University Hospitals of Leicester NHS
NHS Trust

Discharge and Transfer of Care Policy (Going Home Policy)

For Adults Leaving Hospital

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REVIEW DATES AND DETAILS OF CHANGES MADE DURING THE REVIEW

Changes made in February 2024 review:

- The main body of the policy is largely unchanged but reflects the changes to the NHS Hospital Discharge and Community Support Guidance. Published 26th January 2024.

- Change of reference to Changes in Titles of Trust Roles, Phone extensions and Discharge Group names.
- Change of references to Home First Form (HFF) to Referral for discharge form (RDS)
- Update of reference to 'Carer' and role in discharge process
- Update to Homeless and Mental Health referral processes.
- Addition of reference to provision of medical fit notes
- Addition of Appendix 1-3
- Change to Policy monitoring arrangements

KEY WORDS

- Discharge (Simple or Complex)
- Transfer of Care
- Self-Discharge
- Discharge Specialist Team
- Integrated Discharge Team
- LLR Integrated Discharge Hub.

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Patient requires **No** significant change in the support offered to themselves or their carer in the community (able to return home with existing package of care, to existing nursing/care home **(Pathway 0)**

YES

- Nursing Staff to inform patient relative/carer of **E**stimated **D**ate of **D**ischarge (Likely discharge date).
- Refer to Therapy and Social Services if necessary.
- Identify Patient as **'Simple'** on nervecentre.

Provide:

- Out Patients appointment if required.
- Wound Dressings if required.
- Equipment / continence aids if required.
- Information leaflets /advice sheets.
- Make referrals to the necessary community services.

Discharge summery including:

- To Take Out (TTO's medications ordered day before discharge.
- Infectious status / swab results
- Request transport if required.
- Complete discharge care planning documentation on nerve centre.
- Handover to the relevant care agency.
- Provide Discharge and Transfer of care letter and ensure patient/carer has had the opportunity to ask questions and understands discharge arrangements

Aim to Discharge the Patient home in the morning via the discharge lounge before 11am if available.

NO

Complex Patients Pathways 1- 3

- Complete Referral for Discharge Support form (RDS) on Nerve centre at least 48 hours before medically optimised date.
- For patients likely to need a discharge MDT with adult social care please refer as soon as possible and liaise with your CMG Specialist Discharge Team.
- Identify patients as **complex** on Nerve Centre.
- Front Door wards (i.e. ED, AMU, CDU) can request adult social care via telephone.

Patients transferring to another Acute Trust, community rehabilitation, or step down bed, Nursing or residential home. Please ensure that an electronic discharge summary/ transfer letter is completed and verbal handover occurs if required.

Should there be an absolute need to send the original case notes to any other organisation outside of the UHL, our Community hospital partners' and other healthcare providers within Leicester and Leicestershire district then managerial authority must be sought and a risk assessment completed and notes tracked accordingly. **Refer to Records management policy (B31/2005).**

As soon as the Patient has been identified that they are able to 'Go Home' please use **'Home today -Yes** Or **Home Today – maybe** on nervecentre.

1 INTRODUCTION AND OVERVIEW

1.1 Effective hospital discharge can only be achieved when there is cohesive joint working between all organisations, including Acute and Community Hospitals, Primary care, Social care, Integrated Care Boards, Midlands & Lancashire Commissioning Support Unit, Housing Enablement Team, Independent and voluntary sectors.

1.2 This document sets out the University Hospitals of Leicester (UHL) NHS Trusts Policy and Procedures for the safe and timely discharge and transfer of care of adults admitted to the trust.

1.3 This policy describes best practice guidelines for all UHL staff who are transferring an adult patient from UHL (either discharge home or transfer to another care provider or from a UHL virtual ward, excluding maternity patients).

1.4 The policy provides a framework that enables the delivery of safe, effective and timely discharge or transfer of care for all adult inpatients. The core principles and processes are the same for all inpatient areas but there will be a service specification regarding roles, responsibilities, procedures and pathways that will need to be considered within each Clinical Management Group (CMG).

1.5 UHL recognises the importance of the multi-disciplinary team in effective discharge planning.

1.6 The engagement of, and active participation of Patients and their Carer(s) as equal partners where appropriate is central to the delivery of care in the planning of a successful discharge (and where the individual consents their independent advocate or, where a person lacks the capacity to consent, their lasting powers of attorney (LPA) responsible for health and welfare).

1.7 This policy has been developed to support good practice in discharge planning by providing direction for staff involved in the discharge planning process. It aims to improve and strengthen discharge planning and the timely discharge of patients from the Trust in line with the 'Discharge to assess (D2A)/ Home First model. The overriding principles include:

a) Integrated Discharge Team working at ward level with external partners.

b) Minimal assessments to be carried out in UHL (e.g. CHC Fast Track/ Acquired Brain Injury Pathway). Ongoing / long term assessments to be carried out in the community in an appropriate care setting (D2A).

c) Right Patient, right place, right support that maximises their independence and leads to the best possible sustainable outcomes.

d) Always consider discharge back to the original place of residence as first option using Home First principles.

e) Person-cantered and a maximising independence approach

f) Reduced duplication of assessment through trusted assessment principles.

g) Releasing time to care.

2 POLICY SCOPE

2.1 This policy applies to all staff employed within the University Hospitals of Leicester NHS Trust, those staff working in a contracted capacity, and staff contracted with partner agencies or NHS Trusts and working within UHL.

2.2 This policy applies to **all Adult Patients**, 18 years and over being discharged from inpatient care in UHL, regardless of age or diagnosis. This policy should be read in conjunction with the Trust's Safeguarding Adults policy (ref: B26/2011) and The UHL Capacity and Flow Escalation Plan.

2.3 For the purpose of this policy the term **discharge** will refer to the discharge of patients from the Trust to their own home, new or permanent place of residence and to **transfers of care** to another care setting such as a residential home or another acute or community hospital and temporary assessment placements.

2.4 The policy applies to all patients registered as inpatients, ambulatory care or virtual ward patients and those attending the hospital for emergency/ urgent assessment and being discharged following a decision not to admit the patient.

2.5 This policy does not apply to patients attending as out-patients to out-patients areas.

2.6 This policy has been developed to ensure:

a) All patients experience well organised, safe and timely discharge from hospital with an agreed, smooth transfer to community based health and social care services.
b) Each patient is encouraged and supported in self-care activities and helped to achieve the highest possible level of independence.
c) Patients, carers and staff are supported to set realistic expectations of hospital stays.
d) Patient, carers and families are prepared, physically and psychologically for transfer home or to an agreed alternative discharge destination.
e) There is effective and timely involvement of patients, carers and family in discharge and transfer planning.
f) There is effective and timely communication of relevant information regarding discharge and transfer plans to patient and their carers.
g) Patients receive an appropriate, skilled and timely assessment.
h) There is continuity of care between hospital and the agreed discharge care environment, with seamless service transition.
i) There are improved patient outcomes by promoting understanding of and concordance with, follow-up arrangements and discharge medication.
j) There is effective and efficient use of the hospitals inpatient bed capacity by reducing unnecessary delays in the discharge process.
k) Highest standards of communication within the multi-disciplinary team, between primary and secondary care, and with colleagues in health and social care and the independent sector throughout the pathway of care.
l) That discharge planning commences prior to, or immediately on admission to hospital and continues throughout the patient's acute hospital admission.
m) That patients are provided with information/medication/equipment to enable and foster independence for the patient/carer.
n) The provision of appropriate documentation accompanies the patient upon discharge.
o) That unplanned re-admissions do not occur as a result of poor discharge planning.

