Discharge and Transfer Policy

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July-Oct 2021	Project Manager, Unscheduled Care, NHS Lothian Home First Medical Advisor, Edinburgh Health & Social Care Partnership	v1.1-1.6	Under review and development
November – December 2021	Project Manager, Unscheduled Care, NHS Lothian Home First Medical Advisor, Edinburgh HSCP	v1.7	Under review/development following Consultation Zone and Discharge without Delay Scottish Government Guidance
February 2022	Project Manager, Unscheduled Care, NHS Lothian Home First Medical Advisor, Edinburgh HSCP	v1.8	Reviewed and fully updated following additional Consultation period
March 2022	As above	v2.0	Approved by the Policy Approval Group

Executive Summary

This updated Discharge and Transfer Policy has now been written to embrace our integrated working relationships between NHS Lothian Health Board teams and Health and Social Care Partnerships. The detail within the policy defines a collaborative approach to enable and ensure consistent, timely and effective discharge and transfer processes for the residents of Lothian.

Discharge planning is a process and not an isolated event, and those involved should understand the various elements which need to be carried out in parallel, not in sequence, to ensure timely discharge or transfer of care. This process needs to be managed seven days a week and should involve patients, relatives, carers and health and social care teams.

The purpose of this policy is to support the co-ordinated, safe and timely discharge or transfer of care of all NHS Lothian in-patients to their home, homely environment or other healthcare setting with the adoption of Lothian's Home First principles.

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Contents

1.0 Purpose

The purpose of this policy is to support the co-ordinated, safe and timely discharge or transfer of care of all NHS Lothian in-patients to their home, homely environment or other healthcare setting with the adoption of Lothian's Home First principles.

It has been developed as a Pan-Lothian policy, applicable to health and now also social care colleagues across Lothian, to promote a whole system approach because discharge should not be seen in isolation; it is a part of a journey that starts even before admission. A cultural shift is required whereby we work together to ensure only patients who cannot be supported in the community by intermediate care services, primary care and/or third sector organisations are admitted for as short a time as possible and with a reabling approach throughout their journey. Keeping patients in hospital trying to make them 'a little bit better' or 'back to baseline' before discharge is unlikely to improve physical or mental capabilities, may in fact worsen outcomes, and fails to recognise that people can continue their recovery at home. This is especially important for older people who can be harmed by an admission which may end up being longer than necessary and lead to greater dependency.

Everybody should be supported to recover in their own home or in a homely setting, and transfers directly from acute hospital care to long-term residential care should be avoided wherever possible. Ideally, any assessment of long-term needs will be carried out in the individual's own home where people are surrounded by their own belongings in a familiar environment. Where intermediate care beds are available, clear admission criteria should exist in order that these are dedicated for people who may be able to return home after a period of rehabilitation.

This policy should be read in conjunction with the associated materials in section 6.0 and consideration must be given to any relevant future national guidance on the discharge and transfer of patients.

2.0 Policy statement

Appropriate, timely discharge planning is fundamental to the provision of effective health care and enhances the patient's, and their relatives/carer's, experience. Poor 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; patient and carer distress; as well as increased workloads for hospital and community staff. Furthermore, late decision making and planning creates a negative cycle whereby even patients with simple discharge requirements leave hospital later in the day and those beds are not available for the daytime peak in demand; thus resulting 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 and not an isolated event, and those involved should understand the various elements which need to be carried out in parallel, not in sequence, to ensure timely discharge or transfer of care. This process needs to be managed seven days a week and should involve patients, relatives, carers and health and social care teams.

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 negatively affect admission and discharge rates and increase length of stay. All discharges and transfers should be criteria led so that any member of the multidisciplinary can finalise the discharge. This will also facilitate early morning 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.

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.

For the majority of patients discharge from hospital is simple and uncomplicated. For a minority of patients their needs are 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 (TEC).

Lothian Home First Approach

The discharge of NHS Lothian patients will follow a Lothian Home First approach with the following guiding principles;

- We will always ensure people are on the best pathway available, with care being delivered as close to home as possible
- We will ask every person 'What matters to you?', to understand the person in the context of their own life and the things that are most important to them and, wherever possible, treat everyone receiving care as an equal partner able to make choices about their own care ('no decision about me without me')
- We will make sure that assessment of health and care needs are determined by the most appropriate professional at the most appropriate time
- We will embrace the principles of Realistic Medicine. We know that both overuse and underuse of investigation and treatment can result in harm to people
- We will ensure that people stay in hospital when there are clinical needs that can only be met in hospital and, at the earliest opportunity, the person should return home or to a homely setting
- We will ensure that all discharges and transfers of care are planned and co-ordinated, with planning beginning as soon as someone is admitted to hospital. There will be early shared conversations between acute teams, community teams and patients and families/carers, with clear expectations that getting home or to a homely setting is the goal
- We will not make life-changing decisions about long term care in times of acute crisis

The Pathways Planning Model

The Pathways Planning Model developed by NHS Scotland Centre for Sustainable Delivery builds on the Daily Dynamic Discharge approach and describes four pathways. Each pathway requires early discharge planning and as the complexity increases so does the requirement to strengthen the whole system approach to decision-making and planning.

1. Simple Discharge – no ongoing health and social care needs
2. Moderately Complex Discharge – known to Social Care, may need some input
3. Complex Discharge – likely to require significant Social Care input
4. End of Life – should follow a 'fast track' pathway

More detailed information can be found in Discharge without Delay: A Best Practice Discussion Paper (Centre for Sustainable Delivery, NHS Scotland, 2021).

3.0 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 Lothian, including hospitals, intermediate care facilities and hospital based complex clinical care units. 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 the 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.

4.0 Definitions

Criteria Led Discharge: This approach empowers members of the multidisciplinary team to finalise a patient's discharge without relying on one last review by the most senior responsible clinician or on-call medical team. It utilises patient-specific Clinical Criteria for Discharge to ensure the entire team, including the patient, is aware of what needs to happen before that patient can leave the hospital.

Clinical Criteria for Discharge: This is the minimum physiological, therapeutic and functional status the patient needs to achieve before discharge. It should be agreed with the patient and carers where appropriate. It should not be stated as 'back to baseline' as it is important to anticipate that patients continue to recover at home with or without support.

Clinically ready for discharge or transfer: When all clinical specialties consider the patient to be fit for ongoing assessment, recovery and rehabilitation or treatment in a home based or bed based non acute community setting. In general this would identify patients that do not have any further need for acute intervention.

Complex Discharge: These patients tend to have more complex needs such as multi-morbidity or frailty and need additional input from other professionals. Early collaboration between the hospital and health and social care partnerships is crucial to avoid unnecessary delays to discharge.

Daily Dynamic Discharge: The Daily Dynamic Discharge approach is a key element of the Scottish Government 6 Essential Actions. It aims to improve the timeliness and quality of

patient care by planning and progressing, in parallel, all treatment and necessary tasks to ensure the patient can be discharged without delay.

Delayed Discharge: A delayed discharge occurs when a patient, clinically ready for discharge or transfer, cannot leave hospital and continues to occupy a hospital bed because the other necessary care, support or accommodation for them is not available on their planned date of discharge.

Discharge: This is the point when inpatient care ends and the patient either returns home or is transferred to another setting for ongoing rehabilitation or care.

Discharge to Assess: A service where people who are clinically ready for transfer and do not require an acute hospital bed may still require short term support to be discharged to their own home (where appropriate) or another community setting, or in order to assess what longer term needs they may have.

Discharge without Delay (DwD): The Discharge without Delay approach aims to reduce delay in every patient journey by whole-system planning and preparation for discharge and adopting 'home first' with 'discharge to assess' as good practice.

More detailed information can be found in Discharge without Delay: A Best Practice Discussion Paper (Centre for Sustainable Delivery, NHS Scotland, 2021).

Estimated Date of Discharge (EDD): The estimated date of discharge (EDD) is the date when the admitting clinician/clinical team believes they can safely discharge a patient to their home or another place of care.

Front Door: A department/ward of acute hospital where patients are assessed prior to being admitted.

Health and Social Care Partnerships: Local authorities and health boards working together in partnership to plan and deliver adult community health and social care services, including services for older people.

Multidisciplinary Team (MDT): The multi-disciplinary team includes all professions relevant to individual patient care. This includes, but is not limited to, doctors, nurses, allied health professionals, specialist nurses/services, social care workers and voluntary workers.

Planned Date of Discharge (PDD): The date a patient is expected to be clinically ready for discharge or transfer which health and social care teams will use when making arrangements to help the patient leave their current healthcare setting.

Reablement: A service for people with poor physical or mental health to help them accommodate their illness by learning or re-learning the skills necessary for daily living.

Simple Discharge: Simple discharges are those which can be carried out at ward level by the multidisciplinary team. These form the majority of discharges.

Technology Enabled Care (TEC): These services utilise telehealth, telecare, telemedicine and tele coaching to provide convenient, accessible and cost-effective care and support for people in the community.

5.0 Implementation roles and responsibilities

5.1 Planned Date of Discharge (PDD)

NHS Lothian recognises that previous guidance will have advocated the early setting of an Estimated Date of Discharge (EDD). The EDD is often set at the point of admission to the ward before the patient has been seen by the MDT and interventions required in hospital clarified. This means it is often not a helpful date around which discharge plans can be made. In keeping with Scottish Government recommendations, the change of practice will incorporate a move from EDD to PDD – Planned Date of Discharge. This is not just a change of terminology. A cultural shift is required for the health and social care system to collaborate effectively and alongside the patient, family and carers so that early planning for discharge becomes the norm.

A planned date of discharge should be set within the agreed timeframe within each ward and department (no later than 48hrs after admission). The information collated prior to or on admission is critical in providing a focus to enhance patient care and the patient experience. The planned date of discharge should be reviewed daily by the MDT or a senior member of the clinical team involved in the patient's care in line with local discharge and transfer standard operating procedures.

Patients who have exceeded their PDD and are clinically ready for discharge or transfer will be recorded as 'delayed'.

5.2 Daily Discharge Conference Call

Patients requiring coordination across acute and community settings should be discussed at the Daily Discharge Conference Call (these are typically adult inpatients). These meetings will enable system-wide discussion of patients who can be supported elsewhere by alternative pathways (often avoiding an unnecessary admission at front door, patients who have exceeded their PDD, and patients for whom any potential barriers to discharge have been identified in any part of the system.

These meetings are expected to be Partnership-led or system led by Partnership area with appropriate senior oversight and accountability from acute sites to ensure a route for escalation of problems (for example around the setting of PDDs by wards). All members or a nominated delegate must come prepared with person and service level updates to enable real-time decision-making and should proactively raise potential issues which the daily discharge conference team can work collectively to resolve.

The frequency, format and attendance will be agreed locally and detailed in local standard operating procedures.

5.3 Children & Young People

Patients in the Royal Hospital for Children and Young People (RHCYP) will be discharged to the care of a parent(s) or carer that could either be another family member or local authority carer (foster care/residential). The majority of RHCYP inpatients stay/discharges are simple discharges.

Planning is required to develop a bespoke package of care for a child or young person with multiple and complex healthcare needs that have a major impact on health, welfare and development. Multi-disciplinary and multi-agency planning is necessary to ensure a safe transition from hospital to home, and maintain effective long-term support for the child and family.

The discharge is planned and managed by ward staff in partnership with the Discharge Liaison Nurse (DLN) and specialist teams that include the lead clinicians and AHP's. Social Work and Education staff would be included where appropriate. Working in partnership with parent(s)/carers, discharge-planning priorities are identified as actions with timescales.

A very small number of children/young people with exceptional health care needs will require continuing care: where one-to-one home care from trained staff is required for all or part of the time, to meet healthcare needs and ensure safety. Early identification is critical in avoiding discharge delay for these children.

When a child or young person living within Lothian is identified as 'exceptional' then a referral to the Lothian Exceptional Needs Support Group (LENS) is completed. The DLN is referred children and young people from other health boards where policies and processes can be different for bespoke packages of care.

5.4 Involving People

'People' includes patients, family members, friends, carers and guardians.

As part of the delivery of high quality person-centred care, the appropriate people should be involved from the outset; kept informed of any changes to care and treatment; and included in discharge decision making with the appropriate Patient Information leaflet being provided early in the admission. The Carers (Scotland) Act 2016 specifies that discussions must involve carers before a cared for person is discharged or transferred from hospital.

All staff members should be able to have sensitive and helpful discussions with consistent messaging explaining the benefits of hospital treatment, the harms of prolonged hospital stays and that remaining unnecessarily in hospital is not a choice that people have. Guidance within CEL 32 from 2013 remains valid (see Associated Materials).

Discharge planning must take into account the strengths, goals and expectations of people who will be asked to consider what matters most to them and what needs to be in place for them to return home on their planned date of discharge. Staff are expected, where appropriate, to liaise with the patient's family, friends to arrange informal transport and ensure the home is accessible and ready for their return.

5.4.1 Patients with incapacity and the decision making process

When people are clinically well enough to leave hospital, they should receive all necessary information and support to return to their home, whether that is their own house or an alternative community setting which is their home. It is not in anyone's interests to stay in hospital when there is no clinical reason to do so.

When a patient appears to lack capacity to make decisions about their discharge or ongoing care requirements, they should be appropriately assessed as soon as possible under the

definitions in the Adults with Incapacity Act. Someone may only be judged to lack capacity if 'Supported Decision Making' cannot be used to support that person to make the decision for themselves. Examples of Supported Decision Making are found in the Good Practice Guide: Supported Decision Making (Mental Welfare Commission for Scotland, 2016).

For those people who do not have the capacity to fully participate in discharge planning processes, legal frameworks must be considered to ensure appropriate lawful authority and respect for the person's rights. There are three commonly used frameworks:

- Welfare Power of Attorney (PoA) – The certified PoA document must be provided by the person claiming the Power to confirm validity under the current circumstances
- Section 13ZA - This allows a local authority to use Section 13ZA of the Social Work (Scotland) Act 1968 to make significant care arrangements for a person's discharge where they are not capable of making that decision
- Welfare Guardianship - If there is no Welfare Attorney and Section 13ZA is not appropriate, then a Welfare Guardianship Order may be required to support discharge

For further guidance in relation to Patients with Incapacity and the decision making process please see the Scottish Government and Mental Welfare Commission for Scotland: Adults with Incapacity: supporting discharge from hospital as listed in section 6 and the supporting Standard Operating Procedure for AWI (under development).

5.5 Hospital staff responsibilities

5.5.1 Ward staff

In order to improve patient flow and the discharge pathway:

- All staff will follow the Lothian Home First principles and any new service will be developed to support 7 day whole system working
- 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 facilitators) 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
- 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 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 acknowledge that for patients already known to the 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 daily discharge conference call
- 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 7 days. Patients already identified as a delayed discharge should not be moved unnecessarily.

For further details of Ward staff roles and responsibilities please refer to your local Action Cards (currently under development)

5.5.2 Discharge Hub staff

The Discharge Hub staff will support and manage more complex discharges for acute inpatients where this team is operational, and can provide expert advice to ward staff and department managers. Simple discharges remain the responsibility of ward staff to discharge without delay. Co-location of staff with equal access to acute and local authority computer systems will improve communication and working practices.

To support this process;

- All staff will follow the Lothian Home First principles and any new service will be developed to support 7 day whole system working
- Meet daily with the Senior Charge Nurse/Nurse in Charge of each ward
- Attend and contribute to daily discharge conference call and daily ward/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 Hospital Based Complex Clinical Care (HBCCC), Intermediate Care Facility (ICF) and Community Hospitals

For further details of Discharge Hub staff roles and responsibilities please refer to your local Action Cards (currently under development)

5.6 Health and Social Care Partnership responsibilities

- All staff will follow the Lothian Home First principles and any new service will be developed to support 7 day whole system working
- The Duty Senior Social Worker will screen all new requests in real time and take appropriate action without adding delays.
- Social work 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.
- All new and increased packages of care requests should have up to 6 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
- Whilst ward staff can call providers directly to restart a package of care or to request a small increase in the amount of care provided, Home First can support where there are issues
- Any Daily Discharge/transfer conference calls are to be attended by prior request by relevant representatives from the whole system. 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 (AHP) to ensure the service supports timely discharge for patients who no longer require an acute bed

- Partnership/Home First 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/Home First 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 facilitators) 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

For further details of Health and Social Care staff roles and responsibilities please refer to your local Action Cards (currently under development)

6.0 Associated Materials

Patient Information Leaflet - Planning Together: Leaving hospital when the time is right

NHS Lothian Guide to Patient Discharge and Transfer during the COVID-19 Pandemic

Action Cards: Discharge staff roles and responsibilities (under development)

Policy For Adult Inpatient Hospital Based Complex Clinical Care (HBCCC)

Guidance on Hospital Based Complex Clinical Care DL2015

NHS Lothian Patient's Funds and Valuables procedures (available on the NHSL intranet)

Interpretation and Translation Policy

Procedure for the safe transfer/escort of patients within and out with NHS Lothian, 2010

NHS Lothian Taxi Policy

Principles and Procedure for Care and Management of Vulnerable Patients (16+) with a Cognitive Impairment within a Hospital Setting

Policy, Principles and Procedures Caring for Adult Patients (16+) with Learning Disabilities within a Hospital Setting

Adult Support and Protection: Ensuring rights and preventing harm (available on NHSL intranet)

NHS Lothian Child Protection procedures (available on NHSL intranet)

Safe use of Medicines Policy

CEL 32 Guidance on Choosing a Care Home on Discharge from Hospital

Adults with Incapacity: supporting discharge from hospital, Scottish Government and Mental Welfare Commission for Scotland, 2021

Patients with incapacity and the decision making process – Standard Operating Procedure (under development)

7.0 Evidence base

Improving Unscheduled Care 6 Essential Actions (6EA), Scottish Government (2015)

Carers (Scotland) Act 2016

Carers Information (Scotland) Act 2016: Statutory Guidance, Scottish Government

Daily Dynamic Discharge Approach, Scottish Government (2016)

Discharge Planning Policy (Adults) 2019, NHS Portsmouth

Health and Social Care Discharge Policy, NHS Lanarkshire (2020)

Hospital Discharge Service: Policy and Operating Model, NHS England (2020)

Self-discharge from hospital (2020), NHS Royal Devon and Exeter

Discharge without Delay: A Best Practice Discussion Paper (Centre for Sustainable Delivery, NHS Scotland, 2021).

8.0 Stakeholder consultation

This Discharge and Transfer policy was developed and reviewed by a multi-disciplinary working group with input from a range of professional stakeholders from NHS Lothian, Edinburgh Health & Social Care Partnership, East Lothian Health & Social Care Partnership, West Lothian Health & Social Care Partnership and Midlothian Health & Social Care Partnership. Feedback from stakeholder consultation has be considered by the working group in the final policy.

9.0 Monitoring and review

Data relevant to effective discharge planning should be accurately entered in real time in order that all parties across the system are kept up to date. Reports will be generated from the data entered into both health and social care systems. Staff will be expected to be familiar with the data entry requirements which will be detailed in the Discharge and Transfer Standard Operating Procedure.[hyperlink to be added]

Operational reports, including performance metrics, will be routinely disseminated to identify opportunities for improvements across the system and to take action to improve the discharge process and mitigate delays. Performance metrics will be agreed and updated in keeping with local priorities. Performance reports will also be shared, where appropriate, with the relevant Health and Partnership members.

Informal monitoring or issues that require escalation will be highlighted at the daily discharge conference calls.