Humber Teaching
NHS Foundation Trust

STANDARD OPERATING PROCEDURE DISCHARGE AND TRANSFER (ADULT AND OLDER ADULT MENTAL HEALTH INPATIENTS)

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CHANGE RECORD

Version	Date	Change details
1.0	*5 April 2023*	*New SOP. Approved at Mental Health Practice Network Meeting (5 April 2023).*
1.1	*28 Nov 2023*	*Reviewed. Paragraph added to page 10 re: transfer/discharge to external provider. Approved by Divisional Clinical Lead Sign-Off (Kayleigh Brown) 28 November 2023.*

Contents

1. INTRODUCTION

This Standard Operating Procedure (SOP) will support the Discharge and Transfer Policy (N-032) within Adult and Older Adult Mental Health Division and provides associated procedures and core standards to be implemented by these services in relation to discharge and transfer who have been referred and accepted in the services and have been in receipt of a service.

With increasingly complex needs and range of available treatments, some patients may require extra help to safely be discharged from inpatient services. It is vitally important when people are transferred between community teams, or from community teams into inpatient services, between inpatient wards or discharged from inpatient services, that good collaborative working occurs between the inpatient unit and community teams, Social services, primary care, housing associations and the private and voluntary sectors as required, ensuring there is a clear understanding of the person's needs. Without effective discharge planning, there is the potential for patients to continue to have poor experiences as described within the Safely Home Report.

This SOP has been developed to support mental health professionals working within the adult and older adult inpatient settings, Mental Health Crisis Intervention Team (MHCIT), Home Based Treatment Team and Crisis Intervention Team for Older People (CITOP) to support decision making regarding safe and appropriate transfer and discharge, it aims to standardise practice across our services and support staff in assessing patients for transfer and/or discharge.

2. SCOPE

The Standard Operating Procedure is for all staff who work within the Adult and Older Adult Mental Health Division to support safe transfer and discharge planning from all mental health inpatient services. This SOP is designed to support all medical, nursing, social care, occupational therapy, psychology and all other allied health professionals to support people accessing mental health services and to be actively involved in shared decision making and to be supported to be promote ongoing recovery.

3. DUTIES AND RESPONSIBILITIES

Clinical and Operational Leads
Must ensure that all staff are aware and adhere to this SOP and policy for their respective services to ensure quality, patient centred and effective admission, 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.

Responsible Clinicians/Consultants/Clinical Leads
Will be responsible for all medical aspects of the admission, transfer, discharge pathway, authority may be delegated to a suitable and competent deputy.

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

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

Other Trust 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/pathways and protocols.

Where staff are unable to meet the standards and principles outlined in this SOP staff have a responsibility to escalate concerns through operational/clinical structures, identifying barriers in order to explore solutions.

4. PROCEDURE

Specific standards to be followed in addition to Core standards
All patients in receipt of inpatient care will have care co-ordinated within the Care Programme Approach (CPA) framework whilst they remain an inpatient.

The exception to this rule is for those patients who are admitted to an adult mental health inpatient unit who only use mental health services in crisis i.e. 72 hour admissions, or for those with no previous contact with mental health services and for whom the need for a future CPA coordination approach is unclear. In these circumstances the patient will undergo an initial assessment period of 72 hours. On or before that third day of the admission a decision will be made to place the person either on CPA or not, this allows a period of assessment to understand care needs. Daily planning meetings will facilitate this decision making. Discharge planning must also be co-ordinated within the associated requirements of the CPA framework/Section 117 requirements (for further information regarding associated requirements see Trust guidance on delivery of the CPA pathway).

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

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

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

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

Discharge care plans for people who are at high risk of suicide will require more intensive support following discharge from inpatient care. In this event of a patient been deemed high risk by the inpatient MDT the patient should be discharged with a comprehensive and intensive care plan that

is agreed in conjunction with any other agency working with the individual and may be include about additional safeguards needing to be in place.

