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| 0.1 | 20 January 2023 | Final draft as prepared by the SLWG. |
| 0.2 | 17 February 2023 | Updated capacity section following comments from Mental Health Operational Manager & P&CS Associate Director of Nursing. |
| 0.3 | 27 February 2023 | Added glossary & updated with requested wording changes following review by P&CS S-Quad |
| 0.4 | 17 March 2023 | Updated to correct version of cover sheet & updated review history. |
| 0.5 | 12 April 2023 | Updated with requested wording changes following review by Mental Health Quad. |
| 0.6 | 24 April 2023 | Updated Moving on from hospital leaflet in appendix 6 to version approved through Health Information Portal. Included letter templates in appendix 3 for sending to relative/carer. |
| 0.7 | 25 July 2023 | Updated Moving on from hospital leaflet in appendix 6 to version with correct logo placement as advised by Comms. Altered review date to be in one year’s time. |
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**Review History**

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| **Review Date** | **Reviewer (s)** | **Recommendations** |
| 23 February 2023 | P&CS S-Quad | Add glossary, multiple changes to wording throughout main document. |
| 15 March 2023 | P&CS Joint Clinical Governance & Clinical Board | Approved, no changes requested. |
| 16 March 2023 | Acute Quad | Approved, no changes requested. Asked to have final approved policy added to BGH Clinical Governance Group for noting. |
| 30 March 2023 | Public Involvement Partnership Group | Approved, no changes requested. |
| 12 April 2023 | MH Quad | Minor changes to wording in capacity section. |
| 12 June 2023 | Operational Planning Group | Approved, Comms to review leaflet to ensure correct logo placement. |
| 25 July 2023 | Joint Executive Team | Approved, suggested review in one year’s time given ongoing work associated with Discharge Kaizen. |

**GLOSSARY**

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| **13ZA** | Social Work (Scotland) Act 1968 - Section 13ZA: Provision of services to incapable adults. |
| **Allied Health Professional (AHP)** | AHPs work with all age groups and within all specialities.  Their particular skills and expertise can be the most significant factor in helping people to:   * recover movement or mobility; * overcome visual problems; * improve nutritional status; * develop communication skills; and * restore confidence in everyday living skill. |
| **Community Hospitals** | There are four community hospitals in NHS Borders:   * Hawick; * Hay Lodge, Peebles; * Kelso; and * Knoll, Duns. |
| **Delayed Discharge** | A delayed discharge occurs when a hospital patient who is clinically ready for discharge from inpatient hospital care continues to occupy a hospital bed beyond the date they are ready for discharge. |
| **Matching Unit** | Team who reviews requests for individuals who require domicillary support and match these to available services. |
| **Mosaic** | Software used by Social Work & Practice Team holding information on individuals, their families and finances. |
| **Multi Disciplinary Team** | A team of professionals including  representatives of different disciplines who  coordinate the contributions of each  profession, which are not considered to  overlap, in order to improve patient care. |
| **Social Work & Practice Professional** | Individual who works within the Social Work & Practice Team. |
| **Step down to assess** | When a hospital patient who is clinically ready for discharge is “stepped down” to their own home or another community setting where assessment for longer term care needs is completed. |

**1. INTRODUCTION**

Scottish Borders Council and NHS Borders have a responsibility to ensure adequate processes are in place for a safe and timely discharge.

Discharge can be a major life event for patients, their families and carers. It may also have substantial implications for the use of health and social care resources as well as for the voluntary sector and other support services.

The purpose of this policy is to provide a clear and consistent approach to facilitation of effective discharge within the timescales set by the Scottish Government. This will comply with the National Health and Wellbeing Outcomes (see Public Bodies (Joint Working) (National Health and Wellbeing Outcomes) (Scotland) Regulations 2014) and the national Discharge Without Delay (DWD) programme. The DwD programme aims to improve the patient journey, from the initial point of a hospital stay, preventing any delays through early and effective planning. A key aim is to limit hospital stays to what is clinically and functionally essential, getting patients home at the earliest and, crucially, safest opportunity. the foundations of DwD are based on simple patient-centred principles which aim to enhance discharge and prevent delay, through early and effective planning, limiting hospital stays to what is clinically and functionally essential, and getting patients home at the earliest, safest opportunity. These can be distilled down to three basic elements:-

1. Prepare and plan for discharge with patients, from admission - use of a planned date of discharge (PDD) for each patient;
2. Prioritise and protect time to plan as an extended team; and
3. Adopting a ‘Home First’ ethos.

