in a timely manner.
Front Door Team (including FIT Team)	• To complete front door assessments to avoid admission. • To ensure patient safety at home, referring to community services as required. • To highlight complex patients to the ToCH. • To highlight any homelessness or out of area patients to ToCH • Linking with IDAT to support discharges and completion of D2A.
Transfer of Care Hub (ToCH)	• Ensure that all D2A referrals are triaged in a timely manner, as a minimum twice daily to avoid delays in discharge. • Identify the correct level of care required for the patient to be discharged safely. • To confirm discharge plan within 24 of patient being MSFT • To agree, allocate and record the discharge pathway for all complex discharge patients. • To escalate delays/discharge concerns to the ToCH Manager/Head of service for discharge. • Communicate with the ward team to confirm discharge pathway, start date of care package or date of transfer to alternative bed.
Transfer of Care Hub Manager	• Continuous Improvement of systems and processes. • Embedding and monitoring of D2A model. • Identifying themes delaying discharges. • Working with internal and external partners to unblock discharge pathways. • Offering appropriate professional challenge regarding triaging decisions. • Escalating any complex discharges that cannot be resolved in the hub. • Develop learning from case studies with IDAT team and cascade to system partners.

5.0 APPROVAL

Following consultation with:

- Nottinghamshire Integrated Care System (ICS) Integrated Discharge Lead
- Transfer of Care Hub (ToCH) Manager
- Integrated Discharge Advisory Team (IDAT)
- Divisional leadership team
- Associate Director of Operations- Urgent and Emergency Care.

The policy is approved by the Trust Management Team.

6.0 DOCUMENT REQUIREMENTS

There are a series of ICB approved documents for patients and carers to support them to prepare for discharge following an acute stay.

The Discharge to Assess (D2A) document is completed outlining patients' needs for a safe discharge.