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

Every patient discharged from inpatient care who continues to receive secondary mental health services will have an individualised package of care in line with requirements within CPA and relevant care cluster. This will take into account any issues relating to equality and ongoing biopsychosocial needs of the patient. A review of the patient's cluster will take place prior to discharge facilitated by the care co-ordinator.

Patients are accepted onto caseload or admitted to our services where it has been established, they meet relevant criteria for admission or service provision through identified triage or gatekeeping procedures, as identified in the Home Based Treatment (HBT)/Bed Management SOP.

The receiving unit must be fully aware of the transfer/admission and a bed must have been identified as being appropriate for the person's needs and available.

Discharge planning commences immediately prior to or directly on admission. Planning discharge/transfer for those patients who have been in receipt of a service from the Trust will be commenced at the earliest opportunity and must include input from community teams where appropriate.

Upon admission for all patients
When existing Trust patients are admitted to an inpatient unit, the care coordinator, or nominated deputy will provide the inpatient unit with up to date information regarding any current risks and physical health concerns.

During admission

- Review care plans/management plans at regular intervals within Multi-Disciplinary Team (MDT), at Care Programme Approach Meetings, formulations meetings and within key worker sessions with the patient.
- The Estimated Discharge Date should ideally be agreed on admission and progress against this should be regularly reviewed in any subsequent review meetings and any changes to this should be made where possible in collaboration with the patient and carer.
- Ensure that patients are assessed for any acute physical health conditions and then have a detailed physical health assessment undertaken (A Picture of Health, 2022).
- The gate keepers for the admission must ensure that any required specialist equipment needed by the patient is identified at the earliest opportunity, to ensure it can be available on the ward as soon as is practicably possible.
- Any equipment, aids or adaptations required to support a patients physical health need will be assessed and prescribed.
- Where a patient is pregnant or has recently given birth, liaise with local maternity providers. The Specialist Perinatal Mental Health Team will provide advice and liaison regarding maternity providers.

- Where a transfer to another care setting is required, where possible this should be discussed and agreed with the patient and carers.
- There should be proactive actions taken regularly to progress to safe and appropriate patient discharge.
- Consider referral to and involvement from HBT, Crisis Intervention Team for Older People (CITOP) and any other relevant Services to facilitate early discharge into the Community.
- Patients and carers should be involved in making informed decisions and choices that deliver a personalised care pathway and maximise recovery and independence.
- It should be identified if any carer or family member is accessing mental health 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 (as per the Care Act 2014). 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.
- Where a patient has a parental responsibility, this should be discussed and determine whether any support needs are present and appropriate referrals made. This is especially critical where the child is an infant or younger child.
- Planning for discharge should include all appropriate statutory and voluntary agencies necessary to meet the patient's needs. This will avoid unnecessary readmissions through the effective coordination and delivery of services.
- Local authorities should be involved in the discharge process where appropriate and where applicable, relevant notifications are made to them in a timely way to progress any assessment and discharge arrangements. If Community Treatment Order (CTO) is being considered, then any discharge planning **must** include the Community RC and Care Coordinator.
- Carers should be offered an assessment to identify any services they may need to support them in their caring role if appropriate.
- Where appropriate, a patient's eligibility for NHS continuing healthcare must be considered and assessed in a timely fashion with completed checklist, or any extra contractual funding requests/exceptional treatments must be identified and negotiated through identified local arrangements.
- Patients should be assessed on their ability and competency to take their medications correctly as part of the ongoing discharge assessment and any recommended interventions highlighted and shared.
- 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.
- All patients will have access to specialist assessments to identify any ongoing interventions to support their recovery.
- All patients will have access to ward-based activities either on a group or individual basis that supports their recovery

All Transfers
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.

Any potential for Deprivation of Liberty in relation to planned admission and associated care and treatment must be recognised and associated procedures followed. For further information refer to the Mental Capacity Act.

Internal Transfers
For transfers between, Adult and Older Adult Inpatient Services and Learning Disability Services – the Greenlight Framework should be followed and any barriers escalated as required.