3 DEFINITIONS AND ABBREVIATIONS

3.1 The majority of patients who are discharged from hospital will be classified as a **simple** discharge. A simple discharge is one that:

'Involves minimal disturbance to the patients' activity of daily living; does not hamper a return to their usual residence and where there is no significant change in the support offered to the patient or their carer in the community.' These discharges will be managed at ward level.

3.2 This policy also acknowledges that some patient groups are more complex and may require particular attention when planning and delivering discharge care. A **complex** discharge is usually one that involves the input of 2 or more services and involves multidisciplinary planning and will frequently include the following patient groups, this not an exhaustive list, however cases may include:

a) Older people who are frail and who may live alone or with a carer who may have difficulty coping and want to return home.

b) Patients with short term health needs

c) Patients requiring ongoing treatment out of an acute setting

d) Patients with a long term condition with high risk of readmission.

e) Patients being discharged to a care home.

f) Patients at the end of life, terminally ill or require palliative care.

g) Patients with mental ill health/learning disabilities.

h) Victims of neglect or of sexual or domestic violence.

i) Patients who are homeless.

j) Patients that have no recourse to public funding

k) Those who self-discharge against medical advice

l) Patients requiring an increase in their original package of care or new package of care

m) Patients that are subject to court of protection (COP) application.

n) Individuals with safeguarding concerns regarding discharge

o) Organising same day equipment and equipment needed to deliver nursing care

p) Support with Mental Capacity Assessments (MCA), Best Interest meetings and lasting Power of Attorney concerns.

q) Family disputes

r) Patients with brain injuries who require ongoing specialist slow stream rehabilitation in a specialist setting

s) Patients with complex health needs who require specialist care in the community, beyond that of mainstream services.

t) Out of area patients

u) Patients requiring Long term Oxygen therapy

v) Patients with bariatric care needs.

3.3 **Transfer:** Transfer is defined as the movement of a patient and their care and treatment needs from one inpatient ward/ unit to another (of any inpatient setting), or a community based service for continuation of care. This may be because the needs of the patient are best met at another inpatient or care setting.

3.4 **Discharge:** Discharge is the act of concluding an episode of care within an inpatient setting. This may include handing over responsibility of care to another service or care provider or discharge to a person's place of choice: These include:

- Patients own home
- Community Hospitals
- Community team
- Acute mental health team
- Primary care
- Nursing/ Residential Home
- Clinical Commissioning Group's
- Another hospital service e.g. acute hospital.
- Social care.

3.5 **LLR Integrated discharge hub** is a collaborative virtual service bringing together employees from eight Health and Social Care Organisations namely:

- Leicestershire County Council
- Leicester City Council
- Rutland County Council
- Blaby District Council (Housing Enablement Team)
- Leicestershire Partnership Trust (LPT) and
- University Hospitals of Leicester NHS Trust
- Midlands & Lancashire Commissioning Support Unit.
- LLR Integrated Care Board

The model is primarily focused on a multi-agency integrated team providing a single point of access to the Trusts wards by providing expertise and advice in the safe and effective discharge of patients with **complex** discharge needs and acting as experts on discharge planning for the wards.

3.6 **Discharge Situation Report (SitRep)** previously referred to as the Delayed Transfer of Care (DTOC) is an overview of patients that are currently delayed due to an external factor i.e. awaiting a placement. A patient is ready for transfer/ discharge, 'discharge ready'/ medically optimised for discharge when:

- a clinical decision has been made that the patient is ready for transfer, and
- a multidisciplinary team has decided that the patient is ready for transfer,
- the patient is safe to discharge/transfer and

- the patient no longer meets the 'reason to reside' (stay) criteria in an Acute Trust.

3.7 The term **'Patient'** relates to Adults patients.

3.8 The terms **'Family /Carers'** relates to those persons that the patient may refer to as their next of kin, or the person they identify with that acts on their behalf in their best interests.

3.9 A **Carer** is defined as an individual who provides or intends to provide care for an adult, otherwise than by virtue of a contract or as voluntary work.

4 ROLES – Responsibilities within the Organisation

4.1 **The Medical Director and Chief Nurse** have overall responsibility for the quality of medical and nursing intervention to support the policy.

4.2 **The Chief Operating Officer** has overall responsibility for ensuring that there are effective arrangements for discharge and transfer of care planning within the trust.

4.3 It is the responsibility of the **Consultant** to ensure:

a) All patients in their care have an estimated discharge date (EDD) within 24 hours of admission to hospital and that this is discussed with the patient and family/ carer and is reviewed daily in line with the NHS SAFER patient flow bundle and NHS Red2Green bed days approach and recorded on nerve centre.

b) The EDD is the date that the multidisciplinary team (MDT) predict that the patient is likely to meet specific clinical criteria to enable them to be discharged and highlights when support will be required to facilitate discharge at the earliest opportunity.

c) Board/ward rounds occur each working day where resourced to do so alternatively the moderated version outlined in the Board round SOP should be followed, to identify patients who are ready for discharge. Patients potentially ready for discharge should be reviewed as early in the day as is consistent with clinical priorities (i.e. at the beginning of the board/ward rounds wherever possible, sickest patients first then potential discharges, then new patient and then the ward round of remaining patients).

d) The patient is assigned a 'reason to stay' (reside) code on nerve centre each day. If the patient has 'no reason to stay' in an acute trust they are deemed medically optimised for discharge/discharge ready.

e) If the Patient is identified as suitable for discharge that day, they should be identified as **Home today-yes** on nervecentre or **Home today -maybe**.

f) The frequency of individual patient discharge reviews reflects the clinical condition of the patient and the nature of the discharge plans (some patients may require a twice daily review to progress plans).

g) All patients have a Consultant approved care plan that includes physiological and functional clinical criteria for discharge. Consideration being given to whether the patient would be better off in an acute hospital or in an alternative setting to receive on going care and treatment (community hospital for medical step down/ rehabilitation,Home with Home first support services, or Virtual ward). To include consideration for outpatient testing/ follow – up (x-rays, scans etc.).

h) To Take Out (TTO) prescriptions for discharge are written at least 24 hours before discharge or as soon as practicable when discharge is confirmed with less

than 24 hours' notice. If the patient requires dossette box or controlled drugs these should be requested as soon as possible.

i) Plans are put in place to identify patients who may be ready for discharge at weekends and bank holidays when board/ward rounds may not be routine.

j) Consideration should be given to **Criteria Led Discharge.** For further details please refer to the Trust's policy (Trust Ref: B21/2013)

k) The Consultant and MDT have responsibility for agreeing the patient is ready for discharge/transfer and that this is recorded in the medical notes as 'medically optimised' for discharge (the discharge ready date). This is a statutory requirement under the Care Act 2014.

l) Keeping the patients/relatives/carers fully informed of their progress and treatment in order to progress assessment needs.

m) Complete an electronic discharge summary letter for each patient prior to the EDD when possible.

4.4 **The Heads of Nursing, Deputy Heads of Nursing and Matrons** are responsible for ensuring compliance with this policy, supporting audit, reviewing results and implementing change where appropriate. Delays in discharge should be monitored and escalated to the CMG Discharge Specialist team/LLR Discharge hub for support and if necessary improvements made to the process.