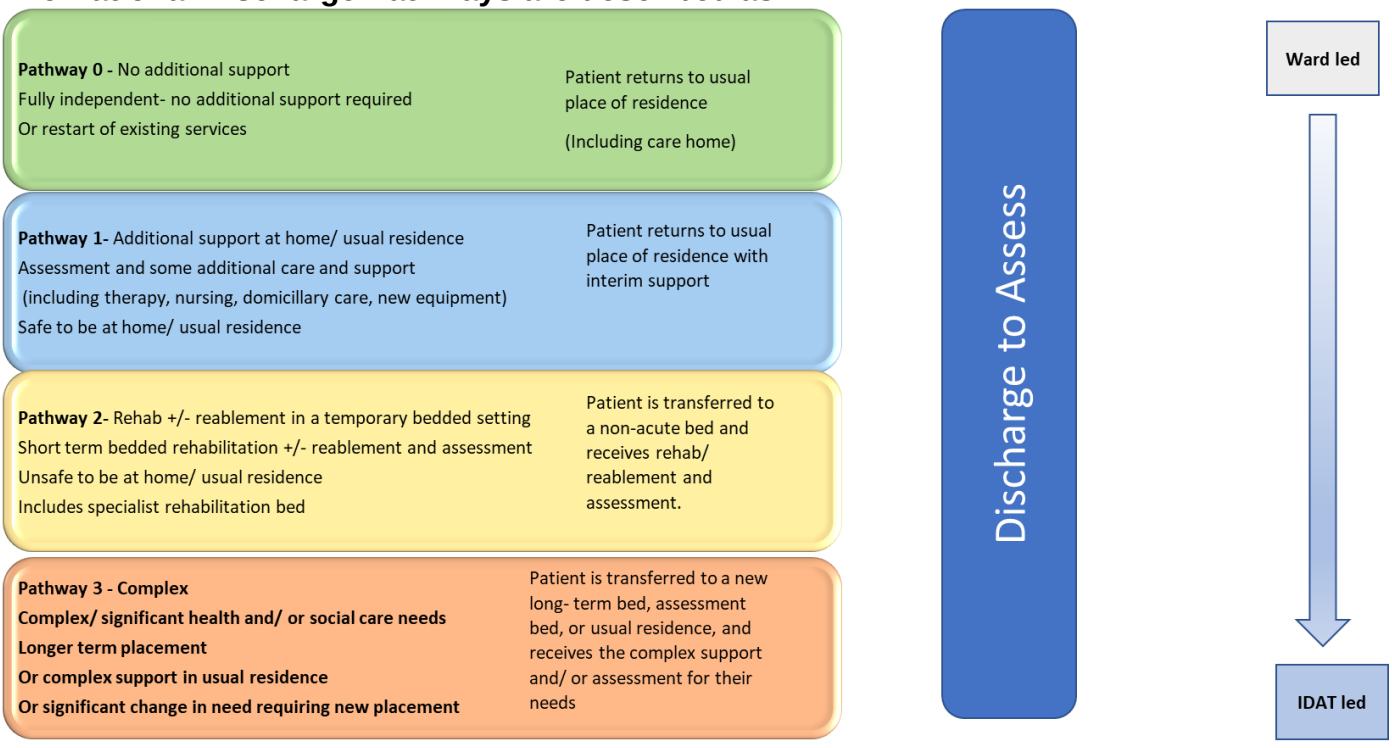
7.0 DISCHARGE PATHWAYS

All patients should be discharged on the most appropriate Discharge to Assess pathway, at least 95% of people will be discharged home. Discharges are described as 'simple' or 'supported'.

Simple discharges are ordinarily managed by the admitting ward and will follow the definition of Pathway 0 as described below. Nevertheless, because a person does not require additional support once discharged this does not necessarily mean that there are no barriers to discharge. At present where an admitted patient does not require onward care but does have other issues which may cause a delay to discharge then they are classed as P0+.

Whilst this is not a nationally recognised pathway it currently differentiates those patients who may require more complex discharge planning. In these cases, ward staff are advised to make contact with Transfer of Care Hub to either discuss discharge options or else seek support in arranging discharge. As the ToCH progress we will look to formalise a process for early identification of these more complex discharges and remove further reference to P0+.

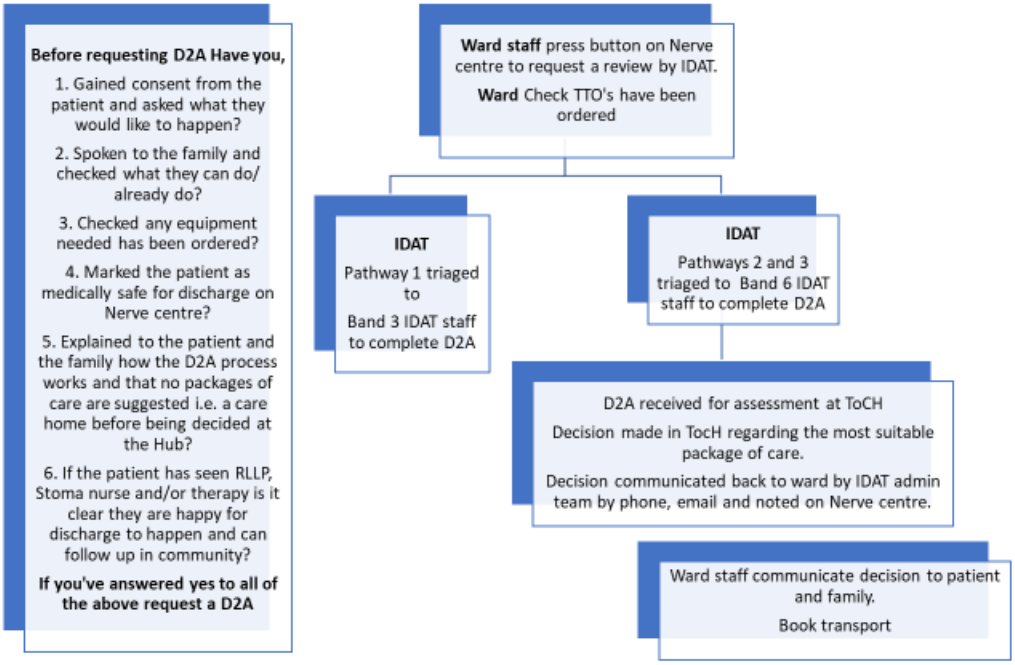
The National Discharge Pathways are described as:



The discharge of patients on Pathways 1 to 3 (supported discharges) are led by the Integrated Discharge and Assessment Team, IDAT team and the Transfer of Care Hub (ToCH). The ToCH currently includes colleagues from IDAT, Adult Social Care, Short Term assessment and Reablement Team (START), Community Therapy, Nottinghamshire Healthcare Trust, Age UK, Tu Vida (An East Midlands based care and support agency).