If it is suspected that a service user on a mental health unit has an undiagnosed learning disability, the clinical team are to make a referral to the Learning Disability Service to request further support and/or opinion. This may result in a period of joint working. For service users whose learning disability is their primary need a transfer to a learning disability unit should be considered if despite reasonable adjustments and joint working their needs are not appropriately met.

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

Adult and Older Adult inpatient wards continue to be needs-led, however, on occasion, due to bed occupancy rates, patients may need to be admitted onto a ward that does not fully meet their needs. For example, an older adult patient may need to be admitted onto a working age ward. In this instance, the teams will identify as soon as possible a bed within the correct ward and an agreement in place about how and who will provide the care to ensure that the needs of the patient can be addressed as soon as possible and a transfer back to the appropriate ward.

For patients presenting at risk of suicide and needing to be admitted to Maister Lodge, a discussion will need to take place between Senior Clinical colleagues due to the environmental risks on the ward (fixed anchor points). These risks may require that the patient be nursed on constant supportive engagements and this may potentially not be the least restrictive option. Consider the most suitable ward environment for the patient based on their level of risk and other assessed needs.

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

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

Any specialist assessments and ongoing interventions needed on transfer to another unit will be documented and shared with receiving unit.

Any equipment, aids and adaptations needed to support a patient's physical health or independence will be supported and available on transfer

Mental Health Legislation must be informed at the earliest opportunity if any inpatient is transferred to another inpatient unit.

Where a patient is pregnant or has a young baby, consider the option of admission/transfer to a Mother and Baby Unit (MBU). The Specialist Perinatal Mental Health Team will offer advice and guidance on suitability and safety issues related to transfer. There are a number of factors to consider in these instances and close liaison with the admitting MBU would need to take place.

Transfers to and from Acute Trusts

Any patient in hospital may become acutely ill. This might require them being conveyed to an acute hospital ward or unit; if the patient is detained this will be in accordance with S17 MHA. The occurrence might be in-hours or out of hours. The core standards for staff to follow do not change, the order might change in an emergency.

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

If a patient needs to be transferred into the acute care setting staff should communicate using the SBARD framework to ensure accurate and relevant information is relayed to the accepting healthcare professional. See the Deteriorating Patient Policy and Deteriorating Patient Protocol.

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

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

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

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

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

Where appropriate all information should be shared via electronic records.

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

1. Clear rationale as to why the transfer of the patient was felt appropriate.
2. The views of the patient and carers/relatives and those clinicians involved in the care of the patient.
3. Concerns that may be highlighted as a result of the transfer.

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

The Deteriorating Patient Policy should be followed in all instances where there is a concern for the physical health of the patient. This needs to be read in conjunction with The Deteriorating Patient protocol, Section 7 when considering transferring a patient to the Acute Trust.

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

In accordance with the Infection Prevention and Control Admission, Transfer and Discharge Policy a risk assessment must be undertaken on all infectious patients transferred or discharged from the trust to determine the potential risk of a patient contracting or spreading infection. The movement of an infectious patient from one care setting to another should generally be avoided unless there is a need for essential medical or psychological treatment. Help and guidance must be sought from the Infection Prevention and Control Team and the Multi Disciplinary Team responsible for patient. See the IPC Admission/Transfer and Discharge Policy.

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

Infectious patients should only be transferred to other departments if clinically necessary. If the patient has an infectious agent transmitted by the airborne/droplet route, then if possible/tolerated the patient should wear a surgical face mask in communal areas during transfer. The receiving department/hospital and transporting staff must be aware of the necessary precautions, National infection prevention and control manual for England.

Any Mental Health inpatient area experiencing a COVID-19 Outbreak and it has been identified as clinically essential that a patient requires transfer to the area this must be discussed with all relevant clinicians in accordance with the Bed Escalation Process.

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

Transfers to out of areas
When existing community or inpatients are transferred between teams or out of area, the care co-ordinator or most suitable practitioner will provide the receiving care professional with copies of all relevant documentation to ensure continuity of care. Mental Health Legislation Team must be made aware prior to transfer if patient is detained under the MHA.

