Discharge and Transfer Principles of Good Practice Policy and Procedure (Inpatient) (N-032)

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Author (name & job title)	Sadie Milner, Quality Standards Practice Development Nurse Nigel Hewitson, Modern Matron, Mental Health
Executive Lead (name & job title):	Hilary Gledhill, Director of Nursing, Allied Health and Social Care Professionals
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Policies should be accessed via the Trust intranet to ensure the current version is used

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1. INTRODUCTION

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

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

This policy describes the core good practice principles to be implemented by all services in relation to discharge and transfer for patients who have been referred and accepted into the Trust's in patient services.

2. PURPOSE

The purpose of this policy is to provide a set of overarching evidence-based best practice principles to support the safe discharge or transfer of patients from all in patient units within the Trust.

3. SCOPE

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

This policy applies equally to people regardless of the funding arrangements and the nature of their ongoing care.

Due to the diversity of in-patient service provision within the Trust each division will have a local Standard Operating Procedure (SOP) which provides additional detail as to how these principles will be operationalised whilst also including any additional services specific requirements

4. DUTIES AND RESPONSIBILITIES

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

Director of Nursing, Allied Health and Social Care Professionals and Chief Operating Officer
Responsible for ensuring this policy is effectively implemented in practice and examines any associated risks identified via the corporate risk register process.

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

They are also responsible for ensuring that any deviation or errors arising are dealt with in the correct manner, according to the Incident Reporting Policy and Procedure. They will, where

appropriate and required, be responsible for formulating, implementing and reviewing where required local Standard Operating Procedures regarding transfer and/or discharge for their respective service areas to ensure best practice is reflected in local Standard Operating Procedures

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

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

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

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

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

5. GOOD PRACTICE PRINCIPLES

Below are a set of core good practice principles for discharge and transfer which need to be applied by all inpatient services. Each local SOP should then provide additional details regarding how these principles will be operationalised including any additional services specific requirements:

5.1. On admission:

- Patients are admitted to our services where it has been established they meet relevant criteria for admission or service provision through identified triage or gatekeeping procedures.
- The receiving ward/unit must be fully aware of the transfer/admission, a bed has been identified as being available and where applicable the senior medical officer (or other responsible clinician/practitioner) has agreed to the transfer/admission.
- Planning for effective discharge / transfer of care, is in collaboration with the patient, family/carer, relevant representatives and all MDT members and should be commenced on admission.
- An initial Expected Date of Discharge (EDD) should be agreed where possible with patients/carers within 24 hours of arrival for those discharges which have been anticipated as being ‘Simple’ and within 48 hours of arrival for those discharges which have been anticipated as being ‘Complex’.

5.2. On-going discharge planning:

- Decisions about a person's care and support will be discussed with the person, their family, and carers, as per the NHS Constitution, and will be provided with high quality support and information to participate where possible. In the context of a discharge decision, the information relevant to the decision will include an understanding of their care needs on discharge, the process and outcome of the assessment of needs, offers of care and options available.
- People should be provided with high quality information, advice and support in a form that is accessible to them as early as possible, before or on admission and throughout their stay, to enable effective participation in the discharge process and in making an informed choice.
- Where it is identified that the patient requires a needs assessment under the Care Act 2014 but would have substantial difficulty in engaging in the assessment and care planning process, the local authority must consider whether there is anyone appropriate who can support the individual to be fully involved, which may be a family member or friend. If there is not an appropriate family member or friend, then the Trust will arrange for an Independent Advocate.
- The Trust is committed to the approach whereby every effort will be made to support the person to be discharged home or to their usual place of residence. To enable this, patients should, as a preference, be offered support from a range of services.
- Where a transfer to another care setting is required, where possible this should be discussed and agreed with the patient and the carers.
- Planning for discharge should include all appropriate statutory and voluntary agencies necessary to meet the patient's needs to avoid unnecessary readmissions through the effective co-ordination and delivery of services.
- Local authorities should be involved in the discharge process where appropriate and where applicable. Ensure relevant notifications are made to them in a timely way to progress any assessment and discharge arrangements.
- Where appropriate, a patient's eligibility for NHS continuing healthcare must be assessed in a timely fashion, or any extra contractual funding requests/exceptional treatments must be identified and negotiated through identified local arrangements.
- Many patients will want to involve others to support them, such as family or friends, carers, or others. Confidential information about the patient should only be shared with those others with the patient's consent and only on the basis that the patient has capacity to make their own decisions about confidentiality and information sharing. See section 5.11.2 regarding patient who lack capacity.
- Where someone is providing care or considering providing care post-discharge, unpaid as a carer, they must be informed and invited to be involved in the discharge process and informed about their rights and sources of support. People have a choice about whether to provide care for other adults and people must be informed about their choices when establishing whether they are willing and able to provide care.
- Carers must be offered the information, training and support they need to provide care following discharge, including a carer's assessment however it is the responsibility of Local Authority (or other delegated agent) to complete the assessments of needs and provide support.
- It should be identified if any carer or family member is accessing health or social care services in their own right at the earliest opportunity following the patient's admission, and this should be recorded in the patient record. Patients who also have a caring role should be offered a Carers Assessment. Where carers/family members are also service users, the discharge planning process must include special consideration of the potential for carer stress, its potential impact on the relationship and each person's mental health including