7.1 SUPPORTED DISCHARGE PROCESS

The process outlined below is our current way of working. This process will be reviewed as discharge delay themes are identified and refined accordingly. Any amendments to the process will be reflected in future versions of this document.



7.2 **TRANSFER OF CARE HUB PROCESS**

The ToCH will triage all supported discharge referrals and determine which pathway will be the most appropriate to meet the needs described on the D2A form following a multi-disciplinary discussion.

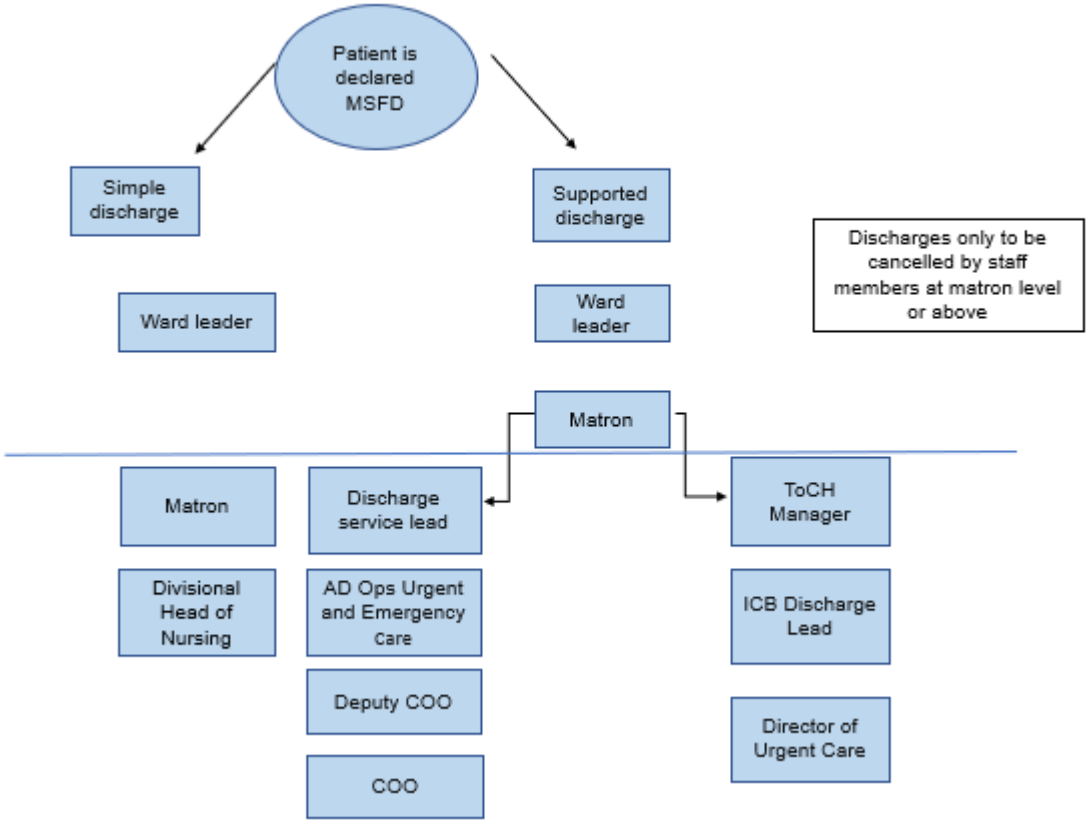
Pathway 1 patients will be allocated to the most appropriate reablement or care provider with available capacity and the decision updated on Nervecentre.

Pathway 2 patients will be listed for the most appropriate, available P2 bed in the area, most local to the patient's home address.