The most appropriate practitioner should liaise with the receiving team and a verbal handover should be given. The details of the handover should be documented in the patient's records. Ensure significant medical records to support safe and seamless continuity of care are transferred with the patient or as a minimum emailed/scanned and sent to the receiving Team. The original section papers for a detained patient must be sent as part of the transfer. The following documentation should be shared as a minimum with the receiving team:

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

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

Where an individual's ongoing support or intervention plan is to be delivered by an external agency (whether that is an established relationship or a new referral), the discharging clinician is responsible for liaising with that service to ensure that the provision is clinically appropriate and available to meet the identified needs. This allows the clinician and service user to formulate an alternative plan, prior to discharge, if required. There may be circumstances under which there is a strong clinical rationale to facilitate the service user in managing their own care/self referral, in those instances a rationale for not liaising with the external agency must be documented.

Delayed Discharge
A delayed transfer (or discharge) of care from a mental health inpatient unit occurs when a patient is ready to depart from such care and is still occupying a bed (Kingsfund,2018)
A patient is ready for transfer when:

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

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

In the first instance if a dispute emerges (non-acceptance of referral/not allocated or reallocated in the case of worker sickness or vacancy) this should ideally be a conversation between the Band 7's of the two services to agree a way forward. If the accepting Team do not consider the patient ready/safe to discharge, this should be part of an MDT discussion/professionals meeting to establish what may be needed. Either of these would be escalated to the Matron or Service Manager for senior level discussion or input depending on the reason for delay. This may require the input of the Division Clinical Lead/General Manager if the Band 7, MDT or Band 8a input does not resolve the dispute.

If the criteria for a delayed discharge are met, Lorenzo must be updated to reflect this. Any delayed discharges are then discussed within the patient flow meeting for adult and older adult on a fortnightly basis.

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

Equipment
Where any essential equipment needed to promote independence or safety when transferring or discharging across to another unit or back in to the community is required, please refer to the Inpatient equipment SOP for further guidance.
Prior to discharge (24-48 hours prior to EDD)

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

If the patient is not on CPA upon admission (this is only related to Avondale) a Clinical Review Meeting will take place and a decision made if the patient needs to be on CPA. All relevant professionals, patient and carers to be involved and a discharge date is arranged. A comprehensive handover and exchange of pertinent clinical information through a mixture of verbal and written information.

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

b. Clinical staff must be assured the patient is both physically and psychologically prepared for discharge from hospital, i.e. meeting the delayed discharge/transfer criteria.

c. A discharge care plan or equivalent must be in place outlining any ongoing arrangements for care and treatment, to include any further recommended specialist assessments and interventions.

d. Their plan of care to be updated to reflect discharge and any follow-up from the community teams, FACE must be updated, and Initial Discharge Letter (IDL)/discharge summary pro forma will be shared with the person's GP and all relevant clinicians, or clinical teams, who will be involved in the patients care on discharge. This will always include details of the current medication prescribed and any physical health needs.

e. Additionally, where relevant, this information will be shared with all other appropriate and relevant healthcare/local authority professionals securely on the day of discharge.

f. 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. The Initial Discharge Letter (IDL), which is completed by the medical team, should be sent as per agreed local procedure, to the GP on discharge and a copy offered to patients/carers for their information.

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

h. If any equipment, aids or adaptations have been assessed as essential to promote independence and safety on discharge or transfer, an environmental assessment should be considered and completed if required and any recommended equipment, aids and adaptations should be in place prior to discharge or transfer.

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

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

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

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

m. Consider the patients parenting responsibilities and whether there are any safeguarding issues that need to be addressed.

Patients wishing to take their own discharge
In most circumstances patients wishing to discharge themselves will be supported by the clinical team. Support and a clear discharge plan will have been formulated and be in place prior to this occurring. However, there may be occasions where discharge is not clinically appropriate or supported by the team. Due to the different risks and procedures in place in the various wards across the Trust some basic principles need to be followed.

Where the patient insists on taking own discharge, request that the patient signs a self-discharge form (Form Z10).

Once completed this is to be filed in the patient's notes/upload onto Lorenzo as per local arrangements.

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

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

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

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

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

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

If the patient is informal and wishes to self-discharge but is judged to be a danger or risk to self or others – Consideration should be given to the use of the holding powers described in the Mental Health Act (1983) and its Code of Practice (2015) if appropriate encouragement to stay does not prove effective. A full record must be made of the discussion and rationale for the use of holding powers in the patient's records. An assessment of the patient's capacity to consent to their admission and treatment should be carried out if this is doubted. Any interventions used to prevent the patient leaving hospital must also be documented in the clinical records as well as any appropriate documentation. If holding powers are used, then a full review of the patient must be held with the appropriate professionals in line with the time frames specified within the Mental Health Act.

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

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

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

A person is considered homeless if:

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

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

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

Referral to a housing authority is via the 'Duty to Refer' form. There is a generic form which can be emailed to the appropriate housing authority (please see the link below for the referral form and email contacts for housing authorities)

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

Aftercare/Follow Up
3 day follow up is a key part of the work to support the Suicide prevention agenda within the Long-Term Plan. The National Confidential Inquiry into Suicide and Safety in Mental Health (2018) found that the highest number of deaths occurred on day 3 post discharge. By completing follow up in 3 days providers support the suicide prevention agenda, ensuring patients have both a timely and well planned discharge. This activity will increase focus on improving the overall quality of support post discharge.

To support the above, during the CPA/clinical review meeting it needs to be agreed who is going to complete the 3 day follow up and whether this will be face to face or telephone. The decision on how this will be completed should be made by reviewing the risk, if a patient is a high risk of suicide/self harm, where possible the follow up should be completed face to face. If a patient is open to CMHT and discharged on a Friday it should be agreed that the ward complete the follow up or HBT if know to this Team. The wards are to ensure there is a up to date contact number, address and next of kin details on the clinical system.

Prior to carrying out the 3 day follow up the staff member must ensure they are aware of any potential risks relating to the patient as well as been familiar with the patient's risk assessment. This is to ensure that both patients and staff are supported during this process.

Where on carrying out the 3 day follow up it is not successfully this must be escalated as appropriate based on the risk to the patient as well as in conjunction with the patient's risk

assessment to the most Senior person on duty or if in working hours to be discussed within the MDT. All efforts must be taken to ensure patient safety is adhered to. A Datix must be completed where 3 day follow up does not take place

Please refer to Appendix 1 for further support/information regarding the above.

Following completion of the 3 day follow up this must be recorded on the clinical system as per local agreement.

5. REFERENCES/POLICY LINKS

https://www.nice.org.uk/guidance/qs159/resources/transition-between-inpatient-mental-health-settings-and-community-or-care-home-settings-pdf-75545548372933
Delayed transfers of care: a quick guide | The King's Fund (kingsfund.org.uk)

https://www.england.nhs.uk/wp-content/uploads/2019/03/CQUIN-Guidance-1920-080319.pdf

A Picture of Health Full report.pdf (ncepod.org.uk)
https://intranet.humber.nhs.uk/Policies/Clinical%20Policies/Clinical%20Protocols/Deteriorating%20Patient%20Protocol.pdf

https://www.ndti.org.uk/resources/green-light-toolkit

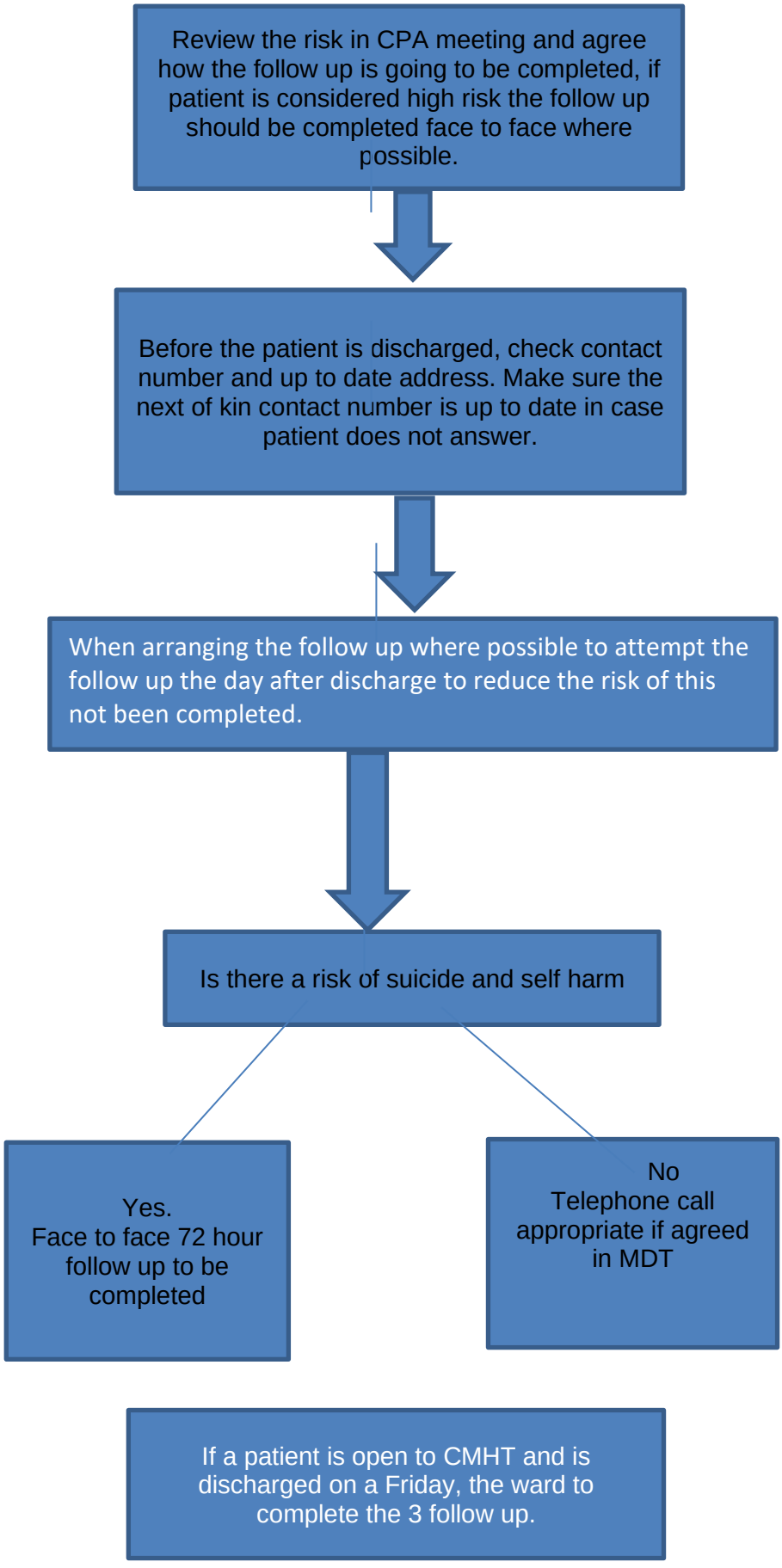
National infection prevention and control manual for England

Trust Infection Prevention and Control Policies

Mental Health Act 1983

Mental Health Act Code of Practice 2015

APPENDIX 1 - FLOW CHART FOR 72 HOUR FOLLOW UP



All 72hr follow up contacts must be completed by a registered mental health practitioner or senior community recovery worker (band 5 Practitioner)

What questions to be asked?

How have you been since discharge?

How do you feel mental health is?

- Suicidal ideation
- Self-harm
- mood

What have you been doing?

- Activities/friends/family

Have you been taking your medication?

- Any side effects
- TTO medications
- Repeat prescriptions

Plans following discharge?

- CMHT appointments
- Physical health appointments

Discuss any actions from Discharge CPA

- Management plan (Care plan)