Sheffield Health and Social Care NHS
NHS Foundation Trust

Policy:

Inpatient Discharge

(Review Date Extended to 31/03/2020 by EDG)

Executive or Associate Director lead	Clive Clarke Deputy Chief Executive
Policy author/ lead	Lisa Johnson – Deputy Service Director
Feedback on implementation to	Lisa Johnson – Deputy Service Director

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Ratified by	Executive Directors Group
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Date for review	31/03/2020 ***[Extended from 31 October 2019 ny EDG on 09/01/2020]***

Target audience	Operational managers of clinical teams Service Directors and Clinical Leads

Keywords	Discharge, inpatient, patient, service, user

Policy Version and advice on document history, availability and storage
This is version 4 of this policy and replaces version 3 (issued April 2013).

This policy will be available to all staff via the Sheffield Health & Social Care NHS Foundation Trust Intranet and on the Trust's website. The previous version will be removed from the Intranet and Trust website and archived. Word and pdf copies of the current and the previous version of this policy are available via the Director of Corporate Governance.

Any printed copies of the previous version (V3) should be destroyed and if a hard copy is required, it should be replaced with this version.

Contents

1. Introduction

Discharge planning is essential to ensure that patients leaving inpatient care have the best chance of recovery or appropriate services to meet their needs.

Poor discharge planning can result in:

- An early return to hospital;
- Adverse consequences for the service user or their carers or relatives;
- The failure of support arrangements;
- Untoward delays in being discharged and over-long inpatient stays.

Delays to discharge may have the following adverse affects:

- The service user loses contact with their social support and friends;
- Independent accommodation may become increasingly at risk and difficult to access;
- Loss of social function and independent living skills;
- Possible financial implications for the service user or their relatives through the reduction or loss of benefits or even loss of employment;
- Inpatient resources are not available to be used by the other service users who may need them.

2. Scope

This policy applies to all staff working on inpatient wards.

This policy covers the discharge of service users from Inpatient Wards within all SHSC mental health and learning disability Services. It is not intended to cover the arrangements for non-hospital accommodation provided or managed by Sheffield Health & Social Care Trust.

Adult Mental Health, Older Adults, Learning Disability Services, and Substance Misuse Services will have specific care path ways setting standards for discharge planning and arrangements according to the specific needs of different service user. These must be referred to for detailed standards.

3. Definitions

Discharge refers to the end of an inpatient care spell within SHSC Trust. As such it does not cover transfer from one ward to another within a Directorate within SHSC Trust, transfer to another ward in a different Directorate within SHSC Trust, or transfer to Inpatient care in another hospital or Trust.

4. Purpose

To clarify the standards which clinical teams should work to, to ensure that discharge from inpatient care is:

- Safe and effective;
- Timely and neither premature or unduly delayed;
- Properly planned.

5. Duties

Consultant medical staff with responsibilities for in-patients hold ultimate responsibility for decisions on discharge from inpatient care, but must take account of the judgement and

opinions of their colleagues in the multidisciplinary team, as well as the views of the service user and their carers or relatives.

The duties of different staff groups within clinical teams with respect to discharge should be identified by the service and team leadership, according to the needs of individual patients and the normal operational duties within the inpatient, and other relevant clinical teams.

There should be a named co-ordinator of discharge arrangements for each patient to ensure that there is a discharge plan that meets the standards expected by this policy (described in Section 6 below).

6. Process

6.1 Standards for Discharge

All patients should have an agreed discharge plan which has been developed with the involvement of:

- The Multi Disciplinary Team / Health Support Team on the Ward;
- The patient / service user;
- Carers or relatives as appropriate;
- The relevant Community Services or Teams, including the Care Coordinator where this is appropriate;
- GP / Primary Care Mental Health service;
- Other relevant agencies, e.g. Probation, Housing.

The discharge plan should:

- Be individual to the service users, reflecting their choices as far as possible and be made available in a form which can be read and understood by the service user, e.g. in an appropriate language. This may be a print-out from Insight system, an audiotape, a series of pictures, for example;
- Be consistent with and developed within the Single Assessment Process (SAP), the Care Programme Approach (CPA), and / or other relevant processes and procedures for ensuring effective multidisciplinary, multi-agency, or across-team working;
- Be developed with the involvement of advocacy services where service users / patients request their help or lack capacity to engage in the process or decision-making;
- Be provided in a written or other form acceptable and accessible to the service user and their carers;
- Be considered and commence development as soon as in-patient care begins.
- Consider Statutory (Mental Health Act) provisions, e.g. Section 117.