Pathway 3 patients will be escalated to the ICB for bespoke funding to support discharge to a care home.

Where there is insufficient information to make a safe decision about the discharge pathway, the IDAT team will attempt to gather the information needed. Where this isn't possible, the IDAT team will speak to the relevant ward via telephone, return the referral for update and add the necessary information on Nervecentre when available. Once a pathway decision has been made, either the ward staff or wider IDAT team will have responsibility for informing the patient and their carers in a timely manner.

7.3 ESCALATION PROCESS FOR PEOPLE IN DELAY



7.4 PATIENTS' RIGHTS AND RESPONSIBILITIES

Patients do not have the right to remain in hospital once they are deemed not to meet the criteria to reside, as per the ICB Choice Policy (2023). This includes occasions where the appropriate level of care cannot be sourced to support a discharge home. In these circumstances, interim care in a care home may be provided until such time as home support can be sourced.

As part of the normal discharge process patients will receive letters A and B1 or B2 of the Choice Policy as required.

For those occasions where a patient has been deemed to not meet the criteria to reside, but refuses to leave:

- The patient must be formally asked to leave by the Nurse in charge/Ward Manager.
- If no resolution can be found, the Matron and then the Divisional Director of Nursing (as required) will speak to the patient and their carers. If no agreement has been reached a Final Notice Letter from the ICB Choice Policy will be issued. It is expected that this letter will only be seldom enacted and only when all other possible avenues have been exhausted. (Letter C). This letter will be delivered only by either the Divisional Director of Nursing or their nominated deputy.
- If there is still no resolution, the Divisional Director of Nursing and Associate Director of Operations will consult with the Trust's Legal Team. Whilst system partners have signed up to the suite of letters, it remains the individual Trust's decision about whether it is appropriate to enforce them.

- The patient will be provided with the details of the Patient experience team, with information on the complaints and appeals procedures throughout the process.

7.5 MENTAL CAPACITY ASSESSMENT

The Mental Capacity Act (MCA, 2005) is designed to protect and empower people who may lack the mental capacity to make their own decisions about their care and treatment. It applies to people aged 16 and over.
It covers decisions about day-to-day things like what to wear or what to buy for the weekly shop, or serious life-changing decisions such as whether to move into a care home or have major surgery. Patients will be assumed to have mental capacity unless there are reasons to suspect otherwise, at which time an MCA will be completed. All staff must follow the five guiding principles of the Mental Capacity Act 2005 ("MCA").

This means:

- Presumption of capacity – every adult has the right to make his or her own decisions and must be assumed to have capacity to do so unless it is proved otherwise.
- Least restrictive option – anything done for or on behalf of people without capacity should be the least restrictive.
- Unwise decision- People have the right to make what others might regard as an unwise or eccentric decision. Everyone has their own values, beliefs and preferences which may not be the same as those of other people. You cannot treat them as lacking capacity for that reason.
- Maximise Capacity - Support individuals to make their own decisions. People must be given all appropriate help before anyone concludes that they cannot make their own decisions.
- Best interest – anything done for or on behalf of people without capacity must be in their best interests.

Where there is a reason to doubt mental capacity for a particular decision, it must be specifically assessed, in accordance with the Mental Capacity Act (MCA), the MCA Code of Practice and relevant case law and documented appropriately.

All practicable steps must be taken to support the patient to make the decision before concluding that they are unable to make it themselves.

The MCA sets out a 2-stage test of capacity.

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

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

In the context of a discharge plan, the information relevant to the decision will include an understanding of their care needs on discharge, offers of care and options available.

A patient with mental capacity cannot insist on staying in hospital or a discharge to assess pathway after they no longer meet the criteria to reside and so this not an option for a patient who lacks mental capacity for the discharge decision.

Where a patient, despite all reasonable efforts to support them, lacks mental capacity for discharge decisions, the decision must be made in their best interests. (Mental Capacity Act (MCA) 2023

7.6 INFORMATION TO BE GIVEN TO THE PATIENT OR CARERS ON DISCHARGE

- Medical Discharge Summary Letter with a copy to patient/GP/pharmacy/healthcare records and any follow up appointments
- Any relevant patient information leaflets for signposting to external agencies.
- Any relevant information/literature relating to patient self-care plan.
- Fit note if appropriate.