The guidance will set out the overarching principles of good discharge planning.

An easy read version is also available for patients and families with a clear visual process for all staff. This will be available on NHS/SBC internal and external websites to ensure a clear and consistent approach to safe and timely discharge whilst ensuring the authority to discharge is achieved.

**2. POLICY STATEMENT**

Discharge planning from point of admission is fundamental to the provision of effective health care and enhances patient, relatives/carer’s, experience. Planned Date of Discharge (PDD) should be discussed and agreed as a Multi Disciplinary Team (MDT) with patient/families and carers within 24-48 hours of admission. Delays to comprehensive discharge planning leads to:

* the inefficient use of beds;
* increases in waiting lists;
* higher re-admission rates;
* patient safety issues such as non-supply of medication and the potential of decondition of patients;
* patient and carer distress; and
* increased workloads for hospital and community staff.

Furthermore, late decision making and planning creates a negative cycle. For example, a patient with simple discharge requirements leaving hospital later in the day will block an available bed for the daytime peak in demand. This results in even more patients being ‘boarded’ to non-specialty beds where they tend to have a longer length of stay.

Discharge planning is a process which begins on point of admission and is not an isolated event, the MDT should undertake the various elements in parallel, see Figure 1, to ensure timely discharge or transfer of care. Discharge planning must be managed seven days a week and involves patients, relatives, carers and all members of the health and social care team.

Figure 1

A screenshot of a computer

Description automatically generated

Figure 1 above shows that the MDT should be planning all elements of a patient’s discharge, e.g. diagnostics/medical treatment, social care input, carer/family discussion, at the same time aiming for the same end date of when the patient is medically fit for discharge.

Our health and social care system should progress towards a seven-day working week. A lack of senior clinicians and alternatives to hospital care at the weekend will negatively affect admission and discharge rates and increase the length of stay of patients. All discharges and transfers should be criteria led and follow a pathways based approach (see Figure 2). so that any member of the MDT can finalise the discharge. This will also facilitate pre-12 and weekend discharges. The clinical criteria for discharge should detail clear parameters relevant to the aims and objectives of each clinical specialty. These should be clearly documented in the electronic patient record in real time.

Figure 2

Graphical user interface, application

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Figure 2 above shows the steps required at each stage of the patient pathway explaining the different pathway types which are:-

* Pathway 1: Simple – medically fit, no formal Social Work & Practice Team involvement, no ongoing care needs;
* Pathway 2: Moderate – known to the Social Work & Practice Team with existing care (restart) or with additional needs identified, e.g. may need simple equipment;
* Pathway 3: Complex – likely to require new care package, unable to return home without input, may not have capacity, may require inpatient enabling care to assess longer term needs; and
* Pathway 4: End of Life – end of life or palliative care.

For the majority of patients, discharge from hospital is simple and uncomplicated. For some patients, their needs can be more complex. Regardless of the discharge type, we need to ensure each patient’s discharge is well-planned and early consideration is giving to technology-enabled care.

**3. SCOPE**

This policy applies to all individuals who are involved in the discharge or transfer of all patients from in-patient care settings within NHS Borders. Early planning and clear communication between every person involved in making those arrangements is essential.

All staff, including agency and bank staff, should be made aware of this policy to understand their roles, responsibilities and accountability for discharge planning.

Any third sector organisations, supporting this whole system approach to discharge and transfer, should be made familiar with the contents of this policy by those teams liaising with them.

**4. GUIDING PRINCIPLES**

Home First Principles should be applied, which are:

1. Discharge planning starts in the community;
2. Every older person should have the greatest opportunity to return to their own home;
3. Decisions about future care needs should not be made when patient is in crisis; and
4. Older people are not assessed for their future care needs in an acute hospital.