The discharge plan should cover arrangements for:

- Supply of medication;
- Further appointments with services or agencies, including follow up within the first week if appropriate;
- Contact with services and agencies which will be involved with ongoing care and support after discharge;
- Ensuring that accommodation is appropriate at the time of the discharge e.g. utilities connected;
- Undertaking the assessment of the needs of carers;
- Social care, including confirmation of continuing or newly funded service provision;
- Finance and benefits;
- Meeting physical health care needs (including issues relating to Infection Control);
- Review of care and treatments plans (including issues relating to Infection Control);
- Management of risk and any community safety concerns;
- Management of the risks of substance misuse;

- Any issues relating to children who may normally live with the service user or for whom the service user has parental responsibilities;
- Information for the services user and their carers or relatives to access help and support in the event of crises;
- The provision of information in an appropriate form outlining the care plan, information about medication, and information necessary to enable the service user or carers attend future appointments or otherwise access the services;
- The return of valuables, possessions, and monies held for safe keeping during the inpatient stay;
- Communicating the discharge plan to others, including accommodation providers, primary care staff, community support, or other services or agencies;
- Transport where appropriate.

The discharge plan should clearly identify the roles and responsibilities of people involved for each part of the plan; and identify a named co-ordinator of these care arrangements.

6.2 Information/Documentation to be provided to the service user when being discharged

- A copy of the discharge plan will be given to the service user, which will include: arrangements for the next appointment or contact with services, information about medication, and information necessary to enable the service user or carers attend future appointments or otherwise access the services;
- Information for the services user and their carers or relatives to access help and support in the event of crises;
- The discharge plan, together with confirmation that this has been communicated to and a copy provided to the service user will be recorded on Insight.

6.3 Information/Documentation to be provided to the receiving healthcare professional

- A copy of the discharge plan will be sent to the service user's GP, together with all others involved in the onward care of the service user, e.g. accommodation providers, community teams, primary care services, probation, other support services or agencies. For SHSC staff, the discharge plan can be accessed through Insight, although receiving staff will be notified of the plan;
- The discharge plan, together with confirmation that this has been communicated to and a copy provided to the receiving healthcare professional/other service/agency will be recorded on Insight.

6.4 Unplanned Discharge, and Discharge outside normal hours

There will be occasions where service users wish to discharge themselves from Inpatient Care which can be facilitated unless they are subject to or requiring detention under the Mental Health Act. In these circumstances, complete discharge plans may not have been developed, or cannot be completely put into place. Where service users do not return from leave, also consider these points alongside the Missing Patient procedure if appropriate.

In these situations, the following must be considered:

- Appropriate arrangements for medication;
- Arrangements for communicating as soon as possible with relatives or carers and community services or teams or outside agencies (e.g. Police) who need to be aware;
- Multi-disciplinary review at the earliest opportunity to consider further plans;
- The consideration of 'leave' rather than discharge;
- The provision of written information for the client and their carers or relatives if appropriate, regarding arrangements for follow-up.

6.5 Disputes

Discharges should not occur until there are clearly agreed arrangements as above which address identified risk. Guidance on the resolution of clinical disputes should be consulted and used where there are clear professional disagreements about discharge arrangements.

Inpatient teams should raise any concerns or problems relating to the implementation of this policy either generally or in relation to specific patients with their Service or Clinical Directors.

7. Dissemination, storage and archiving (Control)

On issue, this policy will be available to all staff via the Sheffield Health & Social Care NHS Foundation Trust Intranet and on the Trust's website. The previous version will be removed from the Intranet and Trust website and archived. Word and pdf copies of the current and the previous version of this policy are available via the Director of Corporate Governance.

On issue, staff will be notified via an entry in the next copy of the Communications Digest. Clinical Directors will be informed of publication via email. The Education, Training and Development team will also be asked to review the policy to update future training.

8. Training and other resource implications

All clinical teams which have contact with service users who may have inpatient care spells should be familiar with the standards within this policy. Training programmes for staff in these teams should refer to these standards.

Specific training is not required, but the standards should be referred to in other relevant training, e.g. Clinical risk training

9. Audit, monitoring and review

NHSLA Risk Management Standards - Monitoring Compliance Template						
Minimum Requirement	Process for Monitoring	Responsible Individual/ group/ committee	Frequency of Monitoring	Review of Results process (e.g. who does this?)	Responsible Individual/group/ committee for action plan development	Responsible Individual/group/ committee for action plan monitoring and implementation
A) Discharge requirements	Review of discharge plans on Insight	Ward manager	Monthly	MDT	MDT	MDT
B) Information given to healthcare professional	Review of discharge plans on Insight	Ward manager	Quarterly	MDT	MDT	MDT
C) Information given to patient	Review of discharge plans on Insight	Ward manager	Quarterly	MDT	MDT	MDT
D) Medicines	Review of discharge plans on Insight	Ward manager	Quarterly	MDT	MDT	MDT
E) Recording B) and C)	Records audit	Ward manager	Annual	MDT/Clinical and Service Directors	MDT	Clinical and Service Directors
F) Out of hours discharge	Review of discharge plans on Insight	Ward manager	Quarterly	MDT	MDT	MDT

Policy documents should be reviewed every three years or earlier where legislation dictates or practices change. This policy will be reviewed by 30 September 2019.

