Leicestershire Partnership NHS Trust

Discharge and Transfer of Care Policy (Going Home Policy) for Community Health Services (CHS) For Adults Leaving Community Hospitals

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1.0 Quick Look Summary

1.0 Introduction and Overview

1.1 Effective hospital discharge can only be achieved when there is cohesive joint working between all organisations, including the hospital, primary care, social care, Clinical Commissioning Groups, Midlands & Lancashire Commissioning Support Unit, housing departments, independent and voluntary sectors.

1.2 This document sets out the Community Health Services (CHS) Leicestershire Partnership NHS Trust (LPT) Policy and Procedures for the safe and timely discharge and transfer of care of adults admitted to the trust.

1.3 This policy describes best practice guidelines for all LPT staff who are transferring an adult patient from LPT CHS (either discharge home or transfer to another care provider).

1.4 The policy provides a framework that enables the delivery of safe, effective and timely discharge or transfer of care for all adult inpatients. The core principles and processes are the same for all inpatient wards.

1.5 LPT recognises the importance of the multi-disciplinary team in effective discharge planning.

1.6 The engagement of, and active participation of patients and their carer(s) as equal partners is central to the delivery of care in the planning of a successful discharge.

1.7 This policy has been developed to support good practice in discharge planning by providing direction for staff involved in the discharge planning process. It aims to improve and strengthen discharge planning and the timely discharge of patients from the Trust in line with the 'Discharge to assess model'. The overriding principles include:

a) Integrated working at ward level and with external partners.

b) Minimal appropriate assessments to be carried out in LPT in patient settings – only assessments for a safe discharge with ongoing/ long term assessments to be carried out in the community in an appropriate care setting. (Discharge to Assess)

c) Right Patient, right place, right care.

d) Always consider discharge back to original place of residence as first option using Home First principles.

e) Person-centred and a maximising independence approach

f) Reduced duplication of assessment through trusted assessment principles.

g) Releasing time to care.

Discharge and Transfer of Care Policy for Adults Going Home Guide on a Page



Patient requires **No** significant change in the support offered to themselves or their carer in the community (able to return home with existing package of care, to existing nursing/care home (Pathway 0)



YES

- Nursing Staff to inform patient relative/carer of **E**stimated **D**ate of **D**ischarge.
- Refer to Therapy and Social Services if necessary.
- Ward managed discharge.

Provide:

- Out Patients appointment if required.
- Wound Dressings if required.
- Equipment / continence aids if required.
- Information leaflets /advice sheets.
- Make referrals to the necessary community services.

Discharge summary including:

- To Take Out (TTO's medications ordered prior to discharge.
- Infection status /Covid 19 swab results
- Request transport if required.
- Complete discharge care planning documentation.
- Handover to the relevant care agency.
- Provide Discharge and Transfer of care letter and ensure patient/carer has had the opportunity to ask questions and understands discharge

NO

Complex Patients Pathways 1- 3

- Complete Home First form on SystmOne at least 48 hours before medically optimised date.
- For patients likely to need a discharge MDT with adult social care therapy to refer as soon as possible in the patients journey to adult social care. – this is via the Home First form with completion of basic demongraphics and a request to attend an MDT on date/time

- Complexity will be decided by the MDT at board round or weekly MDT for Stroke

Patients transferring to another Acute Trust: Records to be printed off SystmOne, medications and a copy of the ePMA Medicines Administration Chart sent with the patient

Nursing or residential home please ensure that the discharge letter is sent with the patient

1.1 Version Control and Summary of Changes

Version number	Date	Comments
2	17.05.23	Full review of guidance/updated appendices
3	14.10.23	Formatting updates, updated appendices
3.1	28.09.26	Extend for 2 months to allow approval
3.2	18.11.26	Safety Forum approved further ext for 2 months to allow review

1.2 Key individuals involved in developing and consulting on the document

Name	**Designation**
Accountable Director	Nikki Beacher – Deputy Director of CHS
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Implementation Lead	Michaela Ireland, Operational & Transformation Lead
Core policy reviewer group	CHS Flow Group
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Andrew Moonesinghe	Pharmacy Manager
Trust Policy Experts	

1.3 Governance

Level 2 or 3 approving delivery group	**Level 1 Committee to ratify policy**
PSIG & Quality Forum	Trust Board

1.4 Equality Statement

Leicestershire Partnership NHS Trust (LPT) aims to design and implement policy documents that meet the diverse needs of our service, population and workforce, ensuring that none are placed at a disadvantage over others. It takes into account the provisions of the Equality Act 2010 and promotes equal opportunities for all. This document has been assessed to ensure that no one receives less favourable treatment on the protected characteristics of their age, disability, sex (gender), gender reassignment, sexual orientation, marriage and civil partnership, race, religion or belief, pregnancy and maternity.

1.5 Due Regard

LPT will ensure that Due regard for equality is taken and as such will undertake an analysis of equality (assessment of impact) on existing and new policies in line with the Equality Act 2010. This process will help to ensure that:

- Strategies, policies and procedures and services are free from discrimination.
- LPT complies with current equality legislation.
- Due regard is given to equality in decision making and subsequent processes.
- Opportunities for promoting equality are identified.

Please refer to due regard assessment (Appendix 4) of this policy

1.5 Definitions that apply to this Policy

TTO	To Take Out
Sitrep	Discharge situation Report
EDD	Estimated Date of Discharge
COP	Court of Protection

2.0 Purposes and Introduction

2.1 This policy applies to all staff employed within CHS in LPT, those staff working in a contracted capacity, and staff contracted with partner agencies or NHS Trusts and working within LPT.

2.2 This policy applies to all adult patients being discharged from inpatient care in CHS LPT, regardless of age or diagnosis. This policy should be read in conjunction with the Trust's Safeguarding Adults policy and is consistent with UHL's Going Home Policy for the discharge of adults.

2.3 For the purpose of this policy the term discharge will refer to the discharge of patients from the Trust to their own home, new or permanent place of residence and to transfers of care to another care setting such as a residential home or another acute or community hospital and temporary assessment placements.

2.4 The policy applies to all patients registered as inpatients

2.5 This policy does not apply to patients attending as out-patients to out-patients areas.

2.6 This policy has been developed to ensure:

a) All patients experience well organised, safe and timely discharge from hospital with an agreed, smooth transfer to community based health and social services.

b) Each patient is encouraged and supported in self-care activities and helped to achieve the highest possible level of independence.

c) Patients, carers and staff are supported to set realistic expectations of hospital stays.

d) Patient carers and families are prepared, physically and psychologically for transfer home or to an agreed alternative discharge destination.

e) There is effective and timely involvement of patients, carers and family in discharge and transfer planning.

f) There is effective and timely communication of relevant information regarding discharge and transfer plans to patient and their carers.

g) Patients receive an appropriate, skilled and timely assessment.

h) There is continuity of care between hospital and the agreed discharge care environment, with seamless service transition.

i) There are improved patient outcomes by promoting understanding of and concordance with follow-up arrangements and discharge medication.

j) There is effective and efficient use of the community hospitals inpatient bed capacity by reducing unnecessary delays in discharge.

k) Highest standards of communication within the multi-disciplinary team, between primary and secondary care, and with colleagues in health and social care and the independent sector throughout the pathway of care.

l) That discharge planning commences prior to, or immediately on admission to hospital and continues throughout the patient's hospital admission.

m) That patients are provided with information/medication/equipment to enable and foster independence for the patient/carer.

n) The provision of appropriate documentation accompanies the patient upon discharge.

n) That unplanned re-admissions do not occur as a result of poor discharge planning.

o) Appendix 1 details guidance/flow chart for Supporting "patient choices" to avoid long hospital stays

3.0 Policy Requirements

3.1 Many patients who are discharged from hospital will be classified as a simple discharge. A simple discharge is one that: Involves minimal disturbance to the patients' activity of daily living; does not hamper a return to their usual residence and where there is no significant change in the support offered to the patient or their carer in the community.' These discharges will be managed at ward level.

3.3 This policy also acknowledges that some patient groups are more complex and may require particular attention when planning and delivering discharge care. A supported discharge is usually one that involves the input of 2 or more services and involves multidisciplinary planning and will frequently include the following patient groups, this not an exhaustive list, however cases may include:

a) Older people who are frail and who may live alone or with a carer who may have difficulty coping and want to return home

b) Patients with short term health needs

c) Patients requiring ongoing treatment out of an inpatient setting

d) Patients with a long term condition with high risk of readmission

e) Patients being discharged to a care home

f) Patients at the end of life, terminally ill or require palliative care

g) Patients with mental ill health/learning disabilities

h) Victims of neglect or of sexual or domestic violence

i) Patients who are homeless

j) Patients that have no recourse to public funding

k) Those who self-discharge against medical advice

l) Patients requiring an increase in their original package of care or new package of care

m) Patients that are subject to court of protection (COP) application

n) Individuals with safeguarding concerns regarding discharge

o) Organising same day equipment and equipment needed to deliver nursing care

p) Support with Mental Capacity Assessments (MCA), Best Interest meetings and lasting Power of Attorney concerns

q) Family disputes

r) Patients with brain injuries whorequire ongoing specialist slow stream rehabilitation in a specialist setting

s) Patients with complex health needs whom requires specialist care in the community, beyond that of mainstream services

t) Out of area patients

3.3 **Transfer:** Transfer is defined as the movement of a patient and their care and treatment needs from one inpatient ward to another (of any inpatient setting). This may be because the needs of the patient are best met at another inpatient or care setting.

3.4 **Discharge:** Discharge is the act of concluding an episode of care within an inpatient setting. This may include handing over responsibility of care to another service or care provider or discharge to a person's place of choice: These include:

- Patients own home
- Community team
- Mental health team
- Primary care
- Nursing/ Residential Home
- Integrated Care Board
- Another hospital service e.g. acute hospital.
- Social care.

3.5 **LLR discharge hub** is a collaborative service bringing together representatives s from seven Health and Social Care Organisations namely:

- Leicestershire County Council
- Leicester City Council
- Rutland County Council
- Leicestershire Partnership Trust (LPT) and
- University Hospitals of Leicester NHS Trust
- LLR Integrated Care Board
- Midlands & Lancashire Commissioning Support Unit.

The model is primarily focused on a multi-agency team providing a single point of access to the Trusts wards by providing expertise and advice in the safe and effective discharge of patients with complex discharge needs and acting as experts on discharge planning for the wards. This will include support to actively facilitate discharges from the inpatients areas.

3.6 **Discharge Situation Report (SitRep)** previously referred to as the Delayed Transfer of Care (DTOC) is an overview of patients that are currently delayed due to an external factor i.e. awaiting a placement. A patient is ready for transfer/ discharge when:

- the patient has met the clinical criteria for discharge, and
- a multidisciplinary team has decided that the patient is ready for transfer,
- the patient is safe to discharge/transfer and
- the patient no longer meets the 'reason to reside' (stay) criteria

3.7 The term **'Patient'** relates to Adults.

3.8 The terms **'Family /Carers'** relates to those persons that the patient may refer to as their next of kin, or the person they identify with that acts on their behalf in their best interests.

4.0 Duties within the Organisation

4.1 **The Medical Director and Head of Nursing** have overall responsibility for the quality of medical and nursing intervention to support the policy.

4.2 **The Director of CHS** has overall responsibility for ensuring that there are effective arrangements for discharge and transfer of care planning within the trust.

4.3 It is the responsibility of the **Consultant and Advanced Nurse Practitioner** to ensure that:

a) All patients in his/her care have an estimated discharge date (EDD) which has been decided at board round and that it is communicated to the patient/family near to discharge. The EDD is reviewed daily by the MDT and documented on SystmOne.

b) The EDD is the date that the multidisciplinary team (MDT) predict that the patient will meet specific clinical criteria to enable them to be discharged and highlights when support will be required to facilitate discharge at the earliest opportunity.

c) Board/ward rounds occur each working day, to identify patients who are ready for discharge. Patients potentially ready for discharge should be reviewed as early in the day as is consistent with clinical priorities

d) The frequency of individual patient discharge reviews reflects the clinical condition of the patient and the nature of the discharge plans (discussions will take place daily at board round and then at red to green)

e) All patients have a Consultant Physician or General Practitioner (GP) approved medical management plan that includes physiological and functional clinical criteria for discharge. Consideration being given to whether the patient would be better off an alternative setting to receive on going care and treatment (Home with Home first support services).

f) To Take Out (TTO) prescriptions for discharge are written at least 24 hours before discharge or as soon as practicable when discharge is confirmed with less than 24 hours' notice.

g) Plans are put in place to identify patients who may be ready for discharge at weekends and bank holidays when board/ward rounds may not be

routine. Consideration should be given to delegated criteria led (nurse led) discharge.

h) The Consultant and MDT have responsibility for agreeing the patient is ready for discharge and that this is recorded in the medical notes as 'medically optimised' for discharge. This is a statutory requirement under the Care Act 2014.

i) Keeping the patients/relatives/carers fully informed of their progress and treatment in order to progress assessment needs.

j) Complete an electronic discharge summary for each patient prior to the EDD.

k) Early discussion with Integrated Community Specialist Palliative Care where a patient is deemed in their last week of life and preferred place of death is home.

4.4 **The Head of Nursing, Deputy Head of Nursing and Community Hospital Matrons** are responsible for ensuring compliance