Leaving Hospital Integrated Care System Policy

Document control			
Title:	LEAVING HOSPITAL INTEGREATED CARE SYSTEM POLICY		
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Document summary	
Purpose:	The overarching aim of this policy is to ensure timely discharge of patients leaving hospital, through early engagement, support, and the implementation of a fair and transparent escalation process. To prevent any patient who is ready for discharge remaining in hospital bed: • Exposure to any unnecessary risk of hospital acquired infection. • Physical decline and loss of mobility / muscle use • Frustration and distress to the patient and relatives due to uncertainty during any wait for a preferred choice to become available • Increased patient independence, as the hospital environment is not designed to meet the needs of people who no longer require acute treatment • Severely ill patients being unable to access services due to beds being occupied by patients who are medically optimised and can leave hospital
Key information:	Patients and families can find it difficult to make decisions and/or make the practical arrangements for a range of reasons. The Hospital Discharge Patient Leaflet is required to be given to the patient as soon as they are admitted to hospital.
Specific colleagues/ teams:	This policy applies in relation to adults being discharged from acute hospitals and community rehabilitation units in BSW, excluding maternity patients. Discharges from mental health hospitals are not within the scope of this guidance. However mental health trusts are encouraged to embed some of the principles, adapted for mental health care pathways. Separate national guidance will be published for those being discharged from mental health settings in due course.
Tables/ Flowcharts:	All discharge SOPs in appendices

1. Introduction and purpose

The Leaving Hospital Policy sets out how Acute and Community Hospitals and Local Authorities can plan and deliver hospital discharge. It applies to NHS bodies and local authorities exercising health and adult social care functions in England and should be used to inform local service planning and delivery.

BSW partners recognises that to facilitate a smooth discharge from care in hospital to care in the community, the discharge plan must be well defined, prepared and agreed with each individual patient. To allow sufficient time for suitable and safe arrangements to be made, discharge planning should begin on admission, or at pre-admission clinics, with an expected date of discharge (EDD) being identified within 48 hours of admission and communicated to patients and, if appropriate, their paid or unpaid carers and their relatives.

This policy is written in accordance with the NHS and Community Care Act 93/98, the Department of Health Discharge from Hospital: Pathways, Process and Practice (2003), The Care Act (Community) (2014), NHS Continuing Care and NHS Funded Nursing Care (2013) and Achieving Simple, Timely Discharge from Hospital (2004) (refer to Section 8). The principles of discharge apply to all patients who have stayed, for however long, in the Trust. However, there are some departments that may have specific processes.

This policy identifies the roles of those involved in the discharge of patients and guides the reader through the processes of discharge. It has long been recognised that collaborative working and good communication between agencies are key in ensuring that people needing care have the supporting services they need at home or elsewhere. The aim of this policy is to ensure that all agencies involved in the provision of social, nursing or medical care work together to deliver an effective, smoothly co-ordinated service that meets the needs of its users, patients, paid and unpaid carers and families.

This policy applies to individuals (and their representatives) who have finished their treatment, are fit for discharge and are safe to transfer (as per the Care Act 2014 definition).

Over-riding principles include:

• Right patient, right place, right care.

• Home first (wherever possible).

• Person - centred and a maximising independence approach.

• Releasing time to care. • Reduced duplication of assessment through Trusted Assessor/Professional.

This policy applies in relation to adults being discharged from acute hospitals and community rehabilitation units in England, excluding maternity patients.

Discharges from mental health hospitals are not within the scope of this guidance. However mental health trusts are encouraged to embed some of the principles, adapted for mental health care pathways. Separate guidance will be published for those being discharged from mental health settings in due course.

From the outset of a patient's admission, the multidisciplinary team leading their care, plus the patient, their family and paid or unpaid carers, all need to have a clear expectation of what is going to happen during their stay. Reducing unnecessary patient waiting should be a priority for all teams, with a patient's time being viewed as the most important currency in healthcare.

2. Scope and definitions

2.1 Scope

This document applies to any health or social care employee, who is working in an acute or community bed setting. Systems should work together across health and social care to jointly plan, commission, and deliver discharge services that are affordable within existing budgets available to NHS commissioners and local authorities, pooling resources where appropriate.

