Humber Teaching
NHS Foundation Trust

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

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1. Policy Statement

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

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

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

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

2. Scope

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

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

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

3. Definitions

Expected Discharge Date (EDD)
The initial, planned date a patient is expected to leave hospital, set at the beginning of their admission to hospital. The purpose is to provide a clear and early target to ensure co-ordination, minimise unnecessary delay and help manage patient flow.

Delayed discharge
A delayed transfer of care (DTOC) from NHS-funded acute or non-acute care occurs when a patient is ready to go home and is still occupying a bed. A patient is ready to go home when all of the following three conditions are met:

- a clinical decision has been made that the patient is ready for transfer home
- a multidisciplinary team (MDT) decision has been made that the patient is ready for transfer home
- the patient is considered to be safe to discharge/transfer home

See Monthly-Delayed-Transfers-of-Care-Situation-Report-Principles-Definitions-and-Guidance.pdf

Immediate Discharge Prescription
An **Immediate Discharge Prescription** (sometimes referred to as an immediate discharge letter or IDL) is “a short document that includes the details of a person's current prescription, the reasons for any changes in medicines and their immediate medication treatment plan” (NICE NG53). This should be sent via the electronic patient record (EPR) to the GP within 24 hours of discharge.

Discharge Summary
A Discharge Summary is “A summary of what happened during a person's admission and hospital stay from a medical perspective. It must include the diagnosis, outcomes of investigations, changes to treatment and the medicines started or stopped, or dosage changes and reasons why” (NICE NG53). This should be sent via the electronic patient record (EPR) to the GP within 7 days of discharge.

4. Duties and Responsibilities

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

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

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

They are also responsible for ensuring that any deviation or errors arising are dealt with in the correct manner, according to the Incident Reporting Policy and Procedure. They will, where appropriate and required, be responsible for formulating, implementing and reviewing ~~where required~~ local Standard Operating Procedures regarding transfer and/or discharge for their respective service areas to ensure best practice is reflected in local Standard Operating Procedures

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

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

Charge Nurses/Ward Sisters/Team Leaders
Will ensure that effective discharge/transfer planning processes are in place and operate effectively.

Will ensure effective and timely communication between services,
Will ensure that staff within their area of responsibility have access to and attend appropriate training.

Will ensure that best clinical care is carried out during patient transfers and/or discharge.

Clinical Pharmacists and Pharmacy Technicians
Will ensure medicines reconciliation is completed at admission.

Clinically review treatment to optimise outcomes, adjusting frequency based on individual needs, and simplify medicine regimens in partnership with patients, including dose optimisation and stopping medicines when appropriate.

Support continuity of care by facilitating access to ongoing medicine supplies, reconciling medications, and minimising delays in discharge or transfer due to supply issues ensuring that One Stop Dispensing is carried out where appropriate. A minimum of 14 days and a maximum of 28 days' supply of medicines will be provided on discharge.

Ensure safe and effective transfer of medicines information by communicating accurate, timely, and legible details to the receiving healthcare professionals, preferably via secure electronic methods, in line with national guidance.

Engage patients and their support networks by providing a complete, understandable list of medicines at transfer, including explanations of usage and changes, promoting active involvement in medicine management.

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

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

5. Procedures Relating to this Policy

This section sets out the core good practice principles for discharge and transfer which need to be applied by all inpatient services. Each local SOP should then provide additional details regarding how these principles will be operationalised including any additional services specific requirements.

In addition, for mental health inpatient settings the 8 principles as outlined in Discharge from mental health inpatient settings - GOV.UK (Jan 2024) statutory guidance should be considered.