10. Implementation plan

Action / Task	Responsible Person	Deadline	Progress update
New policy to be uploaded onto the Intranet and Trust website.	Director of Corporate Governance	Within 5 working days of finalisation	
A communication will be issued to all staff via the Communication Digest immediately following publication.	Director of Corporate Governance	Within 5 working days of issue	
A communication will be sent to Education, Training and Development to review training provision.	Director of Corporate Governance	Within 5 working days of issue	

11. Links to other policies, standards and legislation (associated documents)

This policy should be read in conjunction with the following associated documents:

Acute Care Pathway
Scheduled Care Pathway
Resolution of Clinical Disputes Guidance
Care Programme Approach (CPA) Policies and Procedures
Policy on Difficult to Engage Service Users, including Non-Compliance with Treatment and Non-Attendance.
Learning Disability Assessment and Treatment Unit's Admission and Discharge Care Pathway
Absent without leave and Missing Patient Policy
Records Management Policy

12. Contact details

Title	***Name***	***Phone***	***Email***
Deputy Service Director	Lisa Johnson	01142718541	Lisa.johnson@shsc.nhs.uk

13. References

Department of Health Policy and Guidance
http://www.dh.gov.uk/en/Policyandguidance/Organisationpolicy/IntegratedCare/Delayeddischarges/index.htm

Care Services Improvement Partnership: National Institute for Mental Health in England (2006)
10 High Impact Changes for Mental Health Services
www.nimhe.csip.org.uk/10highimpactchanges

Care Services Improvement Partnership: National Institute for Mental Health in England (2007) A Positive Outlook – a good practice discharge toolkit to improve discharge from inpatient mental health care

Common Assessment Framework information available from:
www.socialcare.csip.org.uk/index.cfm?pid=7

Department of Health (2004)
Achieving timely 'simple' discharge from hospital: A toolkit for the multidisciplinary team
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4088366

Department of Health (2003)
Discharge from hospital, pathways, process and practice

Department of Health (2006)
Dual diagnosis in mental health inpatient and day hospital settings

Department of Health (2005)
Everybody's Business: A service development guide for older people with mental health needs

Department of Health (2005)
Independence, Well being and Choice

Department of Health (2001)
Mental Health Policy Implementation Guide

Department of Health (2002)
Mental Health Policy Implementation Guide: Adult acute inpatient care provision

Department of Health (2002)
Mental Health Policy Implementation Guide: Dual diagnosis good practice guide

Department of Health New Ways of Working
www.newwaysofworking.org.uk

Department of Health (2006)
Our Health, Our Care, Our Say: A new direction for community services

Department of Health (2006) Reviewing the Care Programme Approach
www.nimhe.csip.org.uk/cpa

Mental Capacity Act and Code of Practice 2006 Advance Directives
http://www.dca.gov.uk/legalpolicy/mentalcapacity/guidance.htm

Mental Health Act 1983 and 2015 Code of Practice
http://mhact.csip.org.uk/

Appendix A – Version Control and Amendment Log

Version No.	Type of Change	Date	Description of change(s)
V4 D0.1	Initial draft developed on new policy template.	Oct 2016	Full review undertaken.
4.0	Ratification / issue	Nov 2016	Ratification / finalisation / issue.

Appendix B – Dissemination Record

Version	Date on website (intranet and internet)	Date of "all SHSC staff" email	Any other promotion/ dissemination (include dates)
4.0	Nov 2016	Nov 2016 via Communications Digest	

Appendix C – Stage One Equality Impact Assessment Form

Equality Impact Assessment Process for Policies Developed Under the Policy on Policies

Stage 1 – Complete draft policy

Stage 2 – **Relevance** - Is the policy potentially relevant to equality i.e. will this policy potentially impact on staff, patients or the public? If **NO** – No further action required – please sign and date the following statement. If **YES –** proceed to stage 3

This policy does not impact on staff, patients or the public (insert name and date)

Stage 3 – **Policy Screening** - Public authorities are legally required to have 'due regard' to eliminating discrimination , advancing equal opportunity and fostering good relations , in relation to people who share certain 'protected characteristics' and those that do not. The following table should be used to consider this and inform changes to the policy (indicate yes/no/ don't know and note reasons). Please see the SHSC Guidance on equality impact assessment for examples and detailed advice. This is available by logging-on to the Intranet first and then following this link https://nww.xct.nhs.uk/widget.php?wdg=wdg_general_info&page=464

	Does any aspect of this policy actually or potentially discriminate against this group?	**Can equality of opportunity for this group be improved through this policy or changes to this policy?**	**Can this policy be amended so that it works to enhance relations between people in this group and people not in this group?**
AGE	**No**	**No**	**No**
DISABILITY	**No**	**No**	**No**
GENDER REASSIGNMENT	**No**	**No**	**No**
PREGNANCY AND MATERNITY	**No**	**No**	**No**
RACE	**No**	**No**	**No**
RELIGION OR BELIEF	**No**	**No**	**No**
SEX	**No**	**No**	**No**
SEXUAL ORIENTATION	**No**	**No**	**No**

Stage 4 – **Policy Revision** - Make amendments to the policy or identify any remedial action required (action should be noted in the policy implementation plan section)
Please delete as appropriate: Policy Amended / Action Identified / no changes made.

Impact Assessment Completed by (insert name and date) Lisa Johnson, Deputy Service Director (October 2016)

Appendix D - Human Rights Act Assessment Form and Flowchart

You need to be confident that no aspect of this policy breaches a person's Human Rights. You can assume that if a policy is directly based on a law or national policy it will not therefore breach Human Rights.

If the policy or any procedures in the policy, are based on a local decision which impact on individuals, then you will need to make sure their human rights are not breached. To do this, you will need to refer to the more detailed guidance that is available on the SHSC web site
http://www.justice.gov.uk/downloads/human-rights/act-studyguide.pdf
(Relevant sections numbers are referenced in grey boxes on diagram) and work through the flow chart on the next page.

1. Is your policy based on and in line with the current law (including case law) or policy?

X **Yes. No further action needed.**

☐ **No. Work through the flow diagram over the page and then answer questions 2 and 3 below.**

2. On completion of flow diagram – is further action needed?

☐ **No, no further action needed.**

☐ **Yes, go to question 3**

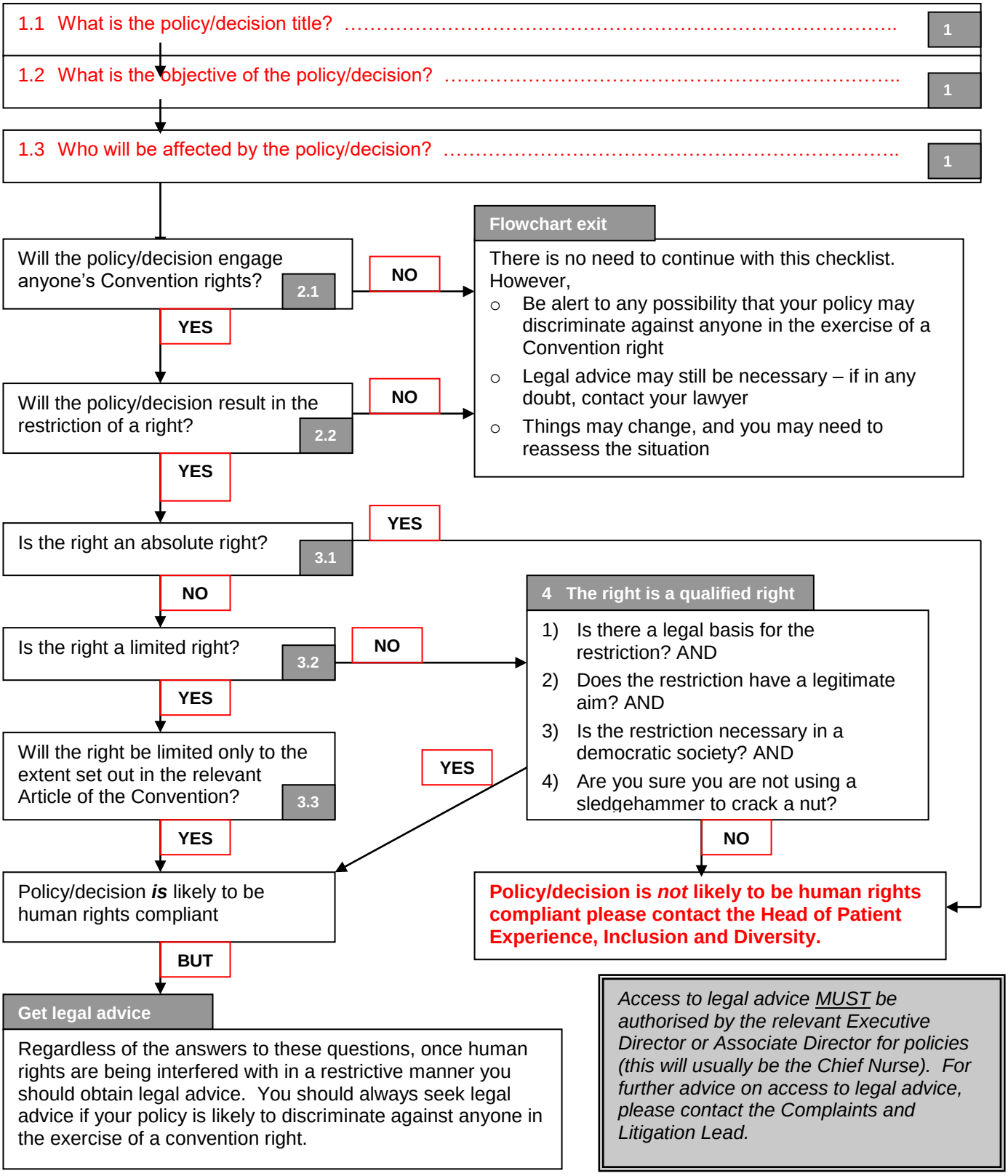
3. Complete the table below to provide details of the actions required

Action required	By what date	Responsible Person

Human Rights Assessment Flow Chart

Complete text answers in boxes 1.1 – 1.3 and highlight your path through the flowchart by filling the YES/NO boxes red (do this by clicking on the YES/NO text boxes and then from the Format menu on the toolbar, choose 'Format Text Box' and choose red from the Fill colour option).

Once the flowchart is completed, return to the previous page to complete the Human Rights Act Assessment Form.



Appendix E – Development, Consultation and Verification

This is version 4 of this policy and has been reviewed and updated as part of the Trust's policy development and review process.

12 October 2016: Initial draft created from previous version 3 and mapped onto the current policy document template.

The policy was verified by the Deputy Chair of the Service Users Safety Group.

Appendix F –Policies Checklist

Please use this as a checklist for policy completion. The style and format of policies should follow the Policy Document Template which can be downloaded on the intranet.

1. Cover sheet ✓

All policies must have a cover sheet which includes:

- The Trust name and logo ✓
- The title of the policy (in large font size as detailed in the template) ✓
- Executive or Associate Director lead for the policy ✓
- The policy author and lead ✓
- The implementation lead (to receive feedback on the implementation) ✓
- Date of initial draft policy ✓
- Date of consultation ✓
- Date of verification ✓
- Date of ratification ✓
- Date of issue ✓
- Ratifying body ✓
- Date for review ✓
- Target audience ✓
- Document type ✓
- Document status ✓
- Keywords ✓
- Policy version and advice on availability and storage ✓

2. Contents page ✓

3. Flowchart N/A

4. Introduction ✓

5. Scope ✓

6. Definitions ✓

7. Purpose ✓

8. Duties ✓

9. Process ✓

10. Dissemination, storage and archiving (control) ✓

11. Training and other resource implications ✓

12. Audit, monitoring and review ✓

This section should describe how the implementation and impact of the policy will be monitored and audited and when it will be reviewed. It should include timescales and frequency of audits. It must include the monitoring template as shown in the policy template (example below).

Monitoring Compliance Template						
Minimum Requirement	Process for Monitoring	Responsible Individual/ group/ committee	Frequency of Monitoring	Review of Results process (e.g. who does this?)	Responsible Individual/group/ committee for action plan development	Responsible Individual/group/ committee for action plan monitoring and implementation
A) Describe which aspect this is monitoring?	e.g. Review, audit	e.g. Education & Training Steering Group	e.g. Annual	e.g. Quality Assurance Committee	e.g. Education & Training Steering Group	e.g. Quality Assurance Committee

13. Implementation plan ✓

14. Links to other policies (associated documents) ✓

15. Contact details ✓

16. References ✓

17. Version control and amendment log (Appendix A) ✓

18. Dissemination Record (Appendix B) ✓

19. Equality Impact Assessment Form (Appendix C) ✓

20. Human Rights Act Assessment Checklist (Appendix D) ✓

21. Policy development and consultation process (Appendix E) ✓

22. Policy Checklist (Appendix F) ✓