Patients should be supported to be discharged to the right place, at the right time, and with the right support that maximises their independence and leads to the best possible sustainable outcomes

2.2 Definitions

- When someone is discharged from hospital they are officially allowed to leave, or told they must leave
- An official release from hospital care from a medical care facility by a medical care worker
- Discharge from the hospital is the point at which the patient leaves the hospital and either returns home or is transferred to another facility such as one for rehabilitation or discharge to assess (D2A)

3. Process / requirements

3. PRINCIPLES

3.1 In the first instance all possible efforts should be made to support people to return to their pre-admission location. Supporting patients to return home instead of residential placements, with options around home care packages and housing adaptations to be considered.

3.2 Patients will not make decisions about their long-term future while in hospital: Home First, reablement or intermediate care or other supportive options should be explored first, where that is appropriate to their needs.

3.3 Patients should be provided with information, advice and support in a form that is accessible to them as early as possible before or on admission and throughout their stay.

3.4 Many patients will want to involve others to support them, such as family or friends or paid or unpaid carers. Where the patient has capacity to make their own decisions about confidentiality and information sharing, confidential information about the patient should only be shared with those others with the patient's consent.

3.5 If a patient is not willing to accept any of the available, appropriate alternatives, then it may be that they are discharged, after being advised of the risks and consequences of doing so.

3.6 If a person's preferred placement or package is not available once they are clinically ready for discharge, they should be offered a suitable alternative while they await availability of their preferred choice. People do not have the right to remain in a hospital bed if they do not need acute care, including to wait for their preferred option to become available.

3.7 Under the Discharge to assess, home first approach to hospital discharge, the vast majority of patients are expected to go home (to their usual place of residence) following discharge. The discharge to assess model is built on evidence that the most effective way to support people is to ensure they are discharged safely when they are clinically ready, with timely and appropriate recovery support if needed. An assessment of longer-term or end of life care needs should take place once they have reached a point of recovery, where it is possible to make an accurate assessment of their longer-term needs.

3.8 The discharge processes should be clearly explained to patients and their families/paid and unpaid carers on the 'discharge to assess, home first' approach.

3.9 Patients who would normally fund their own care will be identified in hospital and supported to make informed choices about their care arrangements. If they have a need for a Care Act assessment and an ability to regain skills and confidence in the interim period, they will be given the option to go through the funded reablement pathway. Patients with health needs, and the potential for gaining skills, may also be supported by community health provider's post-discharge.

3.10 Planning for discharge from hospital should begin on admission. Where patients are undergoing elective procedures, this planning should start pre-admission, with plans reviewed before discharge. This will enable the person and their family or paid or unpaid carers to ask questions, explore choices and receive timely information to make informed choices about the discharge pathway that best meets the person's needs.

3.11 Health and care professionals who are facilitating hospital discharges should work together with individuals, and – where relevant – families and unpaid carers, to discharge

people to the setting that best meets their needs. This process should be person-centred, strengths-based, and driven by choice, dignity, and respect. There is a duty on NHS hospital trusts to ensure that unpaid carers of all ages are involved as soon as feasible when plans for patient's discharge are being made.

3.12 Patients should be discharged to a familiar setting where possible, as they often respond well to the familiarity of their home environment when it is appropriate for supporting their needs.

3.13 Patients in hospital should be supported to participate actively in making informed choices about their care, including, for people who fund their own care, the potential longer-term financial impact of different care options after discharge. These conversations should begin early in a hospital stay, and not when a person is ready to be discharged. This should also include, where appropriate, information about housing options (adaptation of the existing home and possible alternative housing, for example supported living).

3.14 Where an individual wishes to return home and their family member or unpaid carer is unwilling or unable to provide the care needed, NHS bodies, local authorities and care providers should work together to assess and provide the appropriate health and care provision required to facilitate the individual's choice, where possible, and enable a safe discharge.

3.15 Key to enabling choice while preventing delays is early and ongoing discharge planning conversations between healthcare professionals and patients and their families and unpaid carers, following the principles of personalised care.