4.5 **The Ward Sister/Charge nurse** has responsibility for ensuring that systems are in place to facilitate a safe, timely discharge for all patients under their care in line with the SAFER patient flow bundle. Discharge needs to be coordinated through a multidisciplinary approach by the Ward Sister/Charge nurse or their deputy, to enable discharge by the EDD. The sister should ensure that standards of discharge planning are maintained and that staff report any examples of non-adherence to the policy through the hospital adverse events datix reporting system.

a) Ensuring that every patient has a copy of the 'UHL Hospital Discharge Letter' given on admission (Appendix 2.) to the ward and a 'Supporting you to leave hospital' Leaflet if required prior to discharge. Available at:

(http://www.yourhealth.leicestershospitals.nhs.uk/library).

b) Ensuring the Discharge Checklist on nerve centre is completed.

c) Ensuring that the nerve centre board round/ discharge profile is completed and kept up to date with 'simple/ complex discharge, medically optimised for discharge/ reason to stay status and Home today status.

d) Ensuring that all patients have an EDD recorded in their notes, detailed on nerve centre and that this date has been communicated to the patient, relatives/carer, as appropriate.

e) All information relating to the discharge is recorded on the board round/ discharge profile on nerve centre.

f) Ensuring that systems are in place so that patient discharge is co-ordinated and progresses according to plan.

g) Ensuring that where possible all discharges take place before 11am.

h) Jointly work with the Senior Decision Maker to ensure review of patients at daily Board Rounds and later in the day follow up of actions in line with NHS Red2Green principles and a reason to stay (reside) code has been applied.

i) Ensuring that information required to plan and manage patient discharges is gathered, and recorded accurately, especially in respect of conversations with the patient, their family and/or carers: including the date and times of those conversations.

j) Continuously monitoring the discharge progress of all patients, ensure positive action is taken to expedite discharges for those who are medically optimised for discharge/ No reason to stay (reside) in an acute bed and have exceeded their EDD.

k) Any delays to patient progress (diagnostics, tertiary opinion, referrals) to be reviewed and escalated as per Clinical management group (CMG) escalation pathway i.e. through Matron, General Manager or Manager of the day.

l) Ensure Referral for Discharge support form (RDS) is completed for patients requiring referral to the LLR Discharge hub on Nerve Centre in a timely manner using the Home First principles.

4.6 **The Registered Nurse** is responsible for ensuring:

a) Discharge planning commences within 24 hours of admission and that progress is appropriate to achieve the EDD.

b) The patient and relatives / carers are fully involved in the discharge planning process, their needs and wishes are taken into account and they have at least 24 hours notice of the discharge date, whenever possible.

c) In the absence of the Senior Nurse /Nurse in Charge jointly work with the Senior Decision Maker to ensure review of patients at daily Board Rounds and later in the day follow up of actions.

d) All information relating to the patients discharge is recorded on the patients discharge care plan/checklist and on nerve centre.

e) Consider the need for further assessment on discharge, utilising the RDS form.

f) The patient's medication is ordered 24 hours before the discharge for known next day discharges. If the Patient requires a dosette box and/or controlled drugs please ensure as much notice as possible is given.

g) The patient has any tests required for discharge e.g. Swabs. Please refer to the latest Infection Control guidance.

h) Transport should only be provided for discharge when there are no family or friends to transport the patients, they are unable to use a taxi or volunteer driver services and there is a clinical reason.

i) Transport can be booked 24/7 and all staff should access this system to book accordingly to the patient's needs and mobility status. Transport should be made via the On-Line Transport system through the current provider.

j) Appropriate transport arrangements are made and that all pertinent information regarding the patient's condition is given to the ambulance service transporting

patients. (E.g. Do Not Resuscitate (DNACPR) status, infections, issues regarding transferring and in respect to manual handling). When arranging transport for discharge it is vital that the discharge address including Post Code is confirmed and checked as correct, as it may differ to the patient's home address. It is equally important to check that the patient can access their destination address e.g. do they have a key, can they manage any steps at the property.

k) Transport for bariatric patients and for property that is difficult to access must be booked in line with the transport providers policy for the necessary assessments/ access visits to take place.

l) The receiving hospital, care home or social care facility (or community nurse team, if the patient is returning home) is notified of any known infection and the current infection control practices in place e.g. antibiotic therapy, dressing regime, barrier nursing and this is written in the Discharge Summary Letter.

m) The patient has the necessary medication, dressings and relevant information about post discharge care.

n) All arrangements and referrals in relation to discharge planning are clearly documented, signed and dated within the discharge planning documentation.

o) All healthcare professionals involved with the patient are notified of any change in the patient's ward placement and or condition/suitability for discharge with a request for a review as appropriate.

p) Any potential delays in discharge are referred immediately to the IDT/ CMG Specialist Discharge Team as soon as they become known outlining the reasons for the delay or potential delay.

q) All necessary information for discharge/transfer of care and management is gathered, recorded and communicated appropriately.

4.7 **The Discharge Support Assistant/Assistant Practitioner for Discharge** works in support of the MDT team undertaking delegated tasks to facilitate safe and timely discharge of patients.

4.8 **All members of the multidisciplinary team** (MDT) have the responsibility to ensure patients their families and carers are consulted and regularly updated about discharge planning from admission (or preadmission when patients are attending pre-assessment clinics prior to admission); throughout inpatient stay and up until 30 days post discharge; sign posting patients/carers where necessary.

4.9 **The Ward Clerk** is responsible for working in support of the MDT and for arranging outpatient's appointments and ensuring the recording of timely and accurate discharge time within the patient record and the electronic patient information systems.

4.10 **The Allied Health Professionals** (OT, Physio, and other allied groups) provide holistic functional patient assessment and consider equipment, adaptations and/or goals for rehabilitation, for patients who are expected to improve their functional ability. They will liaise with patients, their carers, families and

multidisciplinary teams within UHL and externally to enable the needs of the patient to be met. They form part of the IDT and work using the principles of trusted assessment, Home first and Discharge to assess. Assessments for long term needs will take place outside of the acute hospital setting.

4.11 **Pharmacy staff** are responsible for timely preparation of discharge medication and ensuring medicines are returned to the appropriate ward or discharge lounge when it is open.

4.12 **CMG Matron for Discharge** provides expert clinical leadership in relation to patient flow and discharges specific to the CMG and form part of the wider Integrated Discharge team to ensure safe and timely discharge / transfer of care and best practice is advocated.

4.13 **The CMG Discharge Specialist Team / Emergency Floor Discharge Practitioners** provide expert clinical leadership in relation to complex and delayed discharges in conjunction with the ward sister and multidisciplinary teams by:

a) Promoting good practice in discharge planning across UHL, Leicester, Leicestershire & Rutland, Health & Social care community.

b) Providing active support to the MDT for discharge of patients with complex needs. Seeking solutions to delays in discharge and pursuing all options for effective discharge in line with 'Home first' and Discharge to Assess principles.

c) Developing strong links with all CMG's within UHL, community health services, including community hospitals and other partner agencies to identify and progress delayed discharges.

d) Ensuring that local and national policies and guidelines are used throughout the discharge planning process.

e) Completion of fast track assessments and coordinating discharge for patients who are in the last days/week of life.

f) Arranging patient transfer onto discharge pathways as appropriate e.g. Pathway 1, 2 or 3.

g) Complete risk assessments and order equipment for patients with nursing needs following discharge and ensuring timely handover to appropriate care provider in the community.

h) Provide the Notification of Discharge Plan letter (Appendix 2) as required.

