Humber Teaching
NHS Foundation Trust

STANDARD OPERATING PROCEDURE
PATIENT DISCHARGE / TRANSFER
LEARNING DISABILITY INPATIENT SERVICES

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Ratified and Quality Checked by: **Date Ratified:**	Learning Disability Clinical Network 19 January 2024
Name of Trust Strategy / Policy / Guidelines this SOP refers to:	Discharge and Transfer Principles of Good Practice Policy and Procedure (Inpatient) (N-032)

VALIDITY – All local SOPS should be accessed via the Trust intranet

CHANGE RECORD

Version	Date	Change details
1.0	*Nov 2022*	*New SOP. Approved by Children & Learning Disability Clinical Governance (24 November 2022).*
1.1	*Oct 2023*	*Reviewed. No changes made. Approved at Learning Disability Clinical Network (20 October 2023).*
1.2	*19 Jan 24*	*Reviewed. Hyperlink to discharge checklist updated and minor amends throughout. Approved at Learning Disability Clinical Network (19 Jan 2024).*

Contents

1. INTRODUCTION

The Transforming Care programme aims to improve the lives of children, young people and adults with a learning disability and /or autism who display behaviours that challenge including those with a mental health condition. The programme aims to support people with a learning disability and/or autism in hospital be discharged as soon as possible into a community setting. A hospital is not a person's home and people with learning disabilities in long-term hospital placements are at increased risk of harm and are more likely to be subject to medications for behaviour and restrictive practices.

The programme has three key aims:
To improve quality of care for people with a learning disability and/or autism
To improve quality of life for people with a learning disability and/or autism
To enhance community capacity, thereby reducing inappropriate hospital admissions and length of stay

This programme also focuses on how the views and wishes of people and their families should be made more central to decision-making and ensuring people's individual wellbeing is at the heart of decisions in both health care including from individual care planning to admission and discharge.

This purpose of this Standard Operating Procedure (SOP) is to meet the specific pathways required for transfer / discharge for people with a learning disability within the learning disability inpatient environment.

2. SCOPE

This SOP applies to all service users with a learning disability using learning disability inpatient services

This SOP applies to all staff involved in any aspect of the discharge/transfer and associated care planning and care co-ordination processes for patients receiving inpatient care in the Trust.

3. DUTIES AND RESPONSIBILITIES

Divisional Clinical Leads and General Managers
Must ensure that all staff are aware and adhere to this protocol and relevant appendices for the Learning Disability Service Inpatient Service to ensure quality, patient centred and effective transfer or discharge arrangements.

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 the local SOP regarding transfer and/or discharge for Learning Disability inpatient service to ensure best practice and revised guidance is reflected in this document

Responsible Clinicians/Consultants
Responsible for all aspects of the medical aspects 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
Responsible for ensuring systems are in place to support this SOP 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.

Ward Managers
Will ensure that effective discharge/transfer planning processes are in place and operate effectively.
Ensure effective and timely communication between services.
Ensure that staff have access to and attend appropriate training.
Ensure that best clinical care is carried out during patient transfer and/or discharge.

Other Staff
All staff, both clinical and non-clinical are responsible for applying the principles contained within SOP.
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.

4. PROCEDURES

The duty to start organising a package of accommodation and services arises once the Responsible Clinician has indicated that the patient is ready to be discharged or transferred to an alternative unit / hospital

4.1. Inpatient Transfer

A transfer date will be agreed with the receiving unit/hospital.

A transition period in which the receiving unit staff visit the patient to start to build a therapeutic relationship will take place if deemed clinically appropriate.

Transfer will be planned with the accepting team and in collaboration with the patient, family/carers and other relevant professionals.

Patient and family will be kept up to date regarding progress of any transfers. The unit discharge coordinator will lead on this.

IST/CTLD will also be kept upto date regarding any transfers if actively involved with patient.

Patients family will be informed when the patient leaves the unit to be transported to accepting unit.

The Inpatient Transfer Checklist Clinical Data Capture Form must be completed on the Electronic Patient Record

Learning Disability Inpatient Services - Transfer Checklist

4.2. Inpatient Discharge

Decisions about a person's care and support will be discussed with the patient, their family, and carers.

If it is felt that the patient will need intervention from other Trust services/external services upon discharge these referrals will be made prior to discharge.

A monthly learning disability discharge planning meeting is chaired and facilitated by the Unit discharge coordinator. Appropriate representatives from the ICB, Local Authority and Humber inpatient and community Learning Disability Services will be present. The meeting will review the patients discharge pathways including those accessing out of area beds, using the Transforming Care 12 point discharge plan guidance tool.

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.

Prior to discharge it may be appropriate for identified provider staff to undertake transition work on the inpatient unit. The unit discharge coordinator will work closely with the provider staff to arrange and review this.

The Inpatient Discharge Checklist Clinical Data Capture Form must be completed on the Electronic Patient Record

Learning Disability Inpatient Services - Discharge Checklist

4.3. Delayed Discharge

A patient is ready for discharge when:
a. A clinical decision has been made that patient is ready for transfer
b. A multi-disciplinary team decision has been made that patient is ready for discharge
And
c. The patient is safe to discharge.

A delayed discharge from the Learning Disability Assessment & Treatment Unit may occur for several reasons including but not restricted to

- Lack of funding
- Lack of identified safe housing / accommodation
- Lack of suitable care provider to meet patient individual assessed needs
- Delay due to patient exercising choice

Escalation and management of delayed discharges

All delayed discharges will be reported and escalated to divisional managers. Delayed discharges should be reported via Lorenzo and/or Datix

The responsibility for reviewing DTOC recording remains with clinicians at unit level and updated at each point patient discharge plan is reviewed as part of MDT Review Meetings

Integrated Care Board Case Manager of delayed discharged patient must be informed of delay if not in attendance at MDT Review Meeting

Long delayed discharges will be reviewed and supported by the setting up of Core Group Meetings where necessary and led by NHS England – North East and Yorkshire

4.4. Out of Area Placement

There are at times a need to transfer a patient with a learning disability to an out of area placement that is not in their usual network of services and where the individual is not visited as regularly by their identified local key worker to ensure continuity of care and effective discharge planning

Any assessments required to be completed by potential new care providers must be agreed by patient's ICB Case Load Manager

Any transfer to an out of area placement must be agreed by the patient's ICB Case Load Manager.

5. REFERENCES

Due to the complex nature and needs of this service user group, this SOP should be read in conjunction with the relevant National & Trust strategies /policies / guidelines or documents as documented in

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

STANDARD OPERATING PROCEDURE Greenlight For Mental Health: Provision Of Mental Health Services For Adults With A Learning Disability

Further supporting guidance and reference

https://www.england.nhs.uk/learning-disabilities/care

https://www.england.nhs.uk/publication/the-community-mental-health-framework-for-adults-and-older-adults/

https://www.england.nhs.uk/statistics/wp-content/uploads/sites/2/2015/10/mnth-Sitreps-def-dtoc-v1.09.pdf