3.16 If a patients preferred care placement or package is not available once they are clinically ready for discharge, an available alternative, or alternatives appropriate for their short-term recovery needs should be offered, while they await availability of their preferred choice. People do not have the right to remain in a hospital bed if they no longer require acute care, including to wait for their preferred option to become available

4. MANAGING EXPECTATIONS OF PATIENTS

4.1 By the time the patient is clinically ready for transfer of care they and/or their representative should understand that they cannot continue to occupy the inpatient bed.

4.2 The Multi-Disciplinary Team (MDT) will work jointly to offer advice and support to the patient and/or representative and to involve them as appropriate to support leaving hospital. The MDT will maintain communication with patients and/or their representatives to manage expectations. It is important that the patient and/or their representative understand discharge planning.

4.3 Everyone should have the opportunity to recover and rehabilitate at home (wherever possible) before their long-term health and care needs and options are assessed and agreed.

4.4 This approach reduces exposure to risks such as hospital-acquired infections, falls and loss of physical and cognitive function by reducing time in hospital, and enables patients to regain or achieve maximum independence as soon as possible.

4.5 While NHS organisations should seek to offer choice to patients where such choice exists, in practice, there may be limited situations where an NHS organisation may decide to reduce the choice of services offered to patients on discharge. Such situations include times of extreme operational pressures, for example, for the duration of the UK COVID-19 Level 4 National Incident. A record should be produced of the considerations of the relevant discharging body in deciding to offer that patient a reduced choice, setting out all of the material considerations for and against doing so, and the balancing exercise between the patient choice duty in the NHS Act 2006, and relevant competing duties and countervailing factors.

4.6 From the outset patients should be asked who they wish to be involved and/or informed in discussions and decisions about their hospital discharge, and appropriate consent received. This may include a patient's family members (including their next of kin), friends or neighbours, some of whom would be considered unpaid carers. Paid care workers and personal assistants may also be included. The person or people identified at this stage, including any unpaid carers, may be wider than a person's next of kin. A patient who does not have family or friends to help, or who may find it difficult to understand, communicate or speak up, should be informed of their right to an independent advocate.

4.7 Only in exceptional circumstances should someone be considered to need long-term care at the point of discharge

4.8 Where there is disagreement between a patient and their unpaid carers or family members, and the patient is deemed by the appropriate professional to have capacity to make decisions relevant to their discharge, the patients right to make these decisions should be respected.

5 Specific roles, structures, and responsibilities

5.1 Health and social care services based around our hospital should have an identified executive lead, employed by any partner in the system, to provide strategic oversight of the discharge process. They should ensure that appropriate procedures are followed, including the inclusion and support of paid and unpaid carers, and that there are no avoidable delays to discharge.

5.2 BSW ICB has a Head of System Flow role who acts on behalf of the system to secure safe and timely discharge on the appropriate pathways for all individuals. This system leadership role has a primary function which is to develop a shared system view of

discharge, hold all parts of the system to account and drive the actions that should be taken as a system to address shared challenges.

5.3 multi-disciplinary hospital discharge teams and transfer of care hubs, comprising professionals from all relevant services across sectors (such as health, social care, housing, and the voluntary sector), will work together so that, other than in exceptional circumstances, no one should transfer permanently into a care home for the first time directly following an acute hospital admission.

5.4 The multi-disciplinary team should also ensure that any mental capacity and safeguarding concerns have been considered alongside other support needs post-discharge.

5.5 Senior level support from NHS providers and local authorities should provide strategic leadership and oversight of the discharge process to monitor and eliminate the causes of unnecessary discharge delays and ensure that the agreed hospital discharge procedures are being followed consistently.

5.6 Case Managers should also make arrangements for all persons leaving hospital with ongoing health and care needs to have an initial safety and welfare check on the day of discharge to ensure basic safety and care needs are met and allow time for fuller assessments to take place as the person settles.