Where patients and carers need to be trained to use equipment. It is the ward team's responsibility to ensure training is properly provided and there is an agreed level of competency ahead of discharge.

7.7 ITEMS TO BE GIVEN TO THE PATIENT OR CARERS ON DISCHARGE

- All patient property should be returned to patient on discharge
- A 7-day supply of consumables to support ongoing care and treatment in the community. (Ward staff to refer to the local discharge checklist as a guidance).
- TTOs (Medication, nutritional supplements, feeds, thickening products).

7.8 INFORMATION TO BE GIVEN TO THE RECEIVING HEALTHCARE PROFESSIONAL

Within 24 hours of the patient's discharge, the patient's GP is sent an electronic discharge summary via SystemOne (Electronic Clinical Recording System) by the discharging ward. All relevant healthcare professionals are informed of any discharge against hospital advice (self-discharge) so that continuing treatment can be resumed.

7.9 TRANSPORT

Wherever possible, patients should be encouraged to make their way home with a family member or trusted friend. Patients can wait in the discharge lounge to be collected by their family member or friend where appropriate. As a minimum all transport requests should be made ahead of the Expected date of discharge (EDD) as routinely as possible. Booking staff must ensure that the patient is eligible for hospital transport, as they may not be if receiving a state benefit. If unsure, then the individual making the booking should contact either a member of the Discharge Team or Duty Nurse Manager for clarity.

Staff must arrange transport for patients according to their need and eligibility. This will usually be via family or carers, voluntary sector, or taxi. In the event a patient cannot be collected by family/ friend and hospital transport is not available same day, then an assessment can be made for fitness/suitability to transport in a private taxi, whilst waiting in the discharge lounge. An assessment checklist must be completed by the discharging ward (Checklist for transfer of patient in private taxi for the purpose of discharge.)

Where hospital transport is required, the wards must book by 10 am the day prior to discharge or with as much notice as possible. Patients must be 'made/booked ready' on the patient transport booking system once their TTOs have arrived. This alerts the transport crew to then collect the patient. Where urgent transport is required to facilitate same day discharge or a special journey, the ward can contact the Flow team to obtain authorisation to support this.

Transport for Bariatric patients or patients out of area should be ordered 48 hours prior to discharge and relevant funding discussions must be held.

7.10 PATIENT DISCHARGE LOUNGE

All adult patients should be promptly transferred to the patient Discharge Lounge to await discharge unless there is a clinical reason not to do so.
Where a patient is identified as medically safe for transfer a discharge plan is in place, the ward should indicate this on the relevant field on the appropriate electronic patient records/Nervecentre.
The discharge lounge team will review all the patients listed to determine suitability for transfer to the discharge lounge, as appropriate following eligibility risk assessments.

7.11 DISCHARGE AGAINST HOSPITAL ADVICE AND SELF DISCHARGE

Patients may decide to discharge themselves from the hospital against clinical advice.
If a patient wishes to self-discharge:

- Staff must advise the patient of the reasons why it is in their best interest to remain in hospital.
- The ward must document that the patient wishes to self-discharge clearly within the discharge summary on Orion (Electronic Clinical Recording System). They also will ask the doctor in charge to update the medical notes and also complete an MCA if there is any doubt that the patient lacks capacity.
- The doctor 'on call' must inform their consultant as soon as possible.
- Any medication required for discharge must be provided. If the patient refuses to wait for their medication, then all reasonable steps must be taken to ensure that the patient receives it, e.g., using a courier service to deliver the medications to their usual place of residence. (Please refer to the Medicines policy 2021)
- Where appropriate relatives and Social Services must be contacted.
- A discharge summary must be sent to the GP within 24 hours of the patient leaving hospital.
- The Duty Nurse Managers must also be informed if 'out of hours.