The application of ‘Home First’ principles provides patients with support at home or intermediate care. Wherever possible, patients should also be supported to return to their home for assessment. A discharge to assess model, where going home is the default pathway (with alternative pathways for people who cannot go straight home) is more than good practice – it is the right thing to do.

Staying in hospital for longer than necessary has a negative impact on patient outcomes. Ensuring that patients are given the chance to continue their lives at home is vital for their long-term wellbeing outcomes.

In the circumstances where a person is being considered for discharge from hospital to a care home, this decision must be taken following a full assessment of the individual’s potential for recovery, rehabilitation and reablement. In addition to this, the patients capacity for decision making must be assesses and recorded – see section 5.

In order of preference, the assessment will take place:

1. in the person's own home
2. in an Intermediate Care facility (Community Hospital or SBC)
3. in a hospital setting

Moving into a care home is a major decision for a person and should be treated as such. To ensure people feel supported throughout the process, preparation and planning needs to commence as early as possible. Adequate coordination and agreement across the MDT should take place, taking into account the person's wishes regarding the involvement of family and/or carers to support them.

**5. CAPACITY**

Capactiy means the ability to use and understand information to make a decision and communicate any decision made. A person lacks capacity if their mind is impaired or distriubed in some way, which means they are unable to make a decision at that time.

The issue of the patient’s capacity to make informed decisions about their future care should be assessed as early as possible and reviewed as appropriate in the patient’s journey to avoid unnecessary delays in the patient’s discharge. If it is assessed by the Doctor responsible for the patients care within the MDT that the patient does not have capacity to make decisions regarding their future care needs (in addition to their care and treatment) then consideration should be given immediately to the appropriateness of a 13ZA process. If this is not appropriate, it will be necessary for a Social Work & Practice Professional to arrange to raise an Adult with Incapacity (AWI) referral and arrange AWI Case Conference. Both processes will require MDT discussion which will determine the most appropriate and least restrictive course of action to facilitate discharge. Discharging Patients Who May Lack Capacity Guidance and Capacity Assessment Checklist are available under Appendix 1.

All staff should be clear on what legal authority is being used to support discharge by applying [the principles of the Adults with Incapacity Act (Scotland) 2000](https://www.gov.scot/publications/adults-with-incapacity-act-principles/) as outlined in the Mental Welfare Commission guidance [Authority to discharge: Report into decision making for people in hospital who lack capacity](https://www.mwcscot.org.uk/sites/default/files/2021-05/AuthorityToDischarge-Report_May2021.pdf).

It is important to note that when a patient lacks capacity, this does not mean that they cannot move.

**6. DISCHARGE PLANNING**

Discharge planning should begin on admission, or soon after, in partnership with the patient, family, carer and/or proxy.

As part of ongoing care and discharge planning, each individual identified as requiring health and or social care services will have ongoing multi-disciplinary assessment. As part of this assessment process, PDD should be discussed and agreed by the MDT with the patient and their family, carer and/or proxy.

If a person needs to move to a care home, their future, long term care needs will be agreed with the patient, carer, family and/or proxy as part of the assessment process. This is usually done by a Social Work & Practice Professional based in the hospital. The assessment should be discussed with the patient, carer, family, carer and/or proxy (if the patient agrees). The patient should receive a copy of the assessment and be given the opportunity to discuss it.