6 Best practice

To implement best practice, NHS bodies and local authorities should work together to:

6.1 determine what the patient needs and wants after discharge, if anything, so that they are discharged onto the pathway that best meets their needs

6.2 appropriately refer qualifying patients to independent advocacy services on admission, so their voice is heard during the discharge planning process

6.3 appropriately refer the patient's unpaid carer to carers support services

6.4 plan, commission and deliver appropriate care and support that meets population needs and is affordable within existing budgets available to NHS commissioners and local authorities

6.5 understand the quality, cost and effectiveness of local treatment, care, and support to inform patients of their options

6.6 understand the role each organisation has in safeguarding and put appropriate safeguarding policies and procedures in place

6.7 take joint responsibility for the individual's and unpaid carers, including young carers, welfare when making decisions about discharge and post-discharge support

6.8 transfer patients seamlessly and safely from hospital to their own home or new care setting with joined up care, via clear, evidence-based and accurate assessments that fully represent the medical and psychological needs and social preferences of the patient

6.9 transfer information between settings in a timely way

6.10 identify any carers, including young carers, and determine whether any carer is willing and able to provide care and, if so, what support they might need (including through use of young carers' needs assessments)

7 Escalation

7.1 BSW have an agreed escalation process as per the Flow Operating Model. Our Health and social care system has escalation mechanisms for people with concerns about care and support that are clearly communicated to people using services, their families, their unpaid carers and advocates, and service providers.

8 Palliative and end of life care needs should be anticipated and met as part of an individual's discharge journey

8.1 Priority consideration will be given to patients who have palliative care needs, including those who are nearing the end of their life. Health and social care partners should work together to provide appropriate rehabilitation and reablement support from palliative and end of life specialist services and voluntary organisations. This may include support to maximise the individual's independence or meet other personal goals.

8.2 Patients receiving palliative or end of life care should be supported to, where possible, recover from the incident that resulted in them being admitted to the acute hospital. They should receive appropriate and compassionate support from specialist organisations post-discharge to continue living the remainder of their time with dignity and as fully as possible.

8.3 Patients who are recognised as likely to be in their last year of life may also benefit from further support such as benefits advice and equipment. Systems should have regard to the National framework for NHS continuing healthcare and NHS-funded nursing care for those individuals where an appropriate clinician has decided that an individual has a primary health need arising from a rapidly deteriorating condition and the condition may be entering a terminal phase.

8.4 Health and care providers should collaborate to minimise common issues that may disrupt end of life care during the interim care period. This includes access to medication and support, or trained professionals to administer them where necessary, and access to

24-hour nursing care and support to talk through the patients wishes and preferences. Everyone's care journey should be anticipated and mapped out, including advanced care planning, to ensure they can move through a seamless pathway to end of life care, without unnecessary disruption.

9 Mental capacity, advocacy, and special arrangements for discharge

9.1 Mental capacity should be assessed on a decision-specific basis. If there is a reason to believe a patient may lack the mental capacity to make relevant decisions about their discharge arrangements at the time the decisions need to be made, a capacity assessment should be carried out as part of the discharge planning process. Where the person is assessed to lack the relevant mental capacity to decide about discharge, a best interest's decision must be made in line with the Mental Capacity Act 2005 and usual processes. No one should be discharged to somewhere assessed to be unsafe, and the decision maker must make the best interests decision.

9.2 Onward care and support options which are not suitable (for example, those not considered clinically appropriate) or available (for example, placements which are not available) at the time of hospital discharge should not be considered in either mental capacity assessments or 'best interests' decision making. Just as a patient with capacity does not have a right to remain in a hospital bed if they no longer require acute care, neither is this an option for a patient who lacks the mental capacity to make the discharge decision.

9.3 During discharge planning, health and care providers should continue to meet their responsibilities regarding Deprivation of Liberty Safeguards, where appropriate. This is especially the case for, but not limited to, patients with a learning disability, dementia, acquired brain injury or people currently lacking capacity to make decisions about their mental health treatment. This includes carrying out a capacity assessment before a decision about discharge is made if there is reason to believe a patient may lack the mental capacity to consent to their discharge arrangements which amount to a deprivation of liberty.