4.14 **The Heads of Nursing System Emergency Care / Discharge Improvement** have responsibility for bringing about sustained improvement in discharge planning by working with multidisciplinary teams within UHL and partner agencies by:

a) The development, implementation and evaluation of policies, standards and guidance on discharge planning.

c) Ensuring that clinical areas have access to information and support in the implementation of local and national policy and legislation relating to hospital discharge and transfer of care.

d) Ensuring a programme of audit to monitor effectiveness of discharge tools and practice and identify areas of improvement.

e) Influencing strategic planning to achieve national and local urgent and emergency cate performance targets.

f) Monitoring the patients experience with discharge planning within the Trust

g) Monitoring and escalation of daily 'incomplete' discharge census (sitreps) and working in partnership with multidisciplinary teams within UHL and community services to resolve specific issues relating to delays.

4.15 **The Capacity and Flow Team** manage the daily flow of patients into and out of the Trust and promote/initiate the use of appropriate services and schemes to enable safe and early transition to home. They will maintain and communicate accurate information on bed status and liaise with clinical staff to support an overview and understanding of pressures within the service to inform operational and clinical decision making processes across the system. They will work with clinical colleagues to enable morning transition of patients to home whenever possible so that sufficient beds are available to enable patient's timely access to the most appropriate care setting and level of care.

4.16 The LLR Integrated Discharge Team, Intermediate Care Transformation Steering Group and Acute Care Collaborative will support the working of this policy and the safe and timely discharge improvement work steam.

5. POLICY IMPLEMENTATION AND ASSOCIATED DOCUMENTS –WHAT TO DO AND HOW TO DO IT

5.1 All Discharges/ Transfers of care. (Going Home Process)

There are a number of **key principles**, which underpin practice across all aspects of discharge planning:

5.1.1 Each patient's discharge will be planned by the MDT in conjunction with the patient, relatives, and/or carer, and will begin on or before the patient's admission to hospital. It will be an ongoing process that will involve the patient, relatives and carer, and will provide a seamless transfer from hospital to the most appropriate environment using the Homefirst and Discharge to assess principles.

5.1.2 All patients will receive a Hospital discharge information letter at pre admission or on admission, which can be formatted and translated into various languages upon request.

5.1.3 All patients must be given an Estimated Date of Discharge (EDD) within 24 hours of admission which will be recorded in the case notes and nerve centre and on the 'Supporting you to leave hospital' booklet and be assigned a daily reason to stay (reside) code. This date will be discussed and agreed with patients their relatives or carers and any changes to this date will be discussed with the relevant stakeholders.

5.1.4 The date of discharge should be confirmed with patients and their families, and care homes giving at least 24 hours notice where possible.

5.1.5 All patients will have a UHL Discharge planning care plan/ checklist commenced on admission. The Discharge planning care plan is the single document recording all MDT referrals relating to the patient journey from admission to discharge/transfer of care and is part of the Nursing assessment documentation on nervecentre.

5.1.6 Ensure up to date record of Discharge planning in care plan, within care records and on nerve centre confirming that the patient has no new care needs and has been assessed as meeting the criteria for discharge.

5.1.7 Adults, including older people, who do not require community support can be discharged without the need of referring to social services but may be given a contact number for the relevant Social Services Department should they require help in the future.

5.1.8 Where patients have capacity to, then they must provide consent to share information with partner agencies, families/ carers for discharge planning. If the patient does not have capacity to consent to information sharing, a best interest decision whether or not to share information, will need to be recorded, following consultation with family/carers.

5.1.9 Patients should be informed to plan their own transport arrangements for discharge. Patients with a clinical need can be referred for ambulance transport.

5.1.10 On the day of discharge the discharging nurse must confirm that the patient is medically optimised to leave hospital and check that all arrangements are in place with the patient, family/carer.

5.1.11 A copy of the discharge summary letter (TTO) should be ready 24 hours before discharge/transfer wherever possible.

5.1.12 The discharge/ transfer of care letter must be proof read and checked through and given to the patient/carer at the time of discharge with an opportunity to discuss the content and to ask questions.

a) The letter should be used to confirm the patients/ carers understanding of their condition, treatment, medicines and ongoing care needs at the time of discharge.

b) The nurse discharging the patient should also confirm that the patient and/or carer understands the information provided regarding their condition including: expected signs to look for and when and who to contact for help and advice.

5.1.13 The discharging registered nurse is responsible for ensuring the patient and/ or carer understands their medication regime on discharge by discussing the following:

- The name of medication
- The purpose of the medication
- The times the medication is to be administered
- Make note of any special instructions including side effects,

If appropriate medications counselling by a pharmacist or pharmacy technician should be considered.

Please refer to the TTO Checking - Home Discharge Medications UHL Pharmacy Guideline (B19/2015) for further information.

5.1.14 The nurse discharging the patient will give the patient details of outpatient appointments or other follow up appointments. If the information is not available by the day of discharge, the patient/ carer will be sent an appointment by post; in these circumstances staff need to confirm with the patient/carer, the address the appointment is sent to and the patient and carer should be given a contact number in case the appointment is not received.

5.1.15 The discharge checklist will be completed by the nurse responsible for discharging the patient on the day of discharge.

5.1.16 Those patients planned for discharge will be ready to leave the ward area before/by 11am (this includes all patients where on-going care is expected to be completed on the discharge lounge, where this is available).

5.1.17 An electronic discharge summary letter (TTO) will reach the general practitioner (GP) within one working day of discharge.

5.1.18 All adult patients should be considered for transfer to a Discharge Lounge (if available) or an area to wait away from their bed prior to discharge to assist with early flow and capacity throughout the hospital.

5.2 Out of hours discharge.

5.2.1 Staff should not routinely discharge patients after 10pm, unless the patient or family request and are happy for discharge after this time.

5.2.2 In the event of patients leaving the hospital after 9pm every effort should be made by the ward nurse discharging the patient to contact the family, carers, unless the patient requests otherwise.

5.2.3 Referrals for social care (city & county) e.g. emergency placement for Emergency department (ED), out of hours including weekend and BH: ring 0116 2551606

5.2.5 In times of heightened escalation and extreme bed pressures, later discharges and transfers may be necessary and should be discussed and agreed with patients, carers and families and the receiving care facility and noted in the patient record.

5.3 Where Applicable.

5.3.1 The nurse discharging the patient should confirm that the patient and/or carer understands the information provided and, where English is not the patient's first language, staff should request assistance from an interpreter. Interpreters and written translations including Braille can be booked via their online booking portal on INsite.

5.3.2 Ensure patients with learning disability/ communication problems are offered the appropriate support to be actively involved and participate with their discharge plans e.g. support from Learning Disability liaison nurse; advice from Speech and language therapy to enhance communication difficulties.

5.3.3 The Medical team and the Health Care Professional (Nurses, Occupational Therapists, Pharmacists and Physiotherapists where appropriate to role) and are responsible for discharging the patient will provide a medically fit note covering the whole of the anticipated period of absence from work if the patient is to refrain from work. Refer to: Policy for Signing of Statement of Fitness for work (B9/2013)

5.3.4 The receiving care provider must be informed of any infection risks and this information should be recorded on the discharge letter summary (TTO). Contact Infection prevention for advice and support.