The Social Work and Practice assessment (in part or full) will be shared with relevant third parties such as Care Homes or Service Providers and the patient, carer, family and/or proxy will be informed of the third parties involved. This allows the Care Home/Service provider to establish if they can meet the person’s needs. For more information on Social Work and Practice please refer to the Scottish Borders Council Website for their [Introduction to Social Care Leaflets](https://eur01.safelinks.protection.outlook.com/?url=https%3A%2F%2Fwww.scotborders.gov.uk%2Fdownloads%2Ffile%2F5505%2Fintroduction_to_social_care&data=05%7C01%7CKaren.Maitland%40borders.scot.nhs.uk%7C6ba3fefc8e1b4ddc52a308daf87a2477%7C10efe0bda0304bca809cb5e6745e499a%7C0%7C0%7C638095500751327031%7CUnknown%7CTWFpbGZsb3d8eyJWIjoiMC4wLjAwMDAiLCJQIjoiV2luMzIiLCJBTiI6Ik1haWwiLCJXVCI6Mn0%3D%7C3000%7C%7C%7C&sdata=JvydfsfxUIMsybYRkACcvSWaYCwCoXzqS8avEHcOrt0%3D&reserved=0), [Preparing for assessment Leaflet](https://eur01.safelinks.protection.outlook.com/?url=https%3A%2F%2Fwww.scotborders.gov.uk%2Fdownloads%2Ffile%2F5506%2Fpreparing_for_assessment&data=05%7C01%7CKaren.Maitland%40borders.scot.nhs.uk%7C6ba3fefc8e1b4ddc52a308daf87a2477%7C10efe0bda0304bca809cb5e6745e499a%7C0%7C0%7C638095500751327031%7CUnknown%7CTWFpbGZsb3d8eyJWIjoiMC4wLjAwMDAiLCJQIjoiV2luMzIiLCJBTiI6Ik1haWwiLCJXVCI6Mn0%3D%7C3000%7C%7C%7C&sdata=BAopTQT9yUJ4b3M4CtM3xBg09%2FWGo6Lcm%2FrWwGG4WeM%3D&reserved=0) and [Eligibility Criteria](https://eur01.safelinks.protection.outlook.com/?url=https%3A%2F%2Fwww.scotborders.gov.uk%2Finfo%2F20069%2Fhow_do_i_get_a_service%2F511%2Feligibility_criteria&data=05%7C01%7CKaren.Maitland%40borders.scot.nhs.uk%7C6ba3fefc8e1b4ddc52a308daf87a2477%7C10efe0bda0304bca809cb5e6745e499a%7C0%7C0%7C638095500751327031%7CUnknown%7CTWFpbGZsb3d8eyJWIjoiMC4wLjAwMDAiLCJQIjoiV2luMzIiLCJBTiI6Ik1haWwiLCJXVCI6Mn0%3D%7C3000%7C%7C%7C&sdata=Q7iZ2lBtNbO2%2BEB2O0am8OlrpVRuZ8t7riKf%2Bes%2Bfdo%3D&reserved=0).

The PDD is the date that all teams jointly aim to have the person clinically fit and ready for discharge (the date the patient no longer requires specialist hospital based care); allowing hospital discharge teams up to two working days to secure services. Staff from both health and social care will attend MDT meetings where PDD discussions will take place ensuring good communication of this decision making processes to other relevant staff.

If the patient’s health needs change, the PDD should be adjusted accordingly, again following full discussion with the MDT and the patient, family, carer and/or proxy.

The setting of a PDD will be required both when moving from hospital to an intermediate resource, and when moving on from a intermediate resource.

**7. INTERIM ARRANGEMENTS**

If it becomes clear during the assessment process that the services required are unlikely to be available on the PDD, then interim arrangements must be in place to ensure discharge can take place on the agreed date.

**7.1 Housing**

If rehousing is required, then an appropriate application should be completed as early in the discharge planning process as possible.

However, many patients can return to their existing properties in the short term, even when they require rehousing. If adequate short term arrangements can be made with the support of appropriate equipment (e.g. raised toilet seat or commode) and social care input, then discharge should proceed. This ensures equity for Scottish Borders residents who await rehousing in their existing properties and who may be experiencing similar difficulties

For those patients who cannot be accommodated safely in their existing properties, then Scottish Borders Council (SBC) bed based intermediate care should be considered (see Appendix 2 for criterias). Should this be unavailable or unsuitable, then alternative interim arrangements should be considered.

Advice and guidance regarding housing services are available on the SBC website:

[Council housing and housing associations | Scottish Borders Council (scotborders.gov.uk)](https://www.scotborders.gov.uk/info/20011/housing_and_homeless/490/council_housing_and_housing_associations)

Scottish Borders Local Housing Strategy, Homelessness strategy and additional information are available via the links below:

[Strategies, plans and policies directory - Local housing strategy | Scottish Borders Council (scotborders.gov.uk)](https://www.scotborders.gov.uk/directory_record/45447/local_housing_strategy)

[Scottish Borders Homelessness Services](https://www.scotborders.gov.uk/downloads/file/1875/scottish_borders_homelessness_service)

**7.2 Domiciliary Care Support**

If Home First is not the appropriate pathway then a referral will be made to the Social Work & Practice Team to request a Package of Care. The agreed support plan will be sourced by the Matching Unit.

The PDD should be clearly marked on the referral. Social Work & Practice Professionals should then notify the MDT Meetings to ensure the patient is being discussed.

Should the care be unavailable on the specified date, this should be clearly communicated to the MDT and the patient, family, carer, and/or proxy immediately and discussion should then take place about how to progress the discharge.

**7.3 Care Home Admission**

Admission to a care home from a hospital setting should only take place after the patients needs and views of their representatives have been considered taking account of rehabilitation/ recovery. Before this decision is finalised, step down to assess options should be considered to ensure the patient has an opportunity to optimise their rehabilitation/recovery with appropriate supports in place but outwith a clinical setting. The assessment should be fully discussed with the patient, family, carer and/or proxy and all relevant information should be provided to them.

The patient, family, carer and/or proxy should be provided with information on care homes

which can meet the individual’s needs by the Social Work & Practice Professional. The patient, family, carer and/or proxy must then provide the Social Work & Practice Professional and ward staff with a list of their three preferred care homes, the homes should be listed in order of preference. The Social Work & Practice Professional, with the support of the MDT, must advise the patient, family, carer and/or proxy of this and should issue the standard letter in Appendix 3. A response is then required within seven days of receipt of the letter. The Social Work & Practice Professional must make the patient, family, carer and/or proxy aware during this initial discussion of the choice process in line with [CEL 32(2013) Guidance on Choosing a Care Home on Discharge from hospital](https://www.sehd.scot.nhs.uk/mels/cel2013_32.pdf).

For care homes in the Scottish Borders, the digital referral system, STRATA is used to identify vacancies. Should any of the three choices of care homes not have a vacancy available, the Social Work & Practice Professional will identify a suitable interim care home which the patient will be expected to move to on the identified PDD or when funding is available.

The need to proceed with discharge, even if the preferred home(s) is not available, must be clearly stated by the Social Work & Practice Team as once an assessed need is identified, the local authority have a duty to meet those assessed needs. The Social Work & Practice Professional, with support from the MDT, should explain to the patient, family, carer and/or proxy why an interim move is considered to be in the best interests of the patient, and they should be reassured that they will remain on a waiting list for their preferred home, and will be offered the opportunity to transfer there when a place becomes available, if that is their wish.

The Social Work & Practice Professional should then complete the relevant Mosaic workflows to seek approval for funding and should include the PDD. STRATA should be completed to formalise the referral to the Scottish Borders care homes. If the care home is out of area or a specialised facility, social work will follow internal processes for the referral.

As soon as the patient, family, carer and/or proxy identifies their preferred or interim care home, and funding is approved, the Social Work & Practice Professional should:

* contact the care home manager to discuss the patient’s referral;
* ensure that they can meet their needs; and
* confirm potential admission date to the care home.

If the care home is unable to offer a placement for any reason, then another suitable care home with a vacancy must be identified.

If the patient, family, carer and/or proxy has not advised of their choice of care home within seven days of the initial discussion, and/or there is reasonable reason to assume they are unlikely to do so, the Social Work & Practice Professional must advise their Team Leader who, in partnership with NHS Borders, instigate the Integrated Discharge Case Conference to support the Choice Process and send the family/POA/Patient the letter in Appendix 4.

**8 CHOICE PROCESS**

The procedures outlined below should be followed if, at any stage, the patient, family, carer and/or proxy are unwilling to engage with the above process.

**8.1 When the patient or proxy disagrees**

If the patient, family, carer and/or proxy disagrees with the discharge planning arrangements, the Social Work & Practice Professional will continue to make the practical arrangements for the patient to move to a suitable care home and should advise their Team Leader in order that the Choice Process will be facilitated via an Integrated Discharge Case Conference. While the Integrated Discharge Case Conference is being arranged, the Social Work & Practice Professional should, with the support of the MDT, continue to work with the patient, family or carer to move towards a resolution.

Should it be necessary to convene an Integrated Discharge Case Conference, a formal letter will be sent as soon as possible in the name of NHS Borders to the patient, family or carer, inviting them to attend at a specified time. The Moving On From Hospital Policy process would be led by a representative from NHS Borders and Social Work who would work alongside this to explain and support the process whilst looking to identify relevant care arrangements.

The Integrated Discharge Case Conference will be led by Clincal Nurse Manager/Clinical Service Manager, and should be supported by the Senior Charge Nurse. The Social Work & Practice Professional and a member of the clinical team should also be in attendance to give information and to support the patient.

We aim to achieve a shared resolution. The ongoing discharge arrangements to an appropriate interim care home will be made clear at the Integrated Discharge Case Conference. The patient and their family/carer will be advised that any interim arrangement made will be temporary and that they can continue to seek their preferred choice of care home but that people do not have the right to choose to remain in hospital when there are no medical reasons for them to be there, and remaining in hospital care is not an option during this process.

However, for any patients who the MDT have advised against more than one move, e.g. patients with a dementia diagnosis, this should be taken into consideration when looking at interim moves. Any such patients whose longer term discharge destination will be available within seven days should not be moved to an interim location.

Minutes from the Integrated Discharge Case Conference will be sent by the Clinical Nurse Manager/Clinical Service Manager to the patient or their proxy following the Integrated Discharge Case Conference to outline the discussion held, and any decisions made. See Appendix 4 for letter and minutes template. Should the patient or proxy disagree with the decision from the Case Conference, the Senior Charge Nurse should support them to carry submit an appeal to the Medical Director. This must be done in writing to the Medical Director within 10 working days of the meeting and decision being made.

The Medical Director will review the appeal and then write to the patient/family/proxy advising on the outcome within 5 working days. See Appendix 5 for letter template.

Patients, family or proxies have the right to challenge the decision that the patient is ready for discharge. However, this right does not extend to insisting that the patient remains in hospital, purely on grounds of choice.

A proxy is in no stronger a position than the adult, had they retained capacity. As such, they cannot make a decision requiring that the adult remains in hospital once they are fit for discharge.

**8.2 Changes in patient medical condition, care needs or circumstances**

Should the medical condition, care needs or circumstances change during the implementation of this policy, it is reasonable to pause and restart this process at a later date or stop the process entirely. When this happens, ward staff should ensure this is shared with the Clincal Nurse Manager/Clinical Service Manager.

**9. FAILURE TO PROGRESS WITH PROCESS**

If there are any points during the process that the patient, family, carer and/or proxy are failing to engage with the process, the Clinical Nurse Manager/Clinical Service Manager can escalate this to the Associate Director of Nursing or Associate Medical Director for advice.

Where the patient, family or proxy continue to unreasonably refuse to engage with the choice and/or discharge process NHS Borders can choose, as a last resort, to seek enforcement of the discharge through the courts with support from both organisations legal departments. The NHS legal team would lead the enforcement. The SBC legal position would be focused on the person’s rights dependent on their individual circumstances ie incapacity.

**10. SUMMARY**

Discharge planning must place the patient at the centre of all decision making and should focus on achieving the best outcomes for each individual. All decisions must be achieved through a multidisciplinary process which recognises the risks associated with prolonged stays in hospital past the point of medical fitness, and which seeks to facilitate timely discharge to home, or the most appropriate interim resource to continue the assessment and rehabilitation process.

**11. ROLES AND RESPONSIBILITIES**

Clinical staff

In order to improve patient flow and the discharge pathway:

* The discharge checklist must be commenced at the point of admission; this may be within the person centred care plan on Trak for certain specialties This will help ensure that plans, such as the use of the discharge lounge, the requirement of hospital transport or checking the suitability of equipment, are made in advance.
* It is essential that a range of staff within the hospital (such as occupational therapists, physiotherapists, nurses and discharge coordinators) can assess and order directly any equipment necessary for their patient’s safe discharge. Additional equipment (not immediately required) and further assessments/follow-up in the person’s home environment should be arranged by liaising with the appropriate community teams as part of the discharge process.
* Diagnostic tests, other interventions and assessments must be planned and organised in a timely manner to avoid delays in treatment and discharge. Therapy assessments must commence when patients are clinically stable enough to progress this rather than being delayed until a patient is almost ready for discharge.
* Daily clinical review of the patient’s condition and response to treatment, ensuring collaborative leadership between medical, nursing, pharmacy and allied health professionals to improve decision-making.
* Recording of patients identified as delayed discharges in TrakCare.
* The nuse allocated to the patient will contact the Social Work & Practice Team for all restart or changes in package of care. Home First, depending on capacity, can support on an interim basis if there is a agreed date for the package of care restarting.
* The MDT must consider what value they are adding for the person balanced against the risk of them being away from home and, where appropriate, enable the person to receive care in a less intensive setting.
* For patients who have not reached a point where long-term 24-hour care is required, the MDT must discuss (and record) why they cannot go home that day and review the Planned Date of Discharge.
* The MDT must avoid setting expectations with the patient, their family or carers regarding community provision or Care Home placement as patients’ needs will be different in a non-acute setting.
* The MDT must deliver values based practice and also hold realistic conversations about discharge destinations.
* The MDT must acknowledge that for patients already known to the Health & Social Care Partnerships (HSCPs), partnership colleagues will have a better understanding of that individuals personal circumstances and it is appropriate for HSCPs to take a leading role in decision making during the discharge process.
* An up-to-date list of all patients clinically ready for discharge/transfer must be kept for discussion at the weekly delayed discharge meetings.
* Informal carers (e.g. family members who are providing care) must be given sufficient information to prepare for discharge.
* Effective and timely planning should be in place to ensure that the patient medication and an immediate discharge letter are ready in time for the planned discharge.
* Early communication and, if required, referral to community colleagues such as GP’s and District Nurses by the ward team is crucial to support the patient discharge process and minimise unnecessary readmissions. This will include the completion of timely discharge letters, in order that the community are aware of the patients that have been discharged and what support has been arranged.
* The MDT should also aim to minimise the number of transfers for frail or elderly patients if their long term discharge destination is available within seven days.
* The MDT should record any limitations on number of moves/interim moves for certain patients, e.g. those with a dementia diagnosis, so this can be taken into consideration during discharge planning.
* The MDT should regularly review the medical condition and care needs of patient’s categorised as delayed discharges in case there are any changes in circumstances.
* The MDT should ensure details of reviews are recorded in the patients case notes.
* Should there be any change that affects the delayed discharge status of the patient, TrakCare should be updated accordingly.

Discharge & Pathway Coordination Team (based within BGH)

The Discharge & Pathway Coordination Team will support and manage more complex discharges for acute inpatients, and can provide expert advice to ward staff and department managers. Simple discharges remain the responsibility of ward staff to discharge without delay.

To support this process, this team will:-

* attend BGH Safety Brief and Integrated Primary & Community Services Integrated Huddle daily.
* attend and contribute to ward board rounds and MDT meetings.
* provide advice and guidance to enable ward staff to complete and submit accurate and timely referrals for assessments.
* assist and support difficult conversations with patients and families to support discharge from hospital.
* consider suitability of patients for a less acute care setting such as a community hospitals, Home First or an intermediate care facility.

Clincal Nurse Managers/Clinical Service Managers

* Support ward staff with the implementation of the policy which may include discussions with patients and/or the families/carers.
* Chair case conferences.
* Escalation to Associate Director of Nursing/Associate Medical Director as required.

Assocate Director of Nursing/ Associate Medical Director

* Respond to escalation from Clinical Nurse Manager/Clinical Service Manager as required.

Medical Director

* Respond to Appeal Against Medical Discharge as required.
* Instruct NHS legal teams to enforce patient discharge through courts.

Health and Social Care Partnership responsibilities

* The Social Work & Practice Team will screen all new requests in real time and take appropriate action without adding delays.
* Social Work & Practice assessments should be completed with discharge destination and funding agreed. The process should not routinely add to delays for patients who are clinically ready to leave hospital.
* The Social Work & Practice Professional should provide patient/family with list of care homes for consideration.
* All new and increased packages of care requests should have up to six weeks of reablement to determine the ongoing level of care required. Where reablement services do not currently operate and would be beneficial to support patients, these should be developed.
* Where reablement is not available to match a request for service, external providers should be contacted without delay.
* Respond to ward staff request for all restart or changes in package of care. Home First, depending on capacity, can support on an interim basis if there is a agreed date for the package of care restarting.
* Any Delayed Discharges meetings are to be attended by prior request by relevant representatives from the whole system. Health & Social Care Partnership (HSCP) representatives (or their deputy) must come prepared with updates on people already known to the health and social care system and also know about capacity to accept new referrals.
* All discharge to assess referrals must be screened and allocated by a senior HSCP Allied Health Professional to ensure the service supports timely discharge for patients who no longer require an acute bed.
* Partnership staff will help with the identification and transfer of patients for whom an admission can be avoided at the front door through a continuation or increase in community services. This may include accessing other services to support patients, where appropriate, in the community.
* Partnership staff will liaise between inpatient settings and the community to avoid unnecessary admissions, support discharge planning and help achieve discharges on the planned date of discharge.
* It is essential that a range of staff within the hospital (such as occupational therapists, physiotherapists, nurses and discharge coordinators) can assess and order directly any equipment necessary for their patient’s safe discharge. Additional equipment (not immediately required) and further assessments/follow-up in the person’s home environment should be arranged by liaising with the appropriate community teams as part of the discharge process.

**12. ASSOCIATED GUIDANCE, POLICIES & LEGISLATION**

[CEL 32(2013) Guidance on Choosing a Care Home on Discharge from hospital](https://www.sehd.scot.nhs.uk/mels/cel2013_32.pdf)

[Daiily Dynamic Discharge Approach](https://www.gov.scot/binaries/content/documents/govscot/publications/advice-and-guidance/2016/06/daily-dynamic-discharge-approach-guidance-document/documents/00503010-pdf/00503010-pdf/govscot%3Adocument/00503010.pdf), Scottish Government (2016)

[Social Work (Scotland) Act 1968](https://www.legislation.gov.uk/ukpga/1968/49/contents)

[Social Care (Self-directed Support) (Scotland) Act 2013](https://www.legislation.gov.uk/asp/2013/1/contents/enacted)

[Adults with Incapacity (Scotland) Act 2000](https://www.legislation.gov.uk/asp/2000/4/contents)

[Adults with Incapacity: supporting discharge from hospital](https://www.gov.scot/publications/adults-with-incapacity-supporting-discharge-from-hospital-2/), Scottish Government and Mental Welfare Commission, 2021

[Authority to discharge: Report into decision making for people in hospital who lack capacity](https://www.mwcscot.org.uk/sites/default/files/2021-05/AuthorityToDischarge-Report_May2021.pdf), Mental Welfare Commission, May 2021

[Mental Health (Care and Treatment) (Scotland) Act 2003](https://www.legislation.gov.uk/asp/2003/13/contents)

[Human Rights and Equalities Legislation](https://www.equalityhumanrights.com/en/human-rights/human-rights-act)

[The Public Bodies (Joint Working) (National Health and Wellbeing Outcomes) (Scotland) Regulations 2014](https://www.legislation.gov.uk/sdsi/2014/9780111024522#:~:text=These%20Regulations%20prescribe%20national%20health%20and%20wellbeing%20outcomes,Schedule%20to%20these%20Regulations%20sets%20out%20the%20outcomes.)

**13. APPENDICES**

Appendix 1 – Discharging Patients who may lack capacity

 

Appendix 2 – SB Cares Transitional Care Admission Criteria

Garden View Upper Waverley Upper Deanfield

  

Appendix 3a – Letter Templates – Care Home Choices to be made (for sending to patient)

 

Appendix 3b – Letter Templates – Care Home Choices have been made (for sending to relative/carer)

 

Appendix 4 – Letter & Meeting Templates for Case Conference

  

Appendix 5 – Letter Template Medical Director Appeal Outcome



Appendix 6 – Moving On From Hospital Patient Leaflet



Appendix 7 – Moving On From Hospital Flowcharts & Checklist for Staff