risk, and actions to mitigate these. Where possible this will include joint approaches to discharge planning between individual workers in teams who are working independently with patients who are partners/family members.
- Care plans/management plans should be reviewed at regular intervals within the multi-disciplinary team to ensure proactive actions are taken regularly to progress to safe and appropriate patient discharge.
- The **EDD and progress against this should be regularly reviewed** and any changes to this should be made where possible in collaboration with the patient and carer.
- Make decisions to facilitate planned discharge and transfers over seven days where it is possible to ensure continuity of care delivery can be provided to meet patients care needs on discharge. Where any essential equipment needed to promote independence or safety when transferring or discharging across to another unit or back into the community, please refer to the relevant Inpatient equipment SOP for further guidance

5.3. Decision to discharge:

- A number of terms are used for patients, for whom a clinical decision has been made, that they are ready to transfer including 'medically fit for discharge' 'clinically optimised' or 'medically optimised'.
- If a patient is medically fit for discharge, it is not suitable that they remain in hospital due to the negative impact this can have on their health outcomes. Patients do not have the right to remain in hospital longer than required.
- The determination that a person is fit for discharge is from a Multi-Disciplinary Team perspective
- Where it is what the patient wants and where appropriate, all possible efforts should be made to support people to return to their homes instead of residential placements, with options around home care packages and housing adaptations considered.
- Daily clinical discussions with effective clinical leadership should consider ongoing patient needs and related care/treatment plan, and proactive management of discharge planning including achievement of EDD.

5.4. Prior to discharge:

- Inpatient teams and community-based services must ensure a comprehensive handover and exchange of pertinent clinical information through a combination of verbal, written and face to face information exchange. This must be recorded as per defensible documentation requirements
- Wherever possible patients/family and/or carers will be given at least **24 hours**' notice of discharge.
- Clinical staff must be assured the patient is both physically and psychologically prepared for discharge from hospital and appropriate support is available as described in the appropriate discharge care plan or equivalent which must be in place outlining any ongoing arrangements for care and treatment.
- The process and timelines relating to discharge/transfer should be clearly communicated to the patient so that by the time a patient is medically optimised / MDT fit for discharge/transfer they are aware of and understand the process, decisions, and actions that they may need to undertake and the support they will receive and will be recorded in the clinical system
- For Mental Health patients discharged from hospital arrangements will be put in place with regards to 3 day follow up. It will be agreed with the patient when this will take place as well as who will be carrying out the follow up.

5.5. Day of discharge:

- When patients are discharged from inpatient services staff are to follow the Procedures for Safe and Secure Handling of Medicines, to ensure patients leave with the correct

medication and are able to administer medication safely or if not alternative support for administration of medicines is in place.

- All patients will be offered a copy of their care plan/discharge plan/risk and relapse plan/long-term safety plan and Initial Discharge Letter (IDL) (whichever is appropriate to the care setting)
- A summary of their discharge care plan and where applicable any issues relating to risk and relapse /long-term safety plan and Initial Discharge Letter (IDL)/discharge summary pro forma will be shared with the patient's GP and all relevant clinicians or clinical teams, who will be involved in the patient's care on discharge. This will always include details of the current medication prescribed and any physical health needs.
- Additionally, where relevant this information will be shared with all other appropriate and relevant healthcare/local authority professionals securely on the day of discharge.
- All information shared with healthcare professionals, patients/carers will be documented in patient records
- Additional information required by the patient with regard to any further treatment or ongoing condition is provided along with any appropriate information leaflets.
- Where appropriate, and where consent is gained (or as part of a best interest decision) carers/significant others should be involved in the discharge process and receive a copy of the above documents. This will be documented in the patient record.