7.12 DISCHARGE ARRANGEMENTS FOR HOMELESS PATIENTS/ HOUSING ISSUES

Homelessness patients are at high risk of readmission if discharged without appropriate accommodation.
In accordance with the Department of Health & Social Care Guidance (DH 2018) and the Homelessness Reduction Act (2017), admitting clinicians must identify homeless patients on admission and have a 'Duty to Refer' them via the Duty to Refer Checklist which forms part of the above act.

Safe and effective discharge of homeless patients

The specific needs and rights of homeless individuals and the range of services available to them are important fundamentals in providing informed, effective, and compassionate care.

It is crucial to work in partnership across health, social care, housing, and the voluntary sector to best support homeless patients and ensure, once medically fit, they are safely discharged to an appropriate setting.

Meeting the duty to refer

The Homelessness Reduction Act 2017 places a duty on hospital trusts, emergency departments and urgent treatment centres to refer people who are homeless, or at risk of becoming homeless within 56 days, to their local authority.

Hospital staff need to complete health services checklist entitled 'Duty to Refer Checklist' to activate the homeless referral.

7.13 SPECIALIST HEALTH EQUIPMENT

Specialist health equipment may be essential for discharge from hospital. Entitlement to provision is determined as part of the multi-disciplinary assessment and care planning process and is based on the clinical needs of the patient.
Patients and their carers will be trained in the use and care of any equipment provided by the trust and be given a contact number in case of failure or concern.

- Registered Nursing homes providing nursing care should provide an appropriate level of equipment for prevention and treatment as defined by current legislation (Care Standards Act 2000).
- People at home or in residential care are entitled to appropriate health and social care equipment as determined by assessed need and provided by the community equipment service.

7.14 INFECTION PREVENTION AND CONTROL

The operating policy for infection prevention and control (2023) provides details with regards to discharge of patients and infection control requirements.

7.15 DISCHARGE ARRANGEMENT FOR PATIENTS AT THE END OF LIFE

A fast-track discharge is for patients with a rapidly deteriorating condition that may be entering a terminal phase of their illness. As a result of this decision, the patient may require 'fast tracking' for immediate provision of NHS Continuing Healthcare funding to fund a placement or a package of care to facilitate a rapid discharge.

The process for Fast Track is as follows:

- The medical team caring for the patient should discuss the pathway with the patient and/or family/carers and document the discussion in the patients notes.
- Clearly state why they feel the patient's condition qualifies for fast track.
- Medical team to complete the fast-track tool and refer through the appropriate electronic patient records to IDAT.
- IDAT to apply for fast-track funding to assist with a timely discharge and follow each case through to the point of discharge.
- IDAT to arrange transport and TTOs where applicable.

Sherwood Forest Hospitals NHS Foundation Trust

8.0 MONITORING COMPLIANCE AND EFFECTIVENESS

Minimum Requirement to be Monitored (WHAT – element of compliance or effectiveness within the document will be monitored)	Responsible Individual (WHO – is going to monitor this element)	Process for Monitoring e.g., Audit (HOW – will this element be monitored (method used))	Frequency of Monitoring (WHEN – will this element be monitored (frequency/ how often))	Responsible Individual or Committee/ Group for Review of Results (WHERE – Which individual/ committee or group will this be reported to, in what format (e.g. verbal, formal report etc) and by who)
Discharge Policy implementation	Associate Director of Operation - Urgent & Emergency Care, Hub Manager, IDAT team, Matrons, Ward Leaders and Capacity & Flow Team	Monitoring of: • MSFT patient numbers and delayed discharges • Long Length of Stay patients	Daily review of delayed discharges and twice weekly review of long length of stay patients.	LLOS Meetings Emergency Care Steering Group
Complaints and Compliments	PET team	Monthly reports	Monthly	Divisional Governance
EQIA – Appendix 1	Associate Director of Operation - Urgent & Emergency Care	Document review	Annually or when there is significant change	Emergency Care Steering Group

9.0 TRAINING AND IMPLEMENTATION

To date there has been no formal dissemination of or training in this policy. However, following the approval of this policy, the Associate Director of Operations – Urgent and Emergency will be accountable for the required support and training to be provided to ward and discharge teams to embed the discharge policy.