These include:

- Principle 1: individuals should be regarded as partners in their own care throughout the discharge process and their choice and autonomy should be respected
- Principle 2: chosen carers should be involved in the discharge process as early as possible
- Principle 3: discharge planning should start on admission or before, and should take place throughout the time the person is in hospital
- Principle 4: health and local authority social care partners should support people to be discharged in a timely and safe way as soon as they are clinically ready to leave hospital
- Principle 5: there should be ongoing communication between hospital teams and community services involved in onward care during the admission and post-discharge
- Principle 6: information should be shared effectively across relevant health and care teams and organisations across the system to support the best outcomes for the person
- Principle 7: local areas should build an infrastructure that supports safe and timely discharge, ensuring the right individualised support can be provided post-discharge
- Principle 8: funding mechanisms for discharge should be agreed to achieve the best outcomes for people and their chosen carers and should align with existing statutory duties

Within the statutory guidance are additional elements related to

- children and young people
- people with a learning disability and autistic people
- a person with dementia
- people admitted to forensic inpatient settings
- people experiencing, or at risk of, homelessness
- people with co-occurring mental health and drug and/or alcohol conditions
- a person with no recourse to public funds

5.1. On Admission

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

5.2. Ongoing Discharge Planning

- Decisions about a person's care and support will be discussed with the person, their family, and carers, as per the NHS Constitution, and will be provided with high quality support and information to participate where possible. In the context of a discharge decision, the information relevant to the decision will include an understanding of their care needs on discharge, the process and outcome of the assessment of needs, offers of care and options available.
- People should be provided with high quality information, advice and support in a form that is accessible to them as early as possible, before or on admission and throughout their stay, to enable effective participation in the discharge process and in making an informed choice.
- Where it is identified that the patient requires a needs assessment under the Care Act 2014 but would have substantial difficulty in engaging in the assessment and care planning process, the local authority must consider whether there is anyone appropriate who can support the individual to be fully involved, which may be a family member or friend. If there is not an appropriate family member or friend, then the Trust will arrange for an Independent Advocate.
- The Trust is committed to the approach whereby every effort will be made to support the person to be discharged home or to their usual place of residence. To enable this, patients should, as a preference, be offered support from a range of services.
- Where a transfer to another care setting is required, where possible this should be discussed and agreed with the patient and the carers.
- Planning for discharge should include all appropriate statutory and voluntary agencies necessary to meet the patient's needs to avoid unnecessary readmissions through the effective co-ordination and delivery of services.
- Local authorities should be involved in the discharge process where appropriate and where applicable. Ensure relevant notifications are made to them in a timely way to progress any assessment and discharge arrangements.
- Where appropriate, a patient's eligibility for NHS continuing healthcare must be assessed in a timely fashion, or any extra contractual funding requests/exceptional treatments must be identified and negotiated through identified local arrangements.

- Many patients will want to involve others to support them, such as family or friends, carers, or others. Confidential information about the patient should only be shared with those others with the patient's consent and only on the basis that the patient has capacity to make their own decisions about confidentiality and information sharing. See section 5.11.2 regarding patient who lack capacity.
- Where someone is providing care or considering providing care post-discharge, unpaid as a carer, they must be informed and invited to be involved in the discharge process and informed about their rights and sources of support. People have a choice about whether to provide care for other adults and people must be informed about their choices when establishing whether they are willing and able to provide care.
- Carers must be offered the information, training and support they need to provide care following discharge, including a carer's assessment however it is the responsibility of Local Authority (or other delegated agent) to complete the assessments of needs and provide support.
- It should be identified if any carer or family member is accessing health or social care services in their own right at the earliest opportunity following the patient's admission, and this should be recorded in the patient record. Patients who also have a caring role should be offered a Carers Assessment. Where carers/family members are also service users, the discharge planning process must include special consideration of the potential for carer stress, its potential impact on the relationship and each person's mental health including risk, and actions to mitigate these. Where possible this will include joint approaches to discharge planning between individual workers in teams who are working independently with patients who are partners/family members.
- Care plans/management plans should be reviewed at regular intervals within the multi-disciplinary team to ensure proactive actions are taken regularly to progress to safe and appropriate patient discharge.
- The **EDD and progress against this should be regularly reviewed** and any changes to this should be made where possible in collaboration with the patient and carer.
- Make decisions to facilitate planned discharge and transfers over seven days where it is possible to ensure continuity of care delivery can be provided to meet patients care needs on discharge. Where any essential equipment needed to promote independence or safety when transferring or discharging across to another unit or back into the community, please refer to the relevant Inpatient equipment SOP for further guidance

5.3. Decision to Discharge

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

5.4. Prior to Discharge:

- Inpatient teams and community-based services must ensure a comprehensive handover and exchange of pertinent clinical information through a combination of verbal, written and face to face information exchange. This must be recorded as per defensible documentation requirements
- Wherever possible patients/family and/or carers will be given at least **24 hours** notice of discharge. Consideration will be given to the complexity/individual needs of the patient and their families.
- Clinical staff must be assured the patient is both physically and psychologically prepared for discharge from hospital and appropriate support is available. This should be clearly defined in an appropriate discharge plan/care plan (or equivalent), as agreed with the patient and were appropriate the family/carers. The plan should describe the ongoing arrangements for care and treatment.
- Patient should receive a copy of their discharge summary before leaving hospital.
- The plan relating to discharge/transfer should be clearly communicated to the patient so that by the time a patient is deemed ready for discharge/transfer they understand the process, decisions, and actions that they may need to undertake and the support they will receive.
- For Mental Health patients discharged from hospital, arrangements will be put in place with regards to 3 day follow up. It will be agreed with the patient when and how this will take place. It is important to check contact details are up to date and logged on the patient's EPR and any contacts for family/significant others have also been documented.

5.5. Day of Discharge:

- When patients are discharged from inpatient services staff are to follow the Procedures for Safe and Secure Handling of Medicines, to ensure patients leave with the correct medication and are able to administer medication safely or if not alternative support for administration of medicines is in place.
- All patients will be offered a copy of their care plan/discharge plan/safety plan and **Immediate Discharge Prescription** (sometimes referred to as an IDL) (whichever is appropriate to the care setting)
- An **Immediate Discharge Prescription** must be sent to the GP within 24 hours of discharge via the EPR, followed by the **Discharge Summary** to the GP within 7 days.
- NICE recommends that discharge plans and summaries be shared with all relevant parties, including patients and their GP, as part of a co-ordinated discharge process.
- Additionally, where relevant this information will be shared with all other appropriate and relevant healthcare/local authority professionals securely on the day of discharge.
- All information shared with healthcare professionals, patients/carers will be documented in patient records
- Additional information required by the patient with regard to any further treatment or ongoing condition is provided along with any appropriate information leaflets.
- Where appropriate, and where consent is gained (or as part of a best interest decision) carers/significant others should be involved in the discharge process and receive a copy of the above documents. This will be documented in the patient record.

5.6. Delayed Transfer or Discharge

- The escalation and management of delayed discharges will differ depending on the service from which the patient is being discharged. The process for delayed discharges will be outlined in the divisional/local SOPs and include local processes for reporting.
- All delayed discharges will be reported and escalated to divisional managers. Delayed discharges should be reported via escalation meetings such as the Multi-Agency Discharge Escalation (MADE) meeting.

5.7. Transfer of the Deteriorating Patient to Acute Services

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

5.8. Transfer/Discharge of an Infectious Patient

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

5.9. Patients Wishing to Take their Own Discharge

- All information regarding potential risks of self-discharge and the benefits of continuing with their hospital care must be explained to the patient to allow them to make an informed decision.
- All discussions with the patient must be documented accurately in the patient's ~~nursing~~ electronic patient record.
- Where the patient insists on taking own discharge, request that the patient signs the relevant self-discharge form.
- Where the patient lacks mental capacity in relation to the decision to take self-discharge staff must ensure they follow procedures and consult where practicable with relevant others, as described in the Mental Capacity Act and best interests process to establish if authorisation to detain someone under Deprivation of Liberty Safeguards.
- Where the patient is subject to restrictions under the MHA, self-discharge would be considered to be Absent Without Leave (AWOL).
- 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.
- If the patient is under the age of 18, then the person with parental responsibility will be contacted immediately and any safeguarding concerns be raised with the HTFT safeguarding team.

5.10. Discharging Patients who Disengage from Services

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

5.11. Special Considerations

5.11.1. Transfer of a Patient to an Acute Hospital for Assessment or Treatment

Patients may require transfer to another hospital setting or care provider for a number of reasons for example urgent or emergency treatment due to a deterioration in their physical health, or attendance at a pre-planned hospital outpatient appointment.