5.6. Delayed Transfer or Discharge

- A delayed transfer or discharge of care occurs when a patient is ready to depart from such care and is still occupying a bed as detailed in Delayed transfers of care: a quick guide | The King's Fund (kingsfund.org.uk). Once the patient meets the definition it is from this date onwards that their discharge/transfer is considered to be delayed.
- The escalation and management of delayed discharges will differ depending on the service from which the patient is being discharged. The process for delayed discharges will be outlined in the divisional/local SOPs and include local processes for reporting.
- All delayed discharges will be reported and escalated to divisional managers. Delayed discharges should be reported via Lorenzo and/or Datix

5.7. Transfer of the Deteriorating Patient to Acute Services

See the Deteriorating Patient Protocol Section 7 for details on the transfer of a deteriorating patient to an acute hospital setting

5.8. Transfer/Discharge of an Infectious Patient

See IPC Admission Transfer Discharge Policy N-033.pdf (humber.nhs.uk)

5.9. Patients wishing to take their Own Discharge

- All information regarding potential risks of self-discharge and the benefits of continuing with their hospital care must be explained to the patient to allow them to make an informed decision.
- All discussions with the patient must be documented accurately in the patient's nursing records.
- Where the patient insists on taking own discharge, request that the patient signs the relevant self-discharge form.
- Where the patient lacks mental capacity in relation to the decision to take self-discharge staff must ensure they follow procedures and consult where practicable with relevant others, as described in the Mental Capacity Act and best interests process to establish if authorisation to detain someone under Deprivation of Liberty Safeguards.

- Ensure that the patient's own GP is informed as soon as possible and where possible inform the GP verbally of the situation. Complete the discharge letter stating the patient discharged against professional advice.
- If appropriate, obtain the patient's consent to inform their next of kin of patient's self-discharge. Ensure that the circumstances surrounding the self-discharge process and the actions taken are fully documented in the patient's records. If the patient continues to take their own discharge despite having full explanations of the consequences, they must arrange their own transport by which to leave the hospital.

5.10. Discharging Patients who Disengage from Services

- Every effort should be made to understand why a patient is not readily engaging with services, where consent is given this should include conversations with patient's carer.
- All efforts made in relation to this should be documented in the patient's records.
- Consideration should be given to the patient's mental capacity and the ability to consent to proposed care and treatment and to understand the consequences and implications of not engaging.
- Clinicians should consider if there are any safeguarding considerations or actions required, this may include undertaking responsibilities around self-neglect as outlined in the Care Act (2014) or initiating the Vulnerable Adults Risk Management Meeting (VARM) process. Advice and support is available from the Trust's Safeguarding Team.
- Where appropriate, assessment can be sought under the Mental Health Act to establish if nature of concerns and presentation of patient would meet threshold for detention and treatment.
- Otherwise, having taken reasonable steps to engage the patient and have dialogue around implications, and having discussed the circumstances within either an MDT forum (or with GP and relevant others in community service settings), the decision to discharge the patient from the care of Humber Teaching NHS Foundation Trust can be made and associated procedures followed through.
- In these circumstances, it is important to give written information where possible to the patient/carer, advising should they choose to at a future date, how they can make contact and re-engage with our services.

5.11. Special considerations:

5.11.1. End of Life

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

5.11.2. Patients assessed as lacking capacity

- For patients assessed as lacking mental capacity to consent to discharge/transfer arrangements, best interest decision making process should be followed with collaboration with relevant others. See Consent Policy (N-052) and MCA and Best Interest Decision Making Policy (M-001). For patients who are under 16, the MCA 2005 and best interest decision making process does not apply. In these instances, the child may be determined to be 'Gillick competent' and therefore able to consent to arrangements, however if the child is not competent then a person with parental responsibility should be consulted for consent to the arrangements. See Consent Policy.

5.11.3. Deprivation of Liberty

- Any potential for Deprivation of Liberty in relation to planned admission and associated care and treatment must be recognised and associated procedures followed. See MCA Deprivation of Liberty Safeguards Policy (M-002)

5.11.4. Homelessness

- The health and wellbeing of people who experience homelessness is poorer than that of the general population. They often experience the most significant health inequalities. The longer a person experiences homelessness, the more likely their health and wellbeing will be at risk.
- The Homelessness Reduction Act 2017 places duties on local housing authorities to take reasonable steps to prevent and relieve an eligible applicant's homelessness.
- The Act has introduced a new 'duty to refer', from October 2018, requiring specified public authorities (including all inpatient services) in England to notify Local Housing Authorities of individuals they think may be homeless or threatened with becoming homeless in 56 days.