10.0 IMPACT ASSESSMENTS

- This document has been subject to an Equality Impact Assessment (see completed form at Appendix 1)
- This document is not subject to an Environmental Impact Assessment.

11.0 EVIDENCE BASE (Relevant Legislation/ National Guidance) AND RELATED SFHFT DOCUMENTS

Evidence Base:

- Department of Health and Social Care Hospital Discharge and Community Support Guidance published in (March 2022)
- ECIST SAFER Care Bundle, NHS Improvement, '*The Rapid improvement guide to the SAFER patient flow bundle'* accessed [Online 08/09/2023]
- ECIST Reducing Long Length of Stay Accessed [Online 12/09/2023]
- Health and Social Care Act (2020)
- Mental Health Capacity Act (2005)
- National institute for Health and Care Excellence
- Social care institute for Excellence: Assessment of needs under the Care Act (2014)
- The Department of Health *'The NHS Constitution for England' (2023)* The NHS long term plan (2019) Nottingham and Nottinghamshire ICS Partners in Health and Adult Social Care: Discharge ICB Choice Policy (2023)
- NHS continuing healthcare fast-track pathway tool.

Related SFHFT Documents:

- SFHT Mental Capacity Act (MCA) Policy (v6.0, March 2023)
- Missing Service User Joint Policy and Procedure (v3.0, July 2023) **(**MISPER Policy)
- SFHT Adult patient flow and escalation policy (June 2022)
- SFHT Medicines policy V1.182 (2021)
- Patient assessment for suitability for taxi transport home SOP 2.0 (June 2021)

12.0 KEYWORDS

Transfer; integrated; TTO; taxi; process; planning; NHS Continuing Healthcare; home; MSFT; medically safe for transfer; EDD; Expected Date of Discharge; MCA; Criteria reason to reside; Fast-track; Choice Policy; interim; intermediate; home; of care hub; SAFER; ToCH,

13.0 APPENDICES

Appendix 1 – Equality Impact Assessment
Appendix 2 – Reason to reside checklist
Appendix 3 – Safe and effective discharge of homeless patients

APPENDIX 1 - EQUALITY IMPACT ASSESSMENT FORM (EQIA)

Name of service/policy/procedure being reviewed: Discharge Policy			
New or existing service/policy/procedure: Revised Version			
Date of Assessment: 22 September 2023			
For the service/policy/procedure and its implementation answer the questions a – c below against each characteristic (if relevant consider breaking the policy or implementation down into areas)			
Protected Characteristic	**a) Using data and supporting information, what issues, needs or barriers could the protected characteristic groups' experience? For example, are there any known health inequality or access issues to consider?**	**b) What is already in place in the policy or its implementation to address any inequalities or barriers to access including under representation at clinics, screening?**	**c) Please state any barriers that still need to be addressed and any proposed actions to eliminate inequality**
The area of policy or its implementation being assessed:			
Race and Ethnicity	No race or ethnicity barriers	This policy is appropriate for all race and ethnicities. Interpreters will be made available on wards as required to support understanding. All CHOICE letters come in a range of languages and can be requested from the Integrated Care Board (ICB)	No adverse impact
Gender	No gender barriers	All genders are included within the policy	No adverse impact
Age	This policy will support all ages groups	This policy will support all ages groups to ensure no assumptions are made	No adverse impact
Religion	No adverse impact	No adverse impact	No adverse impact
Disability	No disability barriers	This policy will support all disabilities.	No adverse impact
Sexuality	No sexuality barriers identified	This policy will support sexuality characteristics.	No adverse impact
Pregnancy and Maternity	This policy will support all pregnancy and maternity barriers	This policy will support pregnancy and maternity characteristics.	No adverse impact
Gender Reassignment	This policy will support persons aligning to any preferred gender	This policy is appropriate for persons having undergone gender reassignment	No adverse impact

Marriage and Civil Partnership	No adverse impact	No adverse impact	No adverse impact
Socio-Economic Factors (i.e., living in a poorer neighbourhood / social deprivation)	This policy appropriately addresses the issue of and current advice around homelessness	This policy supports the socio-economic factors of the population the Trust serves.	No adverse impact

What consultation with protected characteristic groups including patient groups have you carried out?

- Consultation with Adult Health and Social Care and ICB Nottinghamshire Health Care NHS Foundation Trust.
- Equality, Diversity & Inclusion Lead

What data or information did you use in support of this EQIA?

- Nottingham and Nottinghamshire ICS Discharge Choice Policy
- Population census

As far as you are aware are there any Human Rights issues be taken into account such as arising from surveys, questionnaires, comments, concerns, complaints or compliments?

No

Level of impact

From the information provided above and following EQIA guidance document Guidance on how to complete an EIA (click here), please indicate the perceived level of impact:

Low Level of Impact

Name of Responsible Person undertaking this assessment:

Yvonne Simpson – Associate Director of Nursing

Signature:

Date: 22 September 2023

APPENDIX 2 – REASON TO RESIDE CHECKLIST

Criteria to reside – maintaining good decision making in acute settings

Every person on every general ward should be reviewed on a twice daily ward round to determine the following. If the answer to each question is 'no', active consideration for discharge to a less acute setting must be made:

• Requiring ITU or HDU care?

• Requiring oxygen therapy/NIV?

• Requiring intravenous fluids?

• NEWS2 > 3? (Clinical judgement required in persons with AF and/or chronic respiratory disease)

• Diminished level of consciousness where recovery realistic?

• Acute functional impairment in excess of home/community care provision?

• Last hours of life?

• Requiring intravenous medication > Breakfast & Dinner (including analgesia)?

• Undergone lower limb surgery within 48 hours?

• Undergone thorax-abdominal/pelvic surgery with 72 hours?

• Within 24 hours of an invasive procedure? (with attendant risk of acute life-threatening deterioration)

Clinical exceptions will occur but must be warranted and justified. Recording the rationale will assist meaningful, time efficient review.

Review and challenge questions for the clinical team

Is the person medically optimised? Do not use 'medically fit' or 'back to baseline'.
What management can be continued as ambulatory, for example heart failure treatment?
What management can be continued outside the hospital with community/district nurses? For example, IV antibiotics?

Persons with low NEWS (0-4) scores – can they be discharged with suitable follow up?

• if not scoring 3 on any one parameter – for example, pulse rate greater than 130

• if their oxygen needs can be met at home

• stable and not needing frequent observations every 4 hours or less

• not needing any medical/nursing care after 8pm:

• people waiting for results – can they come back, or can they be phoned through?

• repeat bloods – can they be done after discharge in an alternative setting?

• people waiting for investigations – can they go home and come back as outpatients with the same waiting as inpatients?

APPENDIX 3 Safe and Effective Discharge of Homeless Patients

Safe and effective discharge of homeless patients

The specific needs and rights of homeless individuals and the range of services available to them are important fundamentals in providing informed, effective, and compassionate care.

People who are homeless

It is crucial to work in partnership across health, social care, housing, and the voluntary sector to best support homeless patients and ensure, once medically fit, they are safely discharged to an appropriate setting.

Meeting the duty to refer

The Homelessness Reduction Act 2017 places a duty on hospital trusts, emergency departments and urgent treatment centres to refer people who are homeless, or at risk of becoming homeless within 56 days, to their local authority. Guidance for NHS trusts and foundation trusts providing emergency departments, urgent treatment centres and inpatient services - GOV.UK (www.gov.uk)

Here is the health services checklist of the information you will need to make the referral; any hospital staff member can make the referral. Duty_to_refer_-_health_services_checklist.odt (live.com)

If you would like to learn more E-Learning is available NHSE elfh Hub (e-lfh.org.uk) search for Duty to Refer for Frontline NHS staff.

This is the website where you make the actual duty to refer https://live.housingjigsaw.co.uk/

Contact details for Local Authority Homeless departments.

Mansfield 01623 463121 or email homelessenquiries@mansfield.gov.uk

Ashfield Telephone (8.30am to 5pm): 01623 450000 out of hours 01623 450000 or email housingoptions@ashfield.gov.uk

Newark and Sherwood Telephone 01636 650000 or via email on customerservices@newark-sherwooddc.gov.uk