9.4 Any decision by the decision maker must be taken specifically for each patient and not for groups of people. The Deprivation of Liberty Safeguards – code of practice outlines further information in relation to mental capacity.

9.5 It may be appropriate for an independent advocate to support a patient during the discharge planning process, and in some cases, this may be a legal requirement. Advocates are independent from the NHS and local authority and are trained to help people understand their rights and options, express their views, and wishes, and help make sure their voice is heard. Advocates play a vital role for people including but not limited to people with a learning disability, dementia, acquired brain injury or people currently lacking capacity to make decisions about their mental health treatment.

Referrals to independent advocacy services should be made as soon as discharge planning begins and ideally upon admission.

10 Equality and diversity

10.1 All public bodies have a statutory duty under The Equality Act 2010 (Statutory Duties) Regulations 2011 to provide "evidence of analysis it undertook to establish whether its policies and practices would further, or had furthered, the aims set out in section 149(1) of the [Equality Act 2010]"; in effect to undertake equality impact assessments on all procedural documents and practices.

10.2 An Equality Impact Assessment (EIA) has been completed for this policy and no significant issues were identified.

10.3 Ensure that the EIA accompanies the policy for approval and, where appropriate, is then published.

Links and access to resources:

Hospital discharge and Community support guidance – GOV UK

https://www.gov.uk/government/publications/hospital-discharge-service-action-cards/hospital-discharge-service-requirements-action-cards-for-staff

https://www.legislation.gov.uk/ukpga/1983/20/section/117

https://www.legislation.gov.uk/ukpga/1989/41/contents

https://www.legislation.gov.uk/ukpga/2014/23/contents/enacted

https://www.legislation.gov.uk/ukpga/2006/41/section/13I

https://www.lgo.org.uk/

https://www.gov.uk/government/publications/national-framework-for-nhs-continuing-healthcare-and-nhs-funded-nursing-care

https://www.ombudsman.org.uk/

https://www.nhs.uk/nhs-services/hospitals/what-is-pals-patient-advice-and-liaison-service/

https://www.legislation.gov.uk/ukpga/2017/13/contents/enacted

https://www.legislation.gov.uk/ukpga/1983/20/contents

https://www.gov.uk/government/publications/national-framework-for-nhs-continuing-healthcare-and-nhs-funded-nursing-care

https://www.legislation.gov.uk/uksi/2012/2996/contents/made

https://www.cqc.org.uk/sites/default/files/Deprivation%20of%20liberty%20safeguards%20code%20of%20practice.pdf

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1003627/Hospital_Discharge_Patient_Leaflets_v1.8.pdf

https://www.whatmatterstoyou.scot/

Optimising Timely DischargeWebinar Series 010222 030222 - ECIST Network - FutureNHS Collaboration Platform

Optimising Timely Discharge Webinar Series - Accelerated Discharge - ECIST Network - FutureNHS Collaboration Platform

Reducing delays in hospital transfers of care for older people - key messages in planning and commissioning (2019) (brookes.ac.uk)

Improving transfer of care (nice.org.uk)

Delayed discharge: how are services and patients being affected? | The BMJ

Delayed hospital handovers: Impact assessment of patient harm (November 2021) (aace.org.uk)

12. Links with other ICB documents

List documents in alphabetical order that impact directly on this document (Parent), or documents that rely on this document (Child).

Policy title, hyperlink [BSW intranet or BSW ICB website].

HM Government

NHS

Looking after family or friends after they leave hospital?

This leaflet lists useful advice for family and friends of people needing ongoing care or support with day-to-day life.

What kind of support could you give someone

Support may be in the home or remotely (e.g. by phone), such as:

- **Emotional support** like helping someone manage anxiety or mental health;
- **Housework** like cooking, cleaning or other chores;
- **Personal support** like help moving around, washing, eating or getting dressed;
- **Assistance with getting essential items** like medicine or food; or
- **Help to manage money, paid care or other services**

If you are not able to care, and/or need help, then you have a right to a carer's assessment to have your needs considered too.

Check what your council or local authority can offer. Find their websites using the online postcode tool at www.gov.uk/find-local-council. Services may change during the pandemic.