Where there is a sudden deterioration in a patient's physical health requiring urgent or emergency treatment, dial 999 requesting an ambulance. See deteriorating-patient-protocol-prot527.pdf. Use the SBARD tool to effectively communicate concerns to the call handler. Ensure the receiving hospital receives relevant clinical details, as required, to effectively and safely manage the patient's care and treatment. Ensure next of kin/significant other is informed at the earliest opportunity.

For planned transfers and for attendance at outpatient appointments ensure the patient is supported as per their individual needs (taking into consideration any restrictions relating to MHA, section 17 leave etc). Ensure appropriate transport arrangements are in place. Communicate and share with receiving hospital all relevant and appropriate clinical details to support a seamless transfer and effective and safe management of ongoing care.

Patients detained to Humber, section due to lapse whilst on S17 leave to the acute trust.

Some patients may need treatment for their physical health in an acute hospital whilst on a section of the MHA, for example S2, and detained to Humber. Section 17 leave is used for these situations.

There maybe an occasion when a section 2 is coming to an end and the patient needs reassessment whilst they are still receiving care and treatment within the acute trust. A section can only be applied to the hospital where the patient is currently situated. If S3 is deemed appropriate this would mean the detention would end with Humber and the patient would be detained to the acute hospital.

The application would be made out to the acute hospital and responsibility for informing the unit within Humber would lie with the mental health legislation department.
Once the new section (S3) has been received this would automatically end any earlier section. The patient would then become the legal responsibility of the acute Trust. This would then mean Humber staff have no legal powers in relation to the use of restraint and the acute hospital would need to put systems in place for this provision.

5.11.2. Patient with Additional or Specific Needs

When planning safe and effective discharge and transfer, due consideration will be given to the individual needs of the patient. This may requirement the need for specific arrangements, considerations or additional support. For example, patients with cognitive impairment, a learning disability or autism, sensory impairment, physical disability, language barriers, risks relating to mental health, pregnant people, children and young people, and supporting the needs of transgender people.

5.11.3. End of Life

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

5.11.4. Patients Assessed as Lacking Capacity

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

5.11.5. Deprivation of Liberty

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

5.11.6. Safeguarding Concerns

As part of the admission process, on-going care and discharge planning, consideration should be given to any identified safeguarding concerns with appropriate measures in place to address concerns to ensure safe and appropriate discharge. Additional advice and guidance should be sought thorough the Local Authority Safeguarding Team and/or Humber Safeguarding Team. Please see safeguarding-adults-policy-n-024.pdf and safeguarding-children-policy-n-045.pdf

5.11.7. Homelessness

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

A person is considered homeless if:

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

Actions to be taken:

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

5.12. Local Standard Operating Procedures

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

Mental Health
The Mental Health SOP will specifically consider:

- NICE Guidance NG53 and Quality Standard QS159 Transition between mental health setting and community or care home settings
- CPA/Section 117 aftercare requirements
- Delayed discharge
- Transfer out of area
- Self-discharge of informal patients including the completion of Z10 form
- Transfer of a deteriorating patient detained under the MHA to an acute setting (Section 17 leave requirements)

Forensic
The Forensic SOP will specifically consider:

- The terms of restriction for patient under the MHA
- Transfer and remission between forensic inpatient ~~secure~~ services and prison
- Discharge, transfer, and flow of patient through services
- Clinical Ready for Discharge and Delayed Transfer of Care
- Liaison with relevant agencies such as the Ministry of Justice, probation services, MAPPA, community care.
- The SOP will consider guidelines for the transition to community forensic services
- Transfer/discharge pathway
- CPA/Section 117 aftercare requirements
- Transfer of a deteriorating patient detained under the MHA to an acute setting (Section 17 leave requirements)

Children's and Learning Disabilities
The Learning Disabilities SOP will specifically consider:

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

The CAMHS SOP will specifically consider:

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

Community Services
The Community Services SOP will specifically consider:

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

6. Training

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

7. Dissemination and Implementation

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

8. Monitoring and Compliance

The best practice principles outlined in this policy will be monitored thorough a series of audits available on the Audit Plus module of InPhase for example The Big 5 audits (specifically Audit 1: Patient and Family Engagement (carer audit) and Audit 5: Quality of Discharge Arrangements) and local record keeping audits. Audit compliance will be monitored through divisional governance and oversight arrangements.