5.3.5 If dressings are required:

a) The nurse discharging the patient should ensure that a referral to the practice nurse is made (via SPA), and the patient is well enough to attend the GP surgery.

b) If the patient is not well enough to attend the surgery, then a referral should be made 48 hours in advance of the planned visit date for the district nurse to visit the patient within their home environment.

5.3.6 The patient should be supplied with a transfer letter recording any wounds, pressure ulcers, bruises or skin blemishes and a minimum of 3 days supply of dressings.

5.3.7 Telephone notification to social care / care agencies to restart package of care (if no change and being received prior to admission)

5.3.8 Contact the CMG Discharge Specialist team for assistance with contact numbers for patients who are out of county or contact the UHL Corporate Discharge administration team on ext:16882 (0116 258 6882).

5.3.9 If an existing care package needs to be restarted, the registered health professional undertaking the assessment will need to confirm this will continue to meet the patient's needs and contact the relevant health or social care provider.

5.3.10 For patients who self-discharge or die whilst in hospital the relevant relatives, carers, agencies and GP should be informed.

5.3.11 Where patients are identified as being at high risk of readmission (PARR 30 tool score >40), staff responsible for discharge planning should check that the patient and carer/family are fully informed about their condition and understand their care plan, including administration of medicines, management of pain & constipation; side effects of medicines and contact numbers for them to contact if they are concerned or worried. They should be highlight as a 'readmission risk' in the transfer/discharge letter to the GP.

5.3.12 Risk assessments will be completed prior to ordering/ issuing any necessary equipment/aids essential for discharge:

a) The physiotherapist will assess for mobility aids e.g. walking frame/ stick, rotunda and order as appropriate and arrange further physiotherapy assessment/support in the community if required.

b) The Occupational therapist will assess for aids to assist transfers e.g. hoist, bed lever, commode and order as appropriate and arrange further occupational therapy assessments/support in the community if required.

c) The CMG Discharge Specialist team will assess for nursing aids e.g. Pressure relieving, hospital bed and accessories, bed rails and arrange further assessments in the community if required.

d) Where appropriate, patients/carers will receive instruction on the use of aids and equipment prior to discharge as a means of encouraging self-management.

e) Referrals for assistive technology can be made via the relevant social service department, patients may be charged for this service.

5.3.13 Where there is an urgent need to discharge a patient prior to the TTO medicines being physically available to ensure placements are not lost due to the delay in discharge. These are limited to discharge to a:

- Residential Home
- Care Home or
- Community Hospital

There are patient exclusion criteria based on certain medicines. Please refer to the Policy for the Discharge of Patients to Residential Homes, Care Homes or Community Hospitals prior to TTO Medicines being available (B19/2018)

5.4 Complex Discharges

5.4.1 Once a patient has been identified as having complex needs they should be referred via a Referral for Discharge Support form (RDS) on nerve centre. At least 24-48 hours prior the EDD.

5.4.2 Where suspicions or disclosures are made for adults at risk of abuse, prompt adherence to existing safeguarding policy and procedures should be made.

5.4.3 Where it is suspected that patients lack capacity regarding decisions relating to discharge an assessment should be undertaken using the 'Mental capacity and Best Interests assessment' on nervecentre.

5.4.4 Where patients lack capacity regarding decisions relating to discharge the views of family members must be sought and considered. It is the relevant decision makers responsibility to determine the future management of the patient's healthcare needs, in the 'best interests' of the patient, unless there is someone who has authority under a valid and applicable Lasting power of attorney or have been authorised to make decisions as a deputy appointed by the court of protection. (Mental Capacity Act 2005). For further details please refer to the Trust's Mental Capacity Act Policy (Trust Ref: B23/2007) and the Trust's Advance Decisions and Lasting Power of Attorney Policy (Trust Ref: B20/2004)

5.4.5 Where patients lack capacity regarding decisions relating to discharge and there are no family or friends the MDT must consider making a referral to an independent mental capacity advocate (IMCA) by completing an IMCA POhWER referral form available on INsite. (Mental Capacity Act 2005). For further details please refer to the Trust's Mental Capacity Act Policy (Trust Ref: B23/2007)

5.5 Assessment of on-going care needs/care packages

5.5.1 Carers will be offered a carer's assessment from social services, where disclosures are made regarding their ability or willingness to continue caring or where staff suspect/observe difficulties in meeting the caring role. This will need to be age appropriate if this is a young carer under the age of 18 years staff should identify any safeguarding issues for both the adult and young carer.

5.5.2 Ward teams will refer Patients to physiotherapy and occupational therapy, if they have not returned to their pre-hospital functional status to determine whether they have potential for their functional ability to improve. To consider suitability for rehabilitation at home via 'Home First Community services' or social care reablement; OR inpatient rehabilitation/ step down in a community hospital if the patient has night time needs.

5.5.3 The MDT are advised to seek early help and advice from the CMG Discharge Specialist Team/IDT with patients who have complex care needs or any issues that could potentially result in a delayed discharge.

5.5.4 The Multidisciplinary Team (MDT) needs to determine whether the patient will benefit from a period of recovery, reablement or rehabilitation at home with Home First services or in one of the systems intermediate care beds. Refer the patient via a RDS form outlining their care needs.

a) If the patient is stable and does not have any care needs e.g. package of care, and requires **community therapy only** a referral form is completed by the MDT identifying specific treatment and goals for improvement and emailed to**: lptchs.spa@nhs.net** or called through on 03003001000 The referral should be recorded in the discharge planning care plan.

5.5.5 Patients who require support with care for the end stage of a terminal illness or have a rapidly deteriorating condition should be referred urgently to the CMG Discharge Specialist Team.

5.5.6 Before issuing any assessments, i.e. RDS forms the MDT must consult with the patient and, where applicable, the carer to gain consent to referral.

5.5.7 If the patient requires enteral feeding following discharge the Leicester Intestinal Failure Team (LIFT) team will need to be contacted to provide support and training to the patient, family, carer or care providers.

5.5.8 Patients requiring home oxygen will require a Home oxygen form and consent form completing, the home oxygen service can assist with this process.

5.5.9 If the patient requires pressure relieving equipment the nurse will need to make a referral to the Specialist discharge team, who will review the patient and order the equipment if required. A referral will be made to the district nursing service to monitor the patient following discharge.

5.5.10 A bed rail risk assessment will be completed by the CMG specialist discharge team for patients requiring bed rails, as identified by ward staff. The referral will be completed via telephone to the service responsible for monitoring post discharge. E.g. Community nurse/ social services/ placement.

5.5.11 If the patient is returning home, lives alone and is unable to answer the door to carers - a key safe may be provided by the service commissioning the care (e.g. social care or continuing health care), and the patient may incur a charge.

5.5.12 If the patient has continence problems a continence assessment should be undertaken. Advice is available from the UHL continence nurse specialist team. 1. day of continence aids should be provided on discharge and if a referral is needed for pads staff should refer to the Community Contenence team via SPA; 03003001000.

A Catheter passport and patient information leaflet to be sent with patients who have been discharged with a urinary catheter in situ. (hard copies are available from the print room). A referral to SPA is required for general catheter care and monitoring.

5.5.13 Staff may need to liaise with the Manual Handling team, therapy team or the Non-emergency transport service for advice regarding patients with Bariatric care needs on discharge.

5.6 Patients who are homeless

5.6.1 Homeless patients frequently have complex health, social and mental health issues. The multidisciplinary team should seek early advice from the CMG Discharge Specialist team.

Under the Homelessness Reduction Act 2017, NHS trusts have a statutory duty to refer, which includes referring admitted patients at risk of or experiencing homelessness to a local housing authority within 56 days. A referral should be made to Housing Enablement Team HET) to complete a duty to refer form as early as possible in the patients hospital stay via HousingEnablementTeam@uhl-tr.nhs.uk.

The Housing Enablement Team work alongside the CMG Discharge Specialist team to support discharge from hospital.

5.6.2 Patients visiting from abroad should be referred to the persons from abroad team (ext. 15734/18908) to determine eligibility for health care services.

5.6.3 Homeless patients with ongoing care needs following discharge should be referred to the relevant social services by sending an RDS form for a community care assessment.

The patients' previous address will help to identify which local authority is responsible for the patients care. If the patient wants to reside in Leicester, then a referral should be made to city social services. The patients consent will be required for the referral.

5.6.5 Patients from abroad who may have no recourse for public funding and want reconnecting to their country of origin should be referred to the Overseas Visitor team on 0116 258 8908

5.6.6 The CMG Discharge Specialist team may seek assistance with repatriation of overseas patients by contacting the appropriate family members or by seeking advice from the appropriate Embassy or various charitable organisations e.g. Red Cross.

5.7 Patient has long term condition, is frail and /or elderly or at risk of readmission

5.7.1 The multidisciplinary team need to contact the CMG Discharge Specialist team as early as possible in the patient journey for support.

5.7.2 A Multidisciplinary meeting needs to be arranged to discuss discharge planning, this will vary depending on the problem e.g. ward medical and nursing staff, social worker; OT, physiotherapist; community matron; via SPA; care home staff if the patient is resident in a care home; CPN or psychiatrist if patient has mental health needs, GP; Primary care coordinator, frequent attender nurse.

5.7.3 The aim of the meeting will be to determine the patients pre hospital functional status prior to admission, including the community social and health care support the patient was receiving and to discuss the patients current ongoing health and social care needs following discharge to enable a medical management plan and appropriate package of care can be commissioned that meets the patients needs.

5.7.4 The Occupational therapist and Physiotherapist may need to consider any equipment, adaptations or assisted technology the patient may require that can help to support the patient in the community.

5.7.5 The patient, family/carer will be provided with a full explanation of their illness, prognosis, likely setbacks to expect and contact numbers of who to contact if concerned or requiring further assistance.

5.7.6 Staff may need to consider a contingency plan if the package of care/ care plan, is likely to breakdown, to prevent the patient from being unnecessarily admitted to acute care e.g. care home placement/ respite care; medical step down in community hospital.

5.8 Patients with mental health/ behavioural issues

5.8.1 The MDT need to contact the CMG Discharge Specialist team as early as possible for support, advice or assistance with discharge planning.

5.8.2 If the patient is displaying signs of acute mental health problems, a deterioration in a known mental health condition or there are concerns around mental health, they should be referred to Mental Health Liason Services for assessment pre -

discharge. All Mental Health referrals from UHL hospital wards must be emailed on the MHLS referral form to: lpt.mentalhealthliaison@nhs.net
The team can be contacted on 07717 484113
If a patient is known to Community Mental Health Services, but no current concerns around mental health, do consider whether it would be beneficial to let the Community Team know of admission, ideally directly or consider contacting MHLS via email to ask them to put information for the relevant team on their system if/ as applicable

5.8.3 If the patient is already known to mental health services the multidisciplinary team should contact the community psychiatric nurse (CPN) or relevant psychiatrist to ascertain background information/ patient baseline (0116 2255911).

5.9 Patients with a learning disability

5.9.1 Establish if patient has known health or social key worker by contacting the GP or social work department (city 0116 454 1004, county 0116 3050013)

5.9.2 Refer to the UHL learning disability acute liaison nurse, for support with discharge planning, if the patient has ongoing care needs or issues relating to discharge.

5.9.3 Determine whether the patient has mental capacity to make decisions regarding discharge, if this is unclear and an assessment is required, ensure the patient receives appropriate support with communication e.g. learning disability nurse, friend, family, speech & language therapist.

5.10 Patients with End of Life care needs : Rapid Discharge Home Support Service(prognosis of no more than 1 week) or Fast Track Discharge refer to the CMG Specialist Discharge Team

5.10.1 Establish that the patient is not for further active treatment and that this is documented in the case notes.

5.10.2 Ensure the patient and the family are aware of the prognosis / rapidly deteriorating condition.

5.10.3 Establish if patient prefers to die at home or remain in hospital.

5.10.4 Ensure DNACPR & End of life medication is prescribed with drug authorisation letter for district nurse.

5.10.5 CMG Discharge Specialist team to contact Hospice at Home to ensure that there is capacity to accept patient. Referrals Mon- Fri before midday, discharge can be arranged on the same day; referrals after midday can be arranged for the next working day.

5.10.6 CMG Discharge Specialist team to determine whether equipment is required for discharge e.g. hospital bed, slide sheets, pressure relieving mattress, and notify Hospice at home who will organise urgent delivery on the same day of discharge.

5.10.7 Three days supply of End of life drugs to be prescribed by medical staff, and community nurse drug authorisation form to be completed.

5.10.8 Complete ReSPECT form, notify patient and carer and GP. Patients to be given original on discharge. Patients transferring to a new care home will be registered with a new GP. It is good practice to make advanced contact with the GP and

advise that the patient is being discharged and that they may need to undertake a symptom review at an early stage.

5.10.9 Refer to home oxygen service if palliative oxygen is required and mark as urgent.

5.10.10 Ensure the patient is pain free and comfortable before discharge.

5.10.11 Arrange ambulance by telephone - ensuring end of life is requested on booking.

5.10.12 Notify GP and Hospice at home (01509 410395 or 0300 300 1000 out of hours and weekends) of actual time of discharge.

5.10.13 Ensure patient has copy of GP letter; ReSPECT form; transfer letter; nursing documentation; drug authorisation form and relevant medicines/ water for injection & syringe driver. Inform discharge team when syringe driver has been sent with patient, so that they can arrange for it to be returned.

5.11 Self-Discharge against medical advice

5.11.1 Self discharge against medical advice may be a significant risk to both the patient and the Trust and on occasions to the public. Patients are under no obligation to follow the medical advice but it is crucial that they understand the implications of a decision to self-discharge and whether they have the capacity to refuse treatment.

5.11.2 Patients or families wishing to take their own/ their loved ones discharge will be advised by nursing staff initially to stay. The medical staff should also be involved in encouraging the patient/ family to stay, informing them of the risks associated with self-discharge. If they believe leaving hospital is not in the patient's best interest medically a Consultant/senior decision maker should make a decision as to whether this constitutes a safeguarding issue.

5.11.3 The doctor and nurse should make an assessment of capacity in relation to the patients' ability to make a decision to self-discharge and this should be recorded on the 'Discharge against medical advice form' and filled in the medical notes (Appendix 3i / 3ii).

5.11.4 If the patient has capacity and is adamant that they wish to leave hospital by their own means. The most senior doctor available who should provide an explanation of the clinical problem and suggested management plan. Furthermore, any discussion of treatment should mention of not only the complications of treatment, but also the potential consequences of declining treatment. The patient should be asked to sign the discharge against medical advice form, which should be countersigned by the doctor/ nurse present. This should then be placed in the patient's medical notes. A Datix should be completed outlining the reasons why the patient has self-discharged.

5.11.5 If the patient does not have capacity the doctor will need to make a best interest's decision whether the patient needs to be detained in hospital and consider whether an urgent DoLS application is required. For further details refer to the Trust's Deprivation of Liberty Safeguards Policy (Trust Ref: B15/2009).

5.11.6 Patients will be offered a prescription for relevant medication. If the patient is unwilling to wait for the medication to be dispensed this should be recorded in the notes and the GP informed.

5.11.7 If the patient requires a district nurse this should be discussed with the patient to be established if the Trust should contact the DN service or if the patient wishes to make their own arrangements. If this is the case, the relevant contact number

should be given to the patient. The decision and action should be documented in the patient's medical records.

5.12 Delayed Transfers of Care

5.12.1 A delayed transfer of care occurs when a patient has no reason to reside in an acute hospital bed / medically optimised for discharge 'discharge ready', but is still occupying such a bed.

5.12.2 Monitoring of delayed transfers of care takes place with LLR system partners and through daily escalation calls.

5.12.3 The Trust informatics team and Head of Nursing for Discharge Improvement coordinate the daily/weekly discharge sitrep report returns ensuring that delays are accurately assigned on the NHS Strategic Data Collection Service.

5.13 Patients who Refuse Discharge

5.13.1 On occasions a person is medically optimised for discharge with no reason to reside in an acute bed and may refuse to leave hospital. In these circumstances the person refusing should be evaluated by the doctor to establish medical/psychological/social basis for that patient's refusal. If no resolution from the MDT involve the CMG Discharge Specialist team to speak to the patient/ family/ carer and issue the notification of discharge letter. (Appendix 4). Patients do not have the right to remain in an acute bed if not clinically indicated, including to wait for their preferred discharge option to become available. If no resolution is found seek advice from the Head of Legal Services.

6 EDUCATION AND TRAINING REQUIREMENTS

6.1 UHL is committed to raising awareness of effective discharge planning by the provision of discharge training for all staff within the Trust and partner agencies.

6.2 The Trusts Head of Nursing Discharge Improvement, CMG Matron for Discharge and CMG Discharge Specialist nursing team are responsible for the development, implementation and evaluation of Trust Discharge Training events.

6.3 Ward Sisters, Matrons, Heads and Deputy Heads of Nursing, CMG Heads of Operations, Consultants and Clinical Directors will ensure that all staff have access to training and education to maintain up to date knowledge of local and national policies relating to discharge planning.

6.4 All staff have responsibility to attend an update of Trust Discharge Training if a training need or gaps in knowledge are identified at appraisal.

7 PROCESS FOR MONITORING COMPLIANCE

7.1 To understand if a discharge or transfer of care is safe, timely and effective the following key performance metrics/indicators will be monitored:

a) Discharge Pathway, Length of stay, Discharge by hour of the day/ day of the week, incomplete discharges and readmission rates.

b) Daily Discharge Sitrep reporting to the Strategic Data Collection Service (SDCS).

c) Datix incidents relating to discharge

d) Complaint trends and themes where discharge is the key theme.

e) Patient satisfaction in relation to the specific national patient experience

questions in relation to discharge.

These are set out in the Policy Monitoring table in Appendix 1.

8 EQUALITY IMPACT ASSESSMENT

8.1 The Trust recognises the diversity of the local community it serves. Our aim therefore is to provide a safe environment free from discrimination and treat all individuals fairly with dignity and appropriately according to their needs.

8.2 As part of its development, this policy and its impact on equality have been reviewed and no detriment was identified.

9 SUPPORTING REFERENCES, EVIDENCE BASE AND RELATED POLICIES

9.1 This document has been developed in conjunction with hospital staff, local LLR Health and social care partners.

9.2 The documents listed below have been used in the formulation of this policy:

a) NHS Hospital Discharge and Community Support Guidance. Published 26th January 2024

b) National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care. October 2018 (Revised) Published March 2018

c) NHS Improvement 'A brief guide to developing Criteria led discharge' (2017)

d) Discharging older patients from hospital. National Audit Office 20th May 2016

e) Transition between inpatient hospital settings and community or care home settings for adults with social care needs. NICE guidelines December 2016. nice.org.uk/guidance/qs136

f) A report of investigations into unsafe discharge form hospital. Parliamentary & Health Ombudsman. May 2016.

g) Healthwatch England Special Enquiry Findings July 2015, 'Safely home: What happens when people leave hospital and care settings. July 2015

h) NHS Commitment to carers (NHS England 2014)

i) Testing the bed blocking hypothesis. Does higher supply of nursing and care homes reduce delayed discharge? ESHCRV CHE Research paper. University of York August 2014.

j) National Framework for NHS Continuing Health Care and NHS Funded Nursing Care. Department of Health revised November 2012

k) Lees, L. (2012) "Timely Discharge from Hospital", M&K Publishing, United Kingdom

l) External Ready to go? - Department of Health, 2010.

m) Transforming Social Care - Department of Health, 2008.

n) Local Authority circular LAC (DH) (2009) 1 - Department of Health, 2009.

o) User-led Organisations Project Policy - Department of Health, 2007.

p) Urgent Care Pathway for Older People with Complex Needs - Best practice guidelines. Department of Health, 2007.

q) Safeguarding Adults Policy and Procedures. Trust reference B26/2011 UHL Mental Capacity Act Policy. Trust reference B23/2007.

r) Carers (Equal Opportunities) Act 2004. Office of Public Sector Information.

s) Achieving timely "simple" discharge from hospital - Department of Health, 2004,

t) Supporting people with long term conditions - Department of Health, 2005.

u) Discharge from hospital: pathway, process and practice (DoH 2003)

10 PROCESS FOR VERSION CONTROL, DOCUMENT ARCHIVING AND REVIEW

10.1 This document will be reviewed and updated every three years, or sooner in response to any identified patient care issues or risks.

10.2 The updated version of the Policy will then be uploaded and available through INsite Documents and the Trust's externally-accessible Freedom of Information publication scheme. It will be archived through the Trusts PAGL system

APPENDIX 1.

POLICY MONITORING TABLE

The top row of the table provides information and descriptors and is to be removed in the final version of the document

What key element(s) need(s) monitoring as per local approved policy or guidance?	**Who will lead on this aspect of monitoring?** **Name the lead and what is the role of other professional groups**	**What tool will be used to monitor/check/** **observe/asses/** **inspect** **Authenticate that everything is working according to this key element from the approved policy?**	**How often is the need to monitor each element?** **How often is the need complete a report?** **How often is the need to share the report?**	**How will each report be interrogated to identify the required actions and how thoroughly should this be documented in e.g. meeting minutes.**
Element to be monitored	**Lead**	**Tool**	**Frequency**	**Reporting arrangements Who or what committee will the completed report go to.**
Discharge Performance Monitoring	CMG HONs / HOOPs/CDs	Live Qlik Discharge Summary	Live Qlik Discharge Summary Board	CMG Quality and Safety Group / Improving Patient Discharge Group
Datix incidents relating to discharge	CMG HONs / HOOPs/CDs	Datix rolling 12 month dash board	Live Datix Discharge Dashboard	CMG Quality and Safety Group / Improving Patient Discharge Group
Complaint trends and themes where discharge is the key theme.	CMG HONs / HOOPs/CDs	Datix rolling 12 month dash board	Live Datix Discharge Dashboard	CMG Quality and Safety Group / Improving Patient Discharge Group
Patient satisfaction in relation to the specific national patient experience questions in relation to discharge.	HON Discharge Improvement	Report pulled from national patient satisfaction survey.	Quarterly	Improving Patient Discharge Group

Appendix 2.

V1 June 2023

On Admission Letter

University Hospitals of Leicester NHS Trust

Leicester Royal Infirmary
Chief Executive's Corridor
Level 3, Balmoral Building
Infirmary Square
Leicester LE1 5WW

Tel: 0116 258 8940
Email: richard.mitchell@uhl-tr.nhs.uk

Date:

Dear

Welcome to the hospital. Our goal is to provide you with great care and to support you to recover as soon as possible.

While you are with us, the team caring for you will keep you informed about your progress. They will speak with you soon after you arrive so you know what to expect and when they hope you will be well enough to leave us. With your permission, they can also speak with your family and/or carer.

These early conversations will include giving you an Estimated Expected Date of Discharge (EDD), which is the date when you will have no need to stay in our hospital for care and will be ready to leave. Setting a date for discharge helps the team working around you plan for your needs and work to prevent any unnecessary waits or delays.

Throughout your stay, the team caring for you will keep you informed about your EDD and involve you in conversations about your discharge and what will happen and when.

In most cases, you will be able to go home after you have been discharged from the hospital. However, if you need additional care or support, they will discuss this with you at the earliest opportunity. You may need to move to different wards or to other care providers, such as a community hospital or care home, to ensure that you receive the appropriate care and treatment while you wait for confirmation of your discharge.

It is important for you to know that you cannot remain here when you no longer require the acute hospital care we provide. This is to ensure that you remain as independent as possible and to reduce your risk of getting a hospital-acquired infection. It also ensures we can offer care to someone else who needs it more.

If you have any questions or if you would like someone else to have a copy of this letter, please speak to a member of the team caring for you. What matters the most to you, is also important to us.

Yours sincerely,

Julie Hogg
Chief Nurse

Andrew Furlong
Medical Director

Jon Melbourne
Chief Operating Officer

Appendix 3 (i)

University Hospitals of Leicester NHS
NHS Trust

DISCHARGE AGAINST MEDICAL ADVICE

The completed Checklist is to be placed in the Patients Medical Records

	YES	NO	N/A
Box1. Mental Capacity assessment if patient requests self-discharge from hospital against medical advice.			
Has the Doctor been informed and spoken with the patient?			
Stage 1. Mental Capacity Assessment			
Please confirm that the person has an impairment of, or a disturbance in the functioning of their mind or brain. If so complete Stage 2 below.			
Stage 2 Mental Capacity Assessment			
a) Can the patient understand the information relevant to the decision? *(inc reasonably foreseeable consequences, benefits and burdens)*			
b) Can the patient retain the information? *(just long enough to make the decision)*			
c) Can the patient use or weigh the information to make a decision? *(Accepted/ believed and took account of the information)*			
d) Can the patient communicate his/her decision? *(by any means)*			
If **YES** to all 4 criteria above the patient has capacity			
If **NO** to any of the 4 criteria above the patient lacks capacity. An immediate best interests decision must be made about whether or not to prevent patient from leaving the hospital, in consultation with the patients consultant/ doctor in charge, and family where available. **Best Interests Decision**- is it deemed to be in the patient's own best interests to prevent them from leaving hospital at this time? If yes follow advice below Box 2. If no, patient should be allowed to leave with an appropriate safety plan in place and relevant agencies should be notified as per box 3			
Box 2 To be completed when the patient has been assessed as lacking capacity to decide to self-discharge against medical advice			
1. Staff involved try to prevent patient from leaving the ward utilising persuasion, calming and de-escalation techniques			
2. Referral to the Psychiatric Liaison Team if considered appropriate (i.e. for advice about possible detention under MH Act/MH medication/ sedation)			
3. Contact CMG senior medical and nursing staff and UHL security staff/ duty manager for support to detain the patient.			
4. Complete an urgent DoLS authorisation			
5. If patient has left the ward staff to follow Missing Patients Policy			
Box 3 To be completed when the patient has been assessed as having capacity to decide to self-discharge against medical advice.			
1. Have you/ senior nurse explained to the patient it is in their best interests to remain in hospital?			
2. Has the patient signed the self-discharge form with date and time as well as Doctor?			
3. Has any medication the patient may require been prescribed and given to the patient?			
4. Has the patient given consent for you to contact community services such as social services, Intensive community support, district nurses etc.?			
5. Have you or a senior nurse contacted community services if above consent given?			
6. Has a Discharge summary been sent to the GP?			

Please File in the Patients Medical Records

Page 1 of 2

Appendix 3 (ii)

University Hospitals of Leicester NHS
NHS Trust

Patient Addressograph

DISCHARGE AGAINST MEDICAL ADVICE

If you are considering leaving hospital and discontinuing the treatment you have been offered before the doctor has judged you 'medically fit for discharge' .**It is important that you receive information about the possible risks or consequences** of your decision before you leave.

For this reason nursing staff are required to arrange that you are seen by a member of the medical team before you leave. The purpose of the discussion is to:

- Allow you to discuss with the doctor the reasons for his/her judgement that you are 'not medically fit' for discharge'.
- To provide you with the information about the possible risks or consequences of your decision to leave hospital and discontinue treatment.

Please sign the declaration below to confirm that you have discussed your plans to leave hospital with a member of the medical team.

I _____ confirm that I have discussed with

_____ my plans to leave hospital against the advice of medical staff. I accept responsibility for any consequences which might arise as a result of my decision.

Signed:_____ Date:_____ Time:_____

Witness:

I confirm that_____ has explained to

_____ the consequences of leaving hospital against the advice of medical staff.

Signed:_____ Date:_____ Time:_____

Please File in the Patients Medical Records

Page 2 of 2

Appendix 4

June V1 2023

Notification of Discharge Plan Letter

Date:

University Hospitals of Leicester NHS Trust

Leicester Royal Infirmary
Chief Executive's Corridor
Level 3, Balmoral Building
Infirmary Square
Leicester LE1 5WW

Tel: 0116 258 8940
Email: richard.mitchell@uhl-tr.nhs.uk

Dear

The team caring for you has agreed that you no longer need care in this hospital, and it is safe for you to continue with your recovery somewhere else.

Staying for longer than necessary may reduce your independence, result in you losing muscle strength or expose you to infection. Leaving hospital when you are ready is not only best for you but will free-up a bed for someone who is very unwell.

The team taking care of you will explain your options for continuing your recovery and who to contact for advice when you leave the hospital. They will also discuss transport and other arrangements for your discharge to make sure it is safe.

If you need more care and support than you did before you came to us, assessments will be carried out in the community to determine the right type of care for you.

If it is not possible for you to go straight home, the team caring for you will offer you an interim service in a community hospital or care home where you can continue your reablement, rehabilitation, or recovery.

You have the right to refuse this service, but once our team confirms that you no longer need acute hospital care, you cannot stay in a hospital bed here. If you choose not to accept the interim service, you will need to make your own arrangements to leave the hospital.

With your permission, your family, a friend, or carer can also be involved in conversations to support you to leave hospital and about your care after you leave.

If you have any questions or concerns, please talk to a member of the team looking after you. They are here to help you.

Yours sincerely,

Julie Hogg	Andrew Furlong	Jon Melbourne
Chief Nurse	Medical Director	Chief Operating Officer