What to consider if you are looking after someone

1. Get help from others with caring and everyday tasks:

- **Go to the Carers UK and Carers Trust websites** for information about support available. Carers UK also have an online forum where you can speak to other carers, and a free helpline, open Monday to Friday, 9am to 6pm on **0808 808 7777**. Carers UK website: www.carersuk.org/

See over…

HM Government

NHS

Planning together: leaving hospital when the time is right

This leaflet explains why it is important to start planning for you to leave hospital.

Why are we starting to plan for me to leave hospital?

Our top priority is to help you get better and support you to leave hospital when the time is right. You will only leave hospital when you no longer need hospital care and it is safe to do so. It is important that, together, we start planning right away to ensure you leave hospital in a safe and timely manner.

In most cases, you will return home. You might need some additional care to help you in your recovery, or practical support such as help with shopping. If you are a care home resident you will most likely return to your care home. If you require more complex care and support this could be in another bed in a community setting.

What might I expect?

Early conversations – Soon after you arrive in hospital we will discuss and plan how you will be able to leave. We will involve your carers, family and/or friends in conversations if you would like them to be included.

'Expected date of discharge' – Soon after you arrive in hospital you will be given an 'expected date of discharge' (expected date you will leave hospital) which will be reviewed during your stay.

What matters most to you to be considered – The team caring for you will ask 'what matters most to you?'. They will ensure this is considered when planning for you to leave hospital.

Questions to ask during your hospital stay:

1. What is the main reason I am in hospital for?
2. What is going to happen to me today and tomorrow?
3. What extra help might I need when I leave hospital?
4. When will I be able to leave hospital?

HM Government

NHS

You are leaving hospital: moving or returning to another place of care

This leaflet explains why you are leaving hospital and what you might expect after you have left.

Why am I leaving hospital?

The team caring for you have agreed that you no longer need hospital care and it is safe for you to move to another place of care to continue your recovery.

Why can't I stay in hospital?

When you no longer need hospital care, it is better to continue your recovery out of hospital. Staying in hospital for longer than necessary may reduce your independence, result in you losing muscle strength or expose you to infection. Leaving hospital when you are ready is not only best for you but will free-up a bed for someone who is very unwell.

Our top priority is to ensure you are in the right place at the right time for the best recovery possible. The best place for you right now is a bed in the community which can best meet your needs at this time. If you are a care home resident this will most likely be your care home.

What might I expect?

The team caring for you will discuss transport and other arrangements with you (and your carers, family and/or friends if you wish). If you have coronavirus you will be provided with relevant advice.

If you need more care and support now than when you came into hospital, the team caring for you will discuss options for how you receive that care and support following discharge. The team will also discuss when you should be assessed for the provision of any long-term care and support. You may be required to contribute towards the cost of your care and support, if you need it.

Who can I contact?

After you have left hospital, if you need to speak to someone, please contact:

HM Government

NHS

You are leaving hospital: returning home

This leaflet explains why you are leaving hospital and what you might expect after you have left.

Why am I leaving hospital?

The team caring for you have agreed that you no longer need hospital care and it is safe for you to return home to continue your recovery.

Why can't I stay in hospital?

When you no longer need hospital care, it is better to continue your recovery out of hospital. Staying in hospital for longer than necessary may reduce your independence, result in you losing muscle strength or expose you to infection. Leaving hospital when you are ready is not only best for you but will free-up a bed for someone who is very unwell.

Our top priority is to ensure you are in the right place at the right time for the best recovery possible. The best place for you right now is at home where you can continue to recover in a familiar environment.

What might I expect?

The team caring for you will discuss transport and other arrangements with you (and your carers, family and/or friends if you wish). If you have coronavirus you will be provided with relevant advice.

If you need more care and support now than when you came into hospital, the team caring for you will discuss options for how you receive that care and support following discharge. The team will also discuss when you should be assessed for the provision of any long-term care and support. You may be required to contribute towards the cost of your care and support, if you need it.

Who can I contact?

After you have left hospital, if you need to speak to someone, please contact: