NHS
Sheffield Health and Social Care
NHS Foundation Trust

Policy: OPS 016 - Inpatient Discharge Policy

Executive Director Lead	Executive Director of Operations and Transformation
Policy Owner	Head of Nursing, Acute and Community
Policy Author	Discharge Team Manager

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Summary of Policy
This policy covers the discharge of service users from Inpatient Wards within all SHSC mental health and learning disability services.

Target Audience	Operational Managers of clinical teams, Clinical Leads and Clinical staff working in inpatient areas.

Keywords	Discharge, inpatient, patient, service user

Storage

Version 6 of this policy is stored and available through the SHSC intranet/internet. This version of the policy supersedes the previous version (v5 August 2020). Any copies of the previous policy held separately should be destroyed and replaced with this version.

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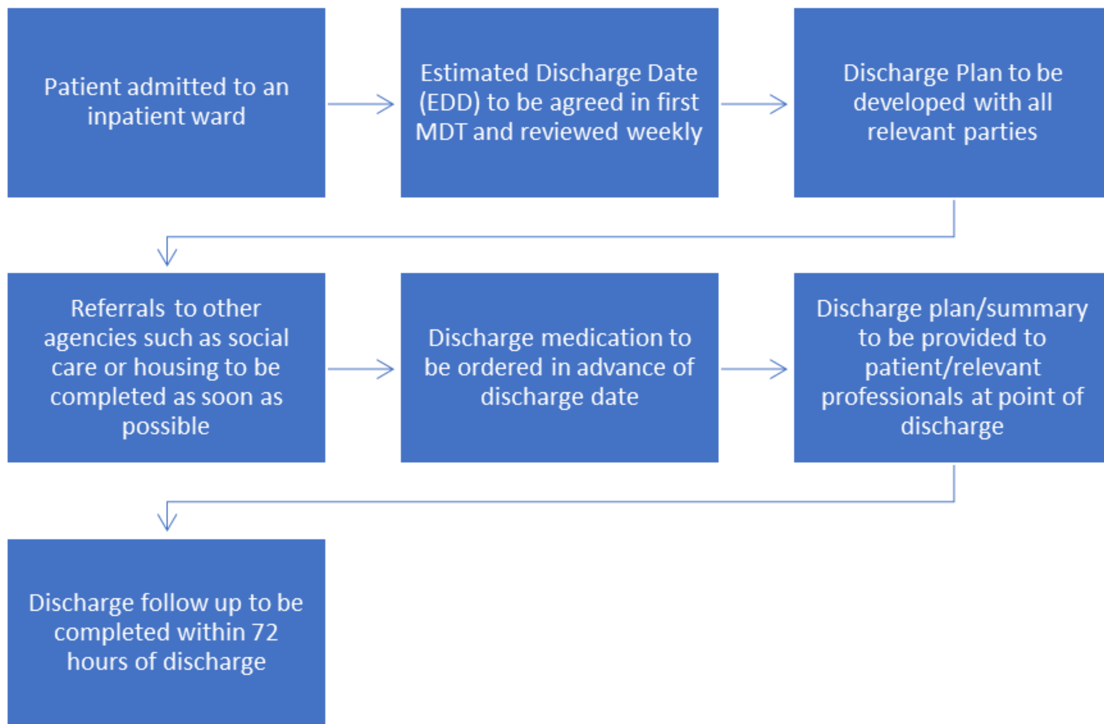
Version Control and Amendment Log

Version No.	Type of Change	Date	Description of change(s)
4 D0.1	Initial draft developed on new policy template.	Oct 2016	Full review undertaken.
4.0	Ratification / issue	Nov 2016	Ratification / finalisation / issue.
5.0	Review	July 2020	Full review undertaken.
6.0	Review	September 2023	Full review undertaken. Changes: 7.1 - Purpose of admission amended to reflect difference for acute and older adult wards and rehab and forensic wards and CeTR included. 7.2 – Added a new sub heading of tools and referrals to support discharge 7.5 – Added more details around medications 7.6 – Added Crisis House 7.7 – Wainwright Crescent is now Beech 7.8 – Added more processes around complex/delayed discharges

Flowchart



1 Introduction

Discharge planning is essential to ensure that patients leaving inpatient care have the best chance of recovery and appropriate services in place to meet their needs and continue their journey to recovery.

Poor discharge planning can result in:

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

Delays to discharge may have the following adverse affects:

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

Health and Social Care System Impacts of blocked access to admissions:

- Inpatient beds are not available to be used by the other service users in the community who need admission, creating pressure on them, their families, friends, Local Authority, Primary Care and other community services who meantime are trying to support the individual.
- Patients may instead present in crisis to the Ambulance Service and Emergency Department or Police, creating avoidable system pressure.
- Patients get inappropriately /avoidably detained within Sheffield Teaching Hospital Emergency Department, Admissions Unit or inpatient wards, creating a further pressure on acute physical health inpatient bed admissions and discharge processes.

2 Scope

This policy applies to all clinical staff working on inpatient wards and in the community.

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

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

3 Purpose

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

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

4 Definitions

Discharge refers to the end of an inpatient episode of care within SHSC Trust. These include the service user' own home or to a carers home, to a Nursing or Residential home, supported living or another NHS hospital or Private sector hospital.

It does not cover transfer from one ward to another within a Care Network.

Within SHSC Trust, transfer to another ward in a different Care Network within SHSC Trust, or transfer to Inpatient care in another hospital or Trust.

5 Detail of The Policy

This policy covers the discharge of service users from Inpatient Wards within all SHSC mental health and learning disability services.

6 Duties

Consultant medical staff with responsibilities for in-patients hold ultimate responsibility for decisions on discharge from inpatient care but must take account of the judgement and opinions of their colleagues in the multidisciplinary team, as well as the views of the service user and their carers or relatives.

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

7 Procedure

7.1 Standards for Discharge

The MDT meeting in collaboration with the patient is to identify what might be needed such as social work or care co-ordinator referral, housing repairs, support or any other issues alongside their mental health needs.

An estimated discharge date must be set at the first MDT and reviewed every week thereafter.

The purpose of admission to our Working Age and Older Adult Acute Wards is to be clarified by the Home Treatment Team (HTT), Community Mental Health Team (CMHT) and/or Approved Mental Health Professionals if unknown to services. This should include any specific treatment and care plan recommendations. This should be recorded on RiO.

The purpose of admission to our Rehabilitation Units is established from the referral and assessment process via Forest Close.

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

- The Multi-Disciplinary Team
- The patient / service user.
- Carers or relatives as appropriate.
- Home treatment team as appropriate
- The relevant Community Mental Health Team including the Care Coordinator where the service user is allocated one.
- The housing provider or hospital team the service user is being discharged to
- GP / Primary Care Mental Health service
- Secondary care physical health care team.
- Other relevant agencies, e.g., Probation, Housing, charities or social enterprises

The discharge plan should:

- Be considered and commence development as soon as in-patient care episode begins utilising the collaborative care plan or service specific care planning.
- Be developed in collaboration with patients and their carers and family.
- Be individual to the service user, reflecting their choices as far as possible.
- Be made available in a format which is accessible for the service user and their carers/family, e.g., in an appropriate language. This may be a print-out from Insight system, an interpreted plan into patients own language or in pictorial form.
- Be consistent with and developed within the Care Programme Approach (CPA), and / or other relevant processes and procedures for ensuring effective multidisciplinary, multi-agency, or across-team working.
- Be developed with the involvement of advocacy services where service users / patients request their help or lack capacity to engage in the process or decision-making.
- Consider statutory requirements including Mental Health Act (1983), Mental Capacity Act, and Care Act (2014) e.g., Section 117 After Care, CTO arrangements, capacity assessments and Best Interest meetings.
- Include leave plans in preparation for discharge that incorporates the service user maintaining or establishing links with the community.
- For people with learning disability or autism, all staff should adhere to NHS England's policy on Conducting Care and/ Education Treatment Reviews, for the duration of the inpatient episode and to enhance discharge planning for this population. https://www.england.nhs.uk/learning-disabilities/care/ctr/
- Should have a clearly identified risk management plan for any identified risks of concern to self or others.
- Consider involvement of the Quit teams (Smoke free)
- Identify the roles and responsibilities of people involved for each part of the plan; and identify a named co-ordinator of these care arrangements.

- Signpost and support people with SMI to access Primary Care to have their mandated Annual Health Check Signpost people as appropriate to employment support, such as Individual Support and Placement/ Good work initiatives.

7.2 Tools and Referrals to support discharge planning

Barriers to Discharge Checklist

The Barriers to Discharge Checklist was developed in conjunction with the Discharge Coordinators in order to highlight possible issues around the discharging of service users. The aim of early recognition of potential barriers is to support the avoidance of delay and guide the work of the discharge team from point of admission. Potential barriers include issues around safe discharge destination or issues around interface. Each service user will have a barriers to discharge checklist within one week of admission.

Please see Appendix D, Figure 1 for the Barriers to Discharge Checklist

Point Discharge Plan

The use of the 12 Point Discharge Plan can be recommended following Care, Education and Treatment Reviews. These are to be used for individuals with a diagnosis of autism spectrum disorder or Learning Disability in order to support to limit admission.

Occupational Therapy

Occupational Therapy (OT) plays a key role in assessing the functioning of service users we work with. All service users are expected to have the commencement of an initial assessment within 7 days of admission. This is with a view of this leading to further assessments if required e.g., Model of Human Occupation Screening Tool. This in turn, can support referrals to external agencies to support discharge planning i.e. First Contact, Mental Health Social Care North and Mental Health Social Care South (All Sheffield City Council) and for appropriate employment support schemes such as Individual Placement Support, etc.

Sheffield City Council

As of April 1st, 2023 the assessment of a service user's social care needs is the responsibility of Sheffield City Council (this responsibility was previously delegated to Sheffield Health and Social Care through secondment arrangements). The outcome of this assessment will determine what support can be provided by social care on discharge. Following this disaggregation, Sheffield City Council and Sheffield Health and Social Care are currently in the process of developing a "Memorandum of Understanding" to develop ways of working, time scales and appropriate escalation points between agencies.

At present there is an agreement to refer to Adult Social Care when services users are "Clinically Fit for Assessment". Whilst discharge coordinators can support our colleagues in Sheffield City Council to identify appropriate placements for service users, ultimate responsibility to refer lies with Sheffield City Council. This will allow for Sheffield City Council to follow their own internal processes to limit delay.

However, staff should work effectively and in collaboration with partners to maximise the success of the discharge plan, seeing themselves as system partners.

In order to access this assessment, service users will require a referral These referrals should happen at the earliest appropriate opportunity when recovery and discharge are beginning to look possible, rather than waiting until the day that the person had been formally deemed medically fit for discharge. If service users are already accessing a social care package and this requires review, they will require referral to Mental Health Social Care North or South (dependent on locality)

If service users have not previously accessed social care or they are from our older adult wards, they will require referral to First Contact – Adult Social Care.

Please see Appendix D, Figure 2 for referral form to Mental Health Social Care North/South and First Contact.

Housing Solutions

If a service user is homeless (no fixed abode), could be homeless within 56 days or has a housing related issue which they require support to be resolved, they can be referred to Housing Solutions. This would be for assessment to establish if they are eligible for support. This is also referred to as a "Duty to Refer". This referral should take place as soon after admission as possible, to ensure that the housing system starts to respond to the request in a timely manner, rather than waiting until the person is MFFD, if their homelessness status or risk is known on admission.

Please see Appendix D, Figure 3 for Medical Duty to Refer.

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

- A copy of the discharge plan will be given to the service user at the point of discharge. It will include arrangements for the next appointment or contact with services, information about medication, information about strategies and tools that had supported recovery and information necessary to enable the service user or carers to attend future appointments or otherwise access the services.
- Information for the services user and their carers or relatives to access help and support in the event of crisis.
- Signposting to the Sheffield Mental Health Guide services for support services in the community that may help to sustain discharges, such as those provided in the Voluntary Sector https://www.sheffieldmentalhealth.co.uk/.
- The discharge plan, together with confirmation who this has been communicated to and that a copy has been provided to the service user will be recorded on RiO.

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

- An e-discharge summary which includes a summary of the patients progress and relevant mental and physical health care and treatment on the ward, risks and management plan and their medication will be completed and sent with 24hours of discharge to the service user's GP, and all others involved in the onward care of the service user, e.g.

accommodation providers, community teams, primary care services, secondary physical health care services, probation, other support services or agencies as appropriate.
- For SHSC staff, the e-discharge summary can be accessed through RiO.
- The e-discharge summary, together with confirmation that this has been communicated to and a copy provided to the receiving healthcare professional/other service/agency will be recorded on RiO.

7.5 Medication

- Discharge medications needs to be ordered with as much notice as possible to give pharmacy time to dispense the discharge medication in time for the discharge.
- Turnaround times of prescriptions can be impacted by site location (pharmacy is based at Michael Carlisle Centre), the run times of pharmacy drivers, cut off times for receiving the prescription, opening hours of the pharmacy, the length of the prescription, if a compliance aid is required and prescription containing controlled drugs (original prescription will be required before the release of the medication). Pharmacy will try to support with any discharges which are needed urgently where possible.
- Detail required on order – amount of medication, depot information regarding when last had depot, which team is administering the depot and where is it being administered as appropriate.
- Discharge medication is normally prescribed for 14 days; however each individual service user should have a supply amount clearly written as there maybe individual variations which should be documented in the medical records and on the discharge summary, examples below.

a) Service users with identified risk of self-harm or suicide may have the amounts of medication ordered reduced. This will be according to the risk management plan or where there is an identified team or individual that will be taking responsibility for storing and administering the medication on discharge. Usually, the amount is reduced to 7 days' supply. If an additional 7 days is required -the prescriber should make it clear on the discharge letter.

b) Clozapine is a hospital only medication. The prescription needs to request 31 days on the discharge, the order needs to include where they are having bloods tests taken and how often. The ward pharmacist or MMT can support with options regarding this. The larger quantity is to allow time for a prescription within the community teams to be established. The actual amount supplied will be dependent on blood test. Ideally the ward should do a FBC the day prior to discharge.

c) Service users maybe on medication that is part of a shared care agreement (such as ADHD medication or lithium). These can be found on the intranet.

d) Where a need for a compliance aid has been identified this should be discussed with the Ward Pharmacist/ Medicines Management Technician as early as possible. The team will be requested to complete a compliance aid assessment form (ask pharmacy team for a copy). The pharmacist will review if the items are suitable for a compliance aid and assess if the patient is suitable for a compliance aid. If it is a new compliance aid for the service user the GP and the identified community chemist will need to be informed of the change and agreeable to the compliance aid (prescriptions will need to be altered to 7 days). At discharge a copy of the medication prescription should be emailed to both the GP and the community chemist. This is to ensure adequate time is available for the changes. Pharmacy require 48hrs notice for the discharge prescription for a compliance aid.

e) On rare occasions the amount supplied will be required greater than 14 days. This will need to be discussed with the pharmacy senior team.

f) If a MAR chart is required to ensure it is clear on the request (MAR charts are only for patients who are having carers administer medications i.e., nursing homes).

g) Ensure whose responsibility it is regards the plan with the medication. For example, ensure if a benzodiazepine is planned to be reduced and stop – that this is clear in the discharge plan and who is responsible -is it the GP or SHSC.

7.6 Post Discharge Follow Up

Home Treatment Team (HTT)

Follow Up

HTT provides 72 hour follow up for every service user discharged from the inpatient wards into the community.

Inpatient Interface

- This is provided to our Working Age and Older Adult Acute Wards
- There is a current plan to have three identified nurses to visit the wards over a 5-day period. They will cover all three inpatient wards whilst also being aware of patients on Psychiatric Intensive Care (PICU) and Dovedale 1. They will link with PICU regarding any SU's that are going to be discharged straight into the community and with Dovedale regarding anyone who is for working aged adult HTT.
- HTT referrals can also be made directly to the interface nurses outside of ward visits.
- After a decision is made for a service user to be discharged with HTT the interface nurse will meet with the service user and also speak to relatives/carers regarding leave arrangements, discharge plans, the role of the HTT and contact on discharge • As part of the interface, first contact on discharge will be planned and arranged.
- HTT can support step down placements to facilitate early discharges or minimise delays in discharge from inpatient wards.
- The Older adult HTT provide follow up within the 72-hour window following discharge where appropriate and can be referred into using Trust referral process or via an identified interface nurse where assigned.
- Once a discharge referral to them has been made a representative will visit the ward and complete the OAHTT assessment of need to ascertain as to whether the referral is suitable for the service, or if referral onwards is needed. Following an accepted referral, the OAHTT commence liaison with the ward, relatives and carers regarding individual needs and care pathway on discharge.

Crisis House

The Crisis House offers an alternative to admission and step down from our acute mental health inpatient wards for people in Sheffield aged 18 or over. They provide therapeutic recovery in a homely environment where an individual cannot be supported at home during a mental health crisis. The service is contracted to Rethink Mental Illness who are the registered provider with the Care Quality Commission (CQC).

Referrals to the Crisis House are accepted from our Recovery Services, Liaison Psychiatry and other secondary mental health services. All referrals should include a crisis assessment and Detailed Risk Assessment (DRAM). Access to the Crisis House is gate-kept by HTT. Current length of stay for our Crisis House is 5 days.

7.7 Stepdown

Beech is a 10-bed step down facility within SHSC for adults over the age of 18. It facilitates early discharge and or minimises delays in discharge from inpatient wards offering a transitional period before service users returning home or supports service users who are accessing supported accommodation.

Beech gatekeeps its own beds. Referrals are to be completed by the inpatient ward staff, all service users referred are to undertake a site visit, have a referral meeting with Beech staff and agree to the service user contract. All referrals to relevant agencies i.e., housing, social care, HTT, CMHT must be undertaken prior to referral to Beech.

7.8 Complex/Delayed discharges

If a patient is identified as no longer requiring inpatient care and treatment and there are anticipated delays in discharge alternative discharge plans are to be explored with:

Escalation to Discharge Team Manager

Discharge Coordinators can access support from Discharge Team Manager in order to discuss complex discharges. This can include attending MDT, facilitating conversations with family and/or carers or with other inpatient/community services.

Clinically Ready for Discharge

Clinically Ready for Discharge is a weekly forum between stakeholders from both Sheffield Health and Social Care and Sheffield City Council. The purpose of the meeting is to highlight either delayed discharges (when service users no longer require acute care) or delays anticipated (when a number of barriers to discharge have been identified and there is potential that these may not be resolved when the service user no longer requires acute care).

The aim of the meeting is establishing actions in order to limit delays or anticipated delays. Actions are reviewed on a weekly basis. The number of stakeholders attending allows for prompt escalation within the correct teams. Data from Clinically Ready for Discharge is also used to support the identification of gaps within service for our client groups, thus representation and prompt updates are essential.

Clinically Ready for Discharge can be used in conjunction with:

- Complex/Delayed Discharge Meeting
- Care Network Directors/Senior managers
- Case Complex Reviews

7.9 Unplanned Discharge, and Discharge outside normal hours

There will be occasions where service users wish to discharge themselves from inpatient care which can be facilitated unless they are subject to or requiring detention under the Mental Health Act. There will also be situations where service users do not return from leave, also consider these points alongside the Missing Patient procedure if appropriate. Refer to Missing Persons Policy.

In both these circumstances, discharge plans may not have been fully completed.
In these situations, the following must be considered:

- Appropriate arrangements for medication see SHSC Pharmacy Out Of hours medication supply guidance about ordering discharge medication from Pharmacy at Northern General Hospital, Sheffield Teaching Hospitals.
- Arrangements for communicating as soon as possible with relatives or carers and community services or teams or outside agencies (e.g., Police Secondary care physical health teams, probation etc) who need to be aware.
- Multi-disciplinary review at the earliest opportunity to consider further plans.
- The consideration of ‘leave’ rather than discharge.
- The consideration of Home Treatment referral.
- The provision of written information for the client and their carers or relatives appropriate, regarding arrangements for follow-up.

7.10 Out of Area Placements

Short term acute placements – weekly review by Out of Area Bed Manager (OOA Bed Manager) or CMHT. Discharge Team Manager and Flow Coordinators can support in the absence of OOA Bed Manager and CMHT.

Long term Rehab or Secure care placement – a review (visit /contact) every 6-8 weeks as per NHS England guidance by care co-ordinator or nominated individual at time of placement agreement. If any concerns safe and well checks to be completed regularly. Weekly oversight is also provided by OOA Bed Manager.

Please refer to Standard Operating Procedure (SOP) for the Allocation, Management and Quality Oversight of Out of Area Hospital Placements for further information regarding the Out of Area Placements.

7.11 Disputes

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

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

Refer to Clinical dispute policy.

8 Development, Consultation and Approval

- Consultation email sent to all key stakeholders: 07/08/2023.
- Draft sent for final comments: date required.

9 Audit, Monitoring and Review

Monitoring Compliance Template						
Minimum Requirement	**Process for Monitoring**	**Responsible Individual/ group/committee**	**Frequency of Monitoring**	**Review of Results process (e.g., who does this?)**	**Responsible Individual/group/ committee for action plan development**	**Responsible Individual/group/ committee for action plan monitoring and implementation**
Implementation	Review	Clinical Operations	Annual	Clinical Operations	Clinical Operations	Quality Assurance Committee
Discharge Collaborative Care plan	Audit	Ward manager	Bi-monthly	Senior Operational Managers	Clinical Operations-Network	Clinical Operations
72hr Follow up	Audit	Service Managers/Matrons	Quarterly	Directorate Leadership Teams	Directorate Leadership Teams	

This policy will be reviewed by September 2026

10 Implementation Plan

Local governance systems should be used to implement the inpatient discharge policy.

Action / Task	Responsible Person	Deadline	Progress update
New policy to be uploaded onto the Intranet and Trust Website and old version to be removed.	Corporate Assurance Team/ Communications Team	Within 5 working days of ratification	Will be uploaded post approval at PGG Meeting on 02/10/2023
Communication to be sent to all staff via Connect	Corporate Assurance Team/ Communications Team	Within 5 working days of ratification	Will be up sent post approval at PGG Meeting on 02/10/2023
Communication to be sent to Crisis and Emergency Network and Planned and Scheduled Network for dissemination	Discharge Team Manager	Within 5 working days of ratification	Will be up sent post approval at PGG Meeting on 02/10/2023
A communication will be sent to Education, Training and Development to review training provision.	Discharge Team Manager	Within 5 working days of ratification	Will be up sent post approval at PGG Meeting on 02/10/2023

11 Dissemination, Storage and Archiving (Control)

Version	Date added to intranet	Date added to internet	Date of inclusion in Connect	Any other promotion/ dissemination (include dates)
V4 D0.1	Oct 2016	Oct 2016		
4.0	Nov 2016	Nov 2016		
5.0	05/08/2020	05/08/2020	06/08/2020	
6.0	October 2023	October 2023	October 2023	

12 Training and Other Resource Implications

To be included in local induction.

13 Links to Other Policies, Standards

- MD 013 Medicines Optimisation Policy - Risks and Processes (Formerly Medicines
- Management Policy Risks and Processes)
- Missing Absent Without Leave and Missing Patients Records Management Policy

14 References

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

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

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

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

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

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

Department of Health (2005)
Independence, Wellbeing and Choice

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

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

Leaving Hospital and Minds: Briefing on discharge from Inpatient mental health services December 2017 https://www.mind.org.uk/media-a/4376/leaving-hospital-minds-good-practice-briefing.pdf

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

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

National Collaborating Centre for Mental Health (Great Britain), 2012. Service User Experience in Adult Mental Health: NICE Guidance on Improving the Experience of Care for People Using Adult NHS Mental Health Services.

Nurjannah, I., Mills, J., Usher, K. and Park, T., 2014. Discharge planning in mental health care: an integrative review of the literature. Journal of Clinical Nursing, 23(9-10), pp.1175-1185.

Transition between inpatient mental health settings and community or care home settings. NICE guideline [NG53] Published date: 30 August 2016
https://www.nice.org.uk/guidance/ng53/resources/transition-between-inpatient-mentalhealth-settings-and-community-or-care-home-settings-pdf-1837511615941

Transition between inpatient mental health settings and community or care home settings. Quality standard [QS159] Published date: 12 September 2017 https://www.nice.org.uk/guidance/qs159

Tyler, N., Wright, N. and Waring, J., 2019. Interventions to improve discharge from acute adult mental health inpatient care to the community: systematic review and narrative synthesis. BMC Health Services Research, 19, pp.1-24.

15 Contact Details

Title	***Name***	***Phone***	***Email***
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Policy Governance			policy.governance@shsc.nhs.uk

Appendix A Equality Impact Assessment

SCREENING RECORD	Does any aspect of this policy or potentially discriminate against this group?	Can equality of opportunity for this group be improved through this policy or changes to this policy?	Can this policy be amended so that it works to enhance relations between people in this group and people not in this group?
Age	No	No	No
Disability	No	No	No
Gender Reassignment	No	No	No
Pregnancy and Maternity	No	No	No
Race	No	No	No
Religion or Belief	No	No	No
Sex	No	No	No
Sexual Orientation	No	No	No
Marriage or Civil Partnership	No		

Please delete as appropriate: - Policy Amended

Impact Assessment Completed by: Alex Sharrock
Name /Date September 2023

Appendix B

Review/New Policy Checklist

This checklist to be used as part of the development or review of a policy and presented to the Policy Governance Group (PGG) with the revised policy.

		Tick to confirm
	Engagement	
1.	Is the Executive Lead sighted on the development/review of the policy?	
2.	Is the local Policy Champion member sighted on the development/review of the policy?	
	Development and Consultation	
3.	If the policy is a new policy, has the development of the policy been approved through the Case for Need approval process?	
4.	Is there evidence of consultation with all relevant services, partners and other relevant bodies?	
5.	Has the policy been discussed and agreed by the local governance groups?	
6.	Have any relevant recommendations from Internal Audit or other relevant bodies been taken into account in preparing the policy?	
	Template Compliance	
7.	Has the version control/storage section been updated?	
8.	Is the policy title clear and unambiguous?	
9.	Is the policy in Arial font 12?	
10.	Have page numbers been inserted?	
11.	Has the policy been quality checked for spelling errors, links, accuracy?	
	Policy Content	
12.	Is the purpose of the policy clear?	
13.	Does the policy comply with requirements of the CQC or other relevant bodies? (Where appropriate)	
14.	Does the policy reflect changes as a result of lessons identified from incidents, complaints, near misses, etc.?	
15.	Where appropriate, does the policy contain a list of definitions of terms used?	
16.	Does the policy include any references to other associated policies and key documents?	
17.	Has the EIA Form been completed (Appendix 1)?	
	Dissemination, Implementation, Review and Audit Compliance	
18.	Does the dissemination plan identify how the policy will be implemented?	
19.	Does the dissemination plan include the necessary training/support to ensure compliance?	
20.	Is there a plan to i. review ii. audit compliance with the document?	
21.	Is the review date identified, and is it appropriate and justifiable?	

Appendix C. Discharge Best Practice guidance

Discharge Checklist
Discharge coordinators to complete Barriers to Discharge Checklist
Identify discharge planning needs at MDT in collaboration with patient and set estimated date of discharge
Discharge collaborative care plan to be completed in collaboration with service user, carers and other healthcare or service providers as appropriate.
Contact with or referral to services and agencies which will be involved with ongoing care and support after discharge;
Review if referral to social care is required
Review need for functional assessment either on wards or in the community.
Review any finance and benefits needs and refer to advocacy as needed.
Professionals' meetings and complex cases arrange meetings or escalate concerns in a timely manner
Consider and make arrangements for the management of any physical health conditions or needs
Consider and make arrangements for the management of risk and any community safety concerns
Consider and make arrangements for the management of the risks of substance misuse
Any issues relating to children who may normally live with the service user or for whom the service user has parental responsibilities;
Ensuring that accommodation is appropriate at the time of the discharge e.g., utilities connected;
Ensure discharge medication and compliance aids are ordered from Pharmacy within recommended timescales
The provision of information in an appropriate format outlining the care plan, information about medication, and information necessary to enable the service user or carers to attend future appointments or otherwise access the services;
Information for the services user and their carers or relatives to access help and support in the event of crises
Ensure follow up appointments are booked
Communicating the discharge plan to others, including accommodation providers, primary care staff, community support, or other services or agencies;
Make arrangements for transport where appropriate.
The return of valuables, possessions, and monies held for safe keeping during
Complete e-discharge summary and send off within 24hours of discharge.
Inform HTT and Flow co-ordinators of discharge

Appendix C: Tools and Referrals to Support Discharge Planning

Figure 1: Barriers to Discharge. Checklist – Version 1

<table>
<tr><td colspan="4">Barrier to discharge screening tool
Name:
Insight No:
Admission Date: Estimated Discharge Date:</td></tr>
<tr><td>Barrier</td><td>Barrier present</td><td>No issues</td><td>Actions to resolve</td></tr>
<tr><td>CTO / LEGAL
Any legal issues with discharge (police, Ministry of Justice)</td><td></td><td></td><td></td></tr>
<tr><td>Safeguarding
Any safeguarding that will prevent safe discharge?</td><td></td><td></td><td></td></tr>
<tr><td>Clinical</td><td></td><td></td><td></td></tr>
<tr><td>Risk</td><td></td><td></td><td></td></tr>
<tr><td>Finances</td><td></td><td></td><td></td></tr>
<tr><td>Accommodation
Do they have the right / safe accommodation?</td><td></td><td></td><td></td></tr>
<tr><td>Pathway/functional assessments
Uncertainty over what the future pathway is</td><td></td><td></td><td>OT Assessments</td></tr>
<tr><td>Interface Issues
Are they allocated to the right team?</td><td></td><td></td><td>Allocation Team:
Allocation worker:</td></tr>
<tr><td>Social Care – allocation of Social Worker</td><td></td><td></td><td>Date of Referral:
Allocated Worker/team:</td></tr>
<tr><td>Family/Carer input</td><td></td><td></td><td></td></tr>
<tr><td>Physical Health
Any physical health that will prevent discharge?</td><td></td><td></td><td></td></tr>
</table>

Figure 2: Referral to First Contact, Mental Health Social Care North and South

Referral for Social Care Assessment (Care Act Assessment)			
Referral type – is the referral for First Contact, MHSC North or MHSC South?			
Referral for First Contact:	**Referral for MHSC North:**	**Referral for MHSC South:**	
URGENT:	**Non-Urgent:**		
Rationale for urgency to help prioritise:			
(Medically fit for discharge, breakdown in care package, to support to prevent admission etc.)			
Client in hospital:	Yes/no	**Client in community:**	Yes/no
Has the client consented to the referral?	Yes/No/Lacks capacity and Mental Capacity assessment required.		
Name:			
DOB:			
Insight (if known):		**LAS Number (if known):**	
117 Aftercare Eligibility?	Yes/No		
Current Residence - if on inpatient please add ward, detention status and permanent address:			
Please tick if No Fixed Abode: ☐			
Action requested to be undertaken by Sheffield City Council and why:			
(i.e., Assessment of need under the Care Act 2014 to support with discharge planning, review of care package due to change in care needs, establishing care package in the community)			
Any details regarding current care team (if applicable):			
(Current community team, names of allocated worker, name/contact of advocate, details of preferred family members to contact, third sector organizations etc.)			
Date of referral:			
Referrer and designation:	**Team:**	**Phone/email:**	

Figure 3: Medical Duty to Refer (Housing Solutions)

<table>
<tr><td colspan="2">Referrals to Sheffield City Council</td></tr>
<tr><td colspan="2">Written Consent to share information.
I agree to the information on this form being shared with Sheffield City Council. I understand that the Council may use this information to contact me, and to help assess my needs for assistance with housing and that I am not making a homelessness application.

Signed: ____
Date: _________________

If no written consent, please complete the box below</td></tr>
<tr><td colspan="2">Oral Consent to share information.
I can confirm that the customer provided me with oral consent to refer their case to Sheffield City Council. I explained to the customer that the Council may use this information to contact them and to help assess their needs for assistance with housing and that this is not a homelessness application.</td></tr>
<tr><td>Signed</td><td>Staff Name</td></tr>
<tr><td colspan="2">Your Details</td></tr>
<tr><td>Your role</td><td></td></tr>
<tr><td>Your name</td><td></td></tr>
<tr><td>Email address</td><td></td></tr>
<tr><td>Phone number of referrer</td><td></td></tr>
<tr><td>Name and contact details of any other person who could be contacted for further information</td><td></td></tr>
<tr><td colspan="2">Customer/patient details</td></tr>
<tr><td>Name</td><td></td></tr>
<tr><td>Household type</td><td></td></tr>
<tr><td>Current or last address</td><td></td></tr>
<tr><td>Home telephone number</td><td></td></tr>
<tr><td>Mobile number</td><td></td></tr>
<tr><td>Email address</td><td></td></tr>
<tr><td>Gender</td><td></td></tr>
<tr><td>Date of birth</td><td></td></tr>
<tr><td>Language and communication needs</td><td></td></tr>
<tr><td colspan="2">Reason for referral</td></tr>
<tr><td>What is the main reason you are referring the individual?</td><td></td></tr>
<tr><td>Please explain your answer (e.g., they are facing eviction from their home, are experiencing domestic abuse etc)</td><td></td></tr>
<tr><td colspan="2">Additional information</td></tr>
<tr><td colspan="2">Current accommodation</td></tr>
<tr><td>What type of accommodation is the individual currently living in?</td><td></td></tr>
</table>

If the customer is threatened with homelessness, on what date are they likely to become homeless?	
If the customer is due to leave medical care, rehab or hospital, please state the date the discharge might take place.	
Are there any needs/risks to be aware of?	
Additional needs/risks might include: • previous history of sleeping rough • lack of support from family/friends • history of substance misuse • risk of domestic or other abuse	
Relevant medical information	
Please provide information on any physical or mental health needs that the service user has, and any treatment that they are receiving and **their GP details**	
Other information	
Please provide any additional information. In particular, are there any known risks to staff visiting the service user at home or any other issues that we need to be aware of prior to initial contact?	
Domestic abuse	**Please attach the DASH to your referral**
Customer ID – please state what ID you have seen	
Sending the referral	
Please email the form to dutytorefer@sheffield.gov.uk This is **not** a secure email address. If you are not on the government secure email system, you must password-protect the referral form attachment and send a subsequent email with the password. **@NHS and @sheffield.gov.uk should be secure to send from** If you are part of the CJSM email service our CJSM secure email is housingsolutionsgeneric@sheffield.cjsm.net	
Urgent referrals	
If you don't have time to complete the form and it is vital that you refer someone, please call our duty number 01142053234 **(THIS SHOULD NEVER BE GIVEN TO THE PUBLIC)** which is open 11 AM – 3PM. **Please have the form with you** as it will guide you through what we need to know. For any follow up or if something urgent happens you can request advice directly to our team email which is monitored by myself, the other senior Lauren and our manager Will: housingadviceandoptions@sheffield.gov.uk	