Admission, discharge and delayed transferred of care and CPA reviews can be analysed locally via the Power BI reports and Level 3 performance reports.

9. References/Related Trust Documents

- Infection, prevention and control Admission, Transfer and Discharge Policy (N-033)
- Medicines Reconciliation Guideline (G358)
- Patients' Property Procedure (Proc433)
- Deteriorating Patient Policy (N-062) and Protocol (Prot527)
- Safe and Secure Handling of Medicines Procedures (Proc431)
- Incident Reporting Policy and Procedure (N-038)
- Mental Capacity Act and Best Interest decision Making Policy (M-001)
- MCA Deprivation of Liberty Safeguards Policy (M-002)
- Consent Policy (N-052)
- Safeguarding Adults Policy (N-024)
- Safeguarding domestic violence and abuse policy (N-054)
- Safeguarding Children Policy and Procedure (N-045)
- Care Quality Commission (2009) 'National report: Managing patients' medicines after discharge from hospital' updated May 2022 NHS must do more to prevent harm to patients from prescribed medicines after leaving hospital, says CQC - Care Quality Commission

- Department of Health and Social care published 2020 updated April 2022 Hospital discharge service guidance - GOV.UK (www.gov.uk)
- Delayed Discharges (Continuing Care) Directions - GOV.UK (www.gov.uk)
- Department of Health (2015) NHS Continuing Healthcare Checklist published November 2012 updated May 2022 National framework for NHS continuing healthcare and NHS-funded nursing care - GOV.UK (www.gov.uk)
- Hospital discharge and community support guidance - GOV.UK (www.gov.uk)
- NICE Guidance NG53 Transition between inpatient mental health settings and community or care home settings | Guidance | NICE
- After care under the MHA 1983 Care Act 2014 - Explanatory Notes (legislation.gov.uk)
- Quality Standard QS159 Transition between inpatient mental health settings and community or care home settings (nice.org.uk)
- NICE Guideline NG49 Transition from children to adults' services for young people using health or social care services | Guidance | NICE
- Mentally disordered offenders: The Restricted Patient System 2017 - GOV.UK (www.gov.uk)
- https://www.gov.uk/government/publications/homelessness-duty-to-refer.
- NICE Guidance NG27 Transition between inpatient hospital settings and community or care home settings for adults with social care needs | Guidance | NICE
- Brief guide-discharge_planning_from_LD_assessment_treatment_or_similar_units_v2.pdf (cqc.org.uk)
- Royal College of Psychiatrist -Standards of adult inpatient learning disability services 3rd-edition
- Monthly-Delayed-Transfers-of-Care-Situation-Report-Principles-Definitions-and-Guidance.pdf

Appendix 1 – Document Control Sheet

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

Document Type	Policy		
Document Purpose	The purpose of this policy is to provide an evidence-based best practice approach to facilitate the safe discharge or transfer of patients from all in patient units within the Trust.		
Consultation:	Date:	Group / Individual	
list in right hand columns consultation groups and dates -	01-10-25	Policy review working group	
	30 October 2025	QPAS	
	22 October 2026	QPaS – minor amendment (V6.1) not a full review.	
Approving Body:	EMT	Date of Approval:	9 December 2025
Date of Board Ratification:	28 January 2026 (full review V6.0)		
Training Impact Analysis:	None [ ]	Minor [✓]	Significant [ ]
Financial Impact Analysis:	None [✓]	Minor [ ]	Significant [ ]
Capacity Impact Analysis:	None [✓]	Minor [ ]	Significant [ ]
Equality and Health Inequalities Impact Assessment (EHIIA) undertaken?	Yes [✓]	No [ ]	N/A [ ] Rationale:

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

			Guidance and reference section updated. Training section added. Monitoring section updated. Approved at QPaS (16 November 2022).
6.0	*Significant amendments* *Reference to new guidance*	*January 2026*	*Full review (3 yearly). Changed to the new Trust policy template. Added Definitions Section 3. Added roles and resposbilites of Clinical Pharmacists and Pharmacy Technicians in Section 4. Section 5 – added the 8 principles as outlined in Discharge from mental health inpatient settings - GOV.UK statutory guidance. Added in the requirements as per NHS contract and NICE guidance relating to immediate discharge letters and discharge summaries. Strengthened element relating to patient's family/carer involvement in the discharge process. Section 5.9 – Added "Where the patient is subject to restrictions under the MHA, self-discharge would be considered to be Absent Without Leave (AWOL)" and "If the patient is under the age of 18, then the person with parental responsibility will be contacted immediately and any safeguarding concerns be raised with the HTFT safeguarding team." Changed VARM to MARM process. Removed reference to Lorenzo and updated to EPR. Section 5.11 – added in sub-section relating to transfer of patients to acute hospital – urgent treatment or outpatients. Section 5.12 – added sub-section - patients with additional or specific needs. Added additional monitoring and compliance via the Big 5 audits into Section 8 and made reference to the Power BI and performance reports. Other minor changes to wording and sentence structure. Updated following comments from QPaS 30th October – additional section 5.11.6 Safegurding concerns, reference to Multi-Agency Discharge Escalation meeting page 9, and equipment provision page 8. Approved at QPaS (30 October 2025) and EMT (9 December 2025) and ratified at Board (28 January 2026).*
6.1	*Minor amendment.*	*October 2026*	Action from internal audit to make clearer the process for IDL (Immediate discharge letter) to GP within 24 hours followed by Discharge Summary to GP within a week as per NICE guidance (NG53) . HTFT refer to IDLs as Immediate Discharge **Prescriptions.** Added details to the definitions section to make clear that were we are refering to Immediate Discharge Prescription (as per HTFT naming conventions) this is equivalent to an IDL. Section 5.5 also updated - An **Immediate Discharge Prescription** must be sent to the GP within 24 hours of discharge via the EPR, followed by the Discharge Summary to the GP within 7 days . QPaS approved with the additional minor changes: Reference to ESR incorrect and changed to EPR. Review of the terminology related to clinical/medically optimised for discharge, agreed to remove reference to equipment in section 5.4 which should be reflected in local SOPs. Patients detained to Humber, section due to lapse whilst on S17 leave to the acute trust added to section 5.11.1 to mirror the physical restraint policy amendment following learning from a patient safety incident. *Approved at QPaS (22 October 2026).*

Appendix 2 – Equality and Health Inequalities Impact Assessment (EHIIA) Toolkit

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

1. Document of Process or Service Name **Discharge and Transfer Policy (N-032)**
2. EHIIA Reviewer (name, job title, base and contact details) **Sadie Milner, Patient Safety Specialist**
3. Is it a Policy, Strategy, Procedure, Process, Tender, Service or Other? **Policy**

Main Aims of the Document, Process or Service
To set out the requirements that must be met for approval, ratification and dissemination of all Humber Teaching NHS FT policies.
Please indicate in the table that follows whether the document or process has the potential to impact adversely, intentionally or unwittingly on the equality target groups contained in the proforma

Equality Target Groups	Is the document or process likely to have a potential or actual differential impact with regards to the equality target groups listed?	How have you arrived at the equality impact score?
This toolkit asks services to consider the impact on people with protected characteristics under the Equality Act 2010 as well as the impact on additional groups who may be at risk of experiencing inequalities in access, outcomes and experiences of health and care.	Equality Impact Score Positive = evidence of positive impact Neutral = little or no evidence of concern (Green) Moderate negative = some evidence of concern (Amber) High negative = significant evidence of concern (Red)	• who have you consulted with? • what have they said? • what information or data have you used? • where are the gaps in your analysis? • how will your document/process or service promote equality and diversity good practice?

Equality Target Group	Definitions (Source: Equality and Human Rights Commission, 2024)	Equality Impact Score	Evidence to support Equality Impact Score
Age	A person belonging to a particular age (for example 32-year-olds) or range of ages (for example 18- to 30-year-olds).	Neutral	Consideration for safe transfer and discharge of children and young people has been considered as part of this policy.
Disability	A person has a disability if she or he has a physical or mental impairment which has a substantial and long-term adverse effect on that person's ability to carry out normal day-to-day activities.	Neutral	Consideration for specific needs of individuals with disabilities has been considered as part of this policy.
Sex	Man/Male, Woman/Female.	Neutral	
Marriage / Civil Partnership	Marriage is a union between a man and a woman or between a same-sex couple. Same-sex couples can also have their relationships legally recognised as 'civil partnerships'. Civil partners must not be treated less favourably than married couples.	Neutral	
Pregnancy / Maternity	Pregnancy is the condition of being pregnant or expecting a baby. Maternity refers to the period after the birth and is linked to maternity leave in the employment context. In the non-work context, protection against maternity discrimination is for 26 weeks after giving birth, and this includes treating a person unfavourably because they are breastfeeding.	Neutral	Consideration for safe transfer and discharge of pregnant people has been considered as part of this policy.
Race	A race is a group of people defined by their colour, nationality (including citizenship) ethnicity or national origins. A racial group can be made up of more than one distinct racial group, such as Black British.	Neutral	

Religion or Belief	Religion refers to any religion, including a lack of religion. Belief refers to any religious or philosophical belief and includes a lack of belief. Generally, a belief should affect your life choices or the way you live for it to be included in the definition.	Neutral	
Sexual Orientation	Whether a person's sexual attraction is towards their own sex, the opposite sex or to both sexes.	Neutral	
Gender Re-assignment	Where people are proposing to undergo, or have undergone a process (or part of a process) for the purpose of reassigning the person's sex by changing physiological or other attribute of sex	Neutral	Consideration of gender identity relating to discharge and transfer as described in the Supporting Transgender Policy (N-060) has been considered as part of this policy.
Poverty	People on welfare benefits, unemployed/low-income, fuel poverty, migrants with no recourse to public funds	Neutral	
Literacy	Low literacy levels, including includes poor understanding of health and health services (health literacy) as well as poor written language skills	Neutral	Consideration for specific needs of individuals with communication barriers has been considered as part of this policy.
People with English as an additional language	People who may have limited understanding and/or ability to communicate in written or spoken English	Neutral	
Digital exclusion	People who can't or don't want to use digital technology due to cost, access to connectivity or devices, digital skills or lack of confidence or trust in digital systems	Neutral	
Inclusion health groups	People who are socially excluded, who typically experience multiple overlapping risk factors for poor health, such as poverty, violence and complex trauma. This includes:	Neutral	
	• People who experience homelessness	Neutral	Consideration for specific needs of individuals experiencing homelessness has been considered as part of this policy.
	• Drug and alcohol dependence	Neutral	
	• Vulnerable migrants	Neutral	
	• Gypsy, Roma and Traveller communities	Neutral	
	• Sex workers	Neutral	
	• People in contact with the justice system	Neutral	
	• Victims of modern slavery	Neutral	
Rurality	People who live in remote or rural locations who may have poor access to services.	Neutral	
Coastal communities	People who live in coastal communities which may experience unemployment, low educational attainment, poor social mobility, poor health outcomes and poorer access to services.	Neutral	

Carers	Carers and families of patients and service users, including unpaid carers and paid carers	Neutral	Carer contact and engagement has been considered as part of this policy
Children looked after	A child or young person who is being cared for by their local authority. They might be living in a children's home, or with foster parents, or in some other family arrangement.	Neutral	
Veterans	Anyone who has served for at least one day in Her Majesty's Armed Forces (Regular or Reserve) or Merchant Mariners who have seen duty on legally defined military operations.	Neutral	
Neurodivergence	People with alternative thinking styles such as autism, attention deficit hyperactivity disorder, dyslexia, developmental co-ordination disorder (dyspraxia), dyscalculia.	Neutral	Consideration for individuals with specific needs including autism has been considered as part of this policy.
Other	Any other groups not specified in this toolkit who may be positively or negatively impacted	Neutral	

Summary

Please describe the main points/actions arising from your assessment that supports your decision above Section 5.11.2 outlines the requirement for additional considerations to be made in relation to discharge and transfer for patient who may otherwise be negatively impacted.	
EIA Review: Sadie Milner	
Date Completed: 18-10-25	**Signature:** S.K.Milner