A person is considered homeless if:

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

Actions to be taken:

- Consider the patient's social circumstances and identify whether the patient is homeless or at risk of homelessness at the earliest opportunity (via ward rounds/medical reviews/assessments).
- Discuss and gain consent with the patient to refer to the housing authority of their choice. The duty allows service users to choose which local housing authority they are referred to. However, when discussing the referral and offering guidance to the service user, it is important to be aware that local housing authorities owe more duties towards homeless applicants who have a local connection with their area.
- Referral to a housing authority is via the 'Duty to Refer' form. There is a generic form which can be emailed to the appropriate housing authority (please see the link below for the referral form and email contacts for housing authorities) https://www.gov.uk/government/publications/homelessness-duty-to-refer.

6. LOCAL STANDARD OPERATING PROCEDURES

In addition to the core principles outlined in this policy each division will have local standard operating procedures (SOP). Local SOPs will provide additional details regarding how the core principles set out in this policy will be operationalised and also include any additional services specific requirements:

6.1. Mental Health

The Mental Health SOP will specifically consider:

- NICE Guidance NG53 and Quality Standard QS159 Transition between mental health setting and community or care home settings
- CPA/Section 117 aftercare requirements
- Delayed discharge
- Transfer out of area
- Self-discharge of informal patients including the completion of Z10 form

- Transfer of a deteriorating patient detained under the MHA to an acute setting (Section 17 leave requirements)

6.2. Forensic

The Forensic SOP will specifically consider:

- Ministry of Justice: Mentally disordered offenders the restricted patient system
- Transfer between secure services and prison
- Discharge, transfer, and flow of patient through services
- Liaison with relevant agencies such as the Ministry of Justice, probation services, MAPPA, community care.
- Transfer/discharge pathway
- CPA/Section 117 aftercare requirements
- Transfer of a deteriorating patient detained under the MHA to an acute setting (Section 17 leave requirements)

6.3. Children's and Learning Disabilities

The Learning Disabilities SOP will specifically consider:

- Principles of good discharge planning as outlined in CQC Brief guide: discharge planning from learning disability assessment and treatment (or similar) units (2019)
- Standards for adult inpatient learning disability services (2016) Royal College of Psychiatrists
- CPA/Section 117 aftercare requirements
- Delayed discharge processes
- Out of area placement
- Transfer to Community services
- Transfer to other service provider

The CAMHS SOP will specifically consider:

- NICE Guidance NG53 and Quality Standard QS159 Transition between mental health setting and community or care home settings
- NICE Guidance NG43 Transition from children's to adults' services for young people using health or social care
- CPA/Section 117 aftercare requirements
- Delayed discharge processes
- Out of area placement
- Transition to Community CAMHS services
- Transition to Adult Mental Health Services
- Transition to other service provider

6.4. Community Services

The Community Services SOP will specifically consider:

- NICE guidance NG27 and Quality Standard QS136 Transition between inpatient hospital setting and community or care home settings for adults with social care needs
- Department of Health and Social Care: Hospital discharge and community support guidance (2022)
- 'Home First' principle
- Supporting patient's choices to avoid long hospital stays
- Continuing healthcare and funding arrangements
- Delayed discharge processes and escalation

7. IMPLEMENTATION AND MONITORING

This policy will be disseminated by the method described in the Document Control Policy (C-003) Monitoring of the policy and local standard operating procedure should be conducted locally by matrons/service managers to ensure compliance with good practice.

8. TRAINING

All staff involved in the discharge and transfer of patients from and between inpatient services will receive local training on the discharge and transfer processes. This will be commenced at the earliest opportunity and be on-going.

9. SUPPORTING GUIDANCE AND REFERENCES

Care Quality Commission (2009) 'National report: Managing patients' medicines after discharge from hospital' updated May 2022 NHS must do more to prevent harm to patients from prescribed medicines after leaving hospital, says CQC - Care Quality Commission

Department of Health and Social care published 2020 updated April 2022 Hospital discharge service guidance - GOV.UK (www.gov.uk)

Delayed Discharges (Continuing Care) Directions - GOV.UK (www.gov.uk)

Department of Health (2015) NHS Continuing Healthcare Checklist published November 2012 updated May 2022 National framework for NHS continuing healthcare and NHS-funded nursing care - GOV.UK (www.gov.uk)

Hospital discharge and community support guidance - GOV.UK (www.gov.uk)

Delayed transfers of care: a quick guide | The King's Fund (kingsfund.org.uk)

NICE Guidance NG53 Transition between inpatient mental health settings and community or care home settings | Guidance | NICE

After care under the MHA 1983 Care Act 2014 - Explanatory Notes (legislation.gov.uk)

Quality Standard QS159 Transition between inpatient mental health settings and community or care home settings (nice.org.uk)

NICE Guideline NG49 Transition from children's to adults' services for young people using health or social care services | Guidance | NICE

Mentally disordered offenders: The Restricted Patient System 2017 - GOV.UK (www.gov.uk)

https://www.gov.uk/government/publications/homelessness-duty-to-refer.

NICE Guidance NG27 Transition between inpatient hospital settings and community or care home settings for adults with social care needs | Guidance | NICE

Brief guide-discharge_planning_from_LD_assessment_treatment_or_similar_units_v2.pdf (cqc.org.uk)

Royal College of Psychiatrist -Standards of adult inpatient learning disability services 3rd-edition

10. RELEVANT POLICIES/PROCEDURES/PROTOCOLS/GUIDELINES

Infection, prevention and control Admission, Transfer and Discharge Policy (N-033)

Medicines Reconciliation Guideline (G358)

Patients' Property Procedure (Proc433)

Deteriorating Patient Policy (N-062) and Protocol (Prot527)

Safe and Secure Handling of Medicines Procedures (Proc431)

Incident Reporting Policy and Procedure (N-038)

Mental Capacity Act and Best Interest decision Making Policy (M-001)

MCA Deprivation of Liberty Safeguards Policy (M-002)

Consent Policy (N-052)

Appendix 1 - Document Control Sheet

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

Document Type	Inpatient Discharge and Transfer Policy and Procedure (N-032)		
Document Purpose	The purpose of this policy is to provide an evidence-based best practice approach to facilitate the safe discharge or transfer of patients from all in patient units within the Trust.		
Consultation/Peer Review:	Date:	Group/Individual	
List in right hand columns consultation groups and dates		Triumvirate – clinical, medical, operational leads, modern matrons representative across all services	
Approving Committee:	QPaS	Date of Approval:	
Ratified at:		Date of Ratification:	
Training Needs Analysis: *(please indicate training required and the timescale for providing assurance to the approving committee that this has been delivered)*		Financial Resource Impact	
Equality Impact Assessment undertaken?	Yes [ ]	No [ ]	N/A [ ] Rationale:
Publication and Dissemination	Intranet [✓]	Internet [ ]	Staff Email [✓]
Master version held by:	Author [ ]	HealthAssure [✓]	
Implementation:	*Describe implementation plans below - to be delivered by the Author:*		
	1. This policy will be disseminated by the method described in the Policy and Procedural Documents Development and Management Policy. 2. This policy may require additional local training resource to ensure knowledge and competencies associated with best practice and discharge planning. 3. Additionally, there will be a resource implication in undertaking identified monitoring and associated actions to continually seek to improve discharge/transfer planning and implementation.		
Monitoring and Compliance:	An organisational audit tool (Appendix 3) has been developed to further understand compliance against agreed quality standards around discharge planning. Divisions should determine frequency and number of audits to be completed to provide assurance of compliance with best practice requirements as described within the policy to give assurance around patient experience and safe and effective care. The Audit tool is based upon best practice as described within: Department of Health (2008) Refocusing the Care Programme Approach – Policy and positive practice guidance		

	Department of Health (2010) – Ready to go: Planning the discharge and transfer of patients from hospital and intermediate care Health watch (2015) – Safely home: what happens when people leave hospital and care settings? Care Quality commission (2015) Community services key lines of enquiry (KLOE)

Document Change History: (please copy from the current version of the document and update with the changes from your latest version)			
Version number/name of procedural document this supersedes	*Type of change, e.g. review/legislation*	*Date*	*Details of change and approving group or executive lead (if done outside of the formal revision process)*
2.2	Review	April 2011	Reviewed
3.0	Review	July 2012	Reviewed and harmonised with ERYPCT Legacy policy CP26
3.1	Amendments	December 2012	Amendments to Section 5.1 and 5.2 following NHSLA assessors visit
3.2	Amendments	December 2013	Amended to reflect NEWS and SBARD
3.3	Minor amendments	April 14	Minor changes made following SI to Section 5.1 regarding all patients transferred internally within mental health/learning disability wards to be reviewed medically and clinically be a member of the admitting wards medical team within two working days. Added patient complaints in the monitoring section. Minor changes to incorporate wider principles of Supreme Court ruling and revised 'Acid test' in relation to Deprivation of Liberty Safeguards (DOLs)
3.4	Minor amendments	November 2014	Minor changes to incorporate wider principles of Supreme Court ruling and revised 'Acid test' in relation to Deprivation of Liberty Safeguards (DOLs)
4.0	Review	Dec 15	Reviewed in line with related national policy, consideration given to Homeless, Refugees and Prisoners in line with national policy requirements. Audit tool developed to be used to evaluate adherence of policy implementation and self-discharge form revised
4.1	Minor amendments	April 16	Minor changes following consultation
5.0	Review	May 19	Removed information in relation to admission criteria. Added section 2 – Background. Changed responsibilities section to show the chief operating officer as responsible or the implementation of the policy. Removed z10 Appendix as current form available on the intranet.
5.1	Minor amendments	Nov 2022	Title changed from Inpatient Discharge and Transfer Policy and Procedure to **Discharge and Transfer Principles of Good Practice Policy and Procedure** Removed all service specific information. Trust wide policy based on principles of good practice relating to discharge and transfer. Reference to the requirement for divisional SOPs for local processes. Guidance and reference section updated. Training section added. Monitoring section updated. Approved at QPaS (16 November 2022).

Appendix 2 - Equality Impact Assessment (EIA)

For strategies, policies, procedures, processes, guidelines, protocols, tenders, services

1. Document or Process or Service Name: **Discharge and Transfer Principles of Good Practice Policy and Procedure**
2. EIA Reviewer **Sadie Milner, Quality Standards Practice Development Nurse**
3. Is it a Policy, Strategy, Procedure, Process, Tender, Service or Other? **Policy and Procedure**

Main Aims of the Document, Process or Service
The purpose of this policy is to provide a set of overarching evidence-based best practice principles to support the safe discharge or transfer of patients from all in patient units within the Trust.
Please indicate in the table that follows whether the document or process has the potential to impact adversely, intentionally or unwittingly on the equality target groups contained in the pro forma

Equality Target Group	Is the document or process likely to have a potential or actual differential impact with regards to the equality target groups listed?	How have you arrived at the equality impact score?
Age Disability Sex Marriage/Civil Partnership Pregnancy/Maternity Race Religion/Belief Sexual Orientation Gender re-assignment	**Equality Impact Score** Low = Little or No evidence or concern (Green) Medium = some evidence or concern(Amber) High = significant evidence or concern (Red)	1. who have you consulted with 2. what have they said 3. what information or data have you used 4. where are the gaps in your analysis 5. how will your document/process or service

Equality Target Group	**Definitions**	Equality Impact Score	Evidence to support Equality Impact Score
Age	Including specific ages and age groups: Older people, Young people, Children, Early years	Low	
Disability	Where the impairment has a substantial and long term adverse effect on the ability of the person to carry out their day to day activities: Sensory, Physical, Learning, Mental Health (and including cancer, HIV, multiple sclerosis)	Low	
Sex	Men/Male, Women/Female	Low	
Married/Civil Partnership		Low	
Pregnancy/ Maternity			
Race	Colour, Nationality, Ethnic/national origins	Low	
Religion or Belief	All Religions Including lack of religion or belief and where belief includes any religious or philosophical belief	Low	
Sexual Orientation	Lesbian, Gay Men, Bisexual	Low	
Gender re-assignment	Where people are proposing to undergo, or have undergone a process (or part of a process) for the purpose of reassigning the person's sex by changing physiological or other attribute of sex	Low	

Summary

Please describe the main points/actions arising from your assessment that supports your decision above			
There is no evidence of potentially negative effect on groups in the categories above. In relation to capacity, where a patient is unable to make decisions or give consent in relation to discharge and transfer the policy describes the legal frameworks to support this. (MCA and Best Interest Decision Making).			
EIA Reviewer	Sadie Milner		
Date completed;	16/11/22	Signature	S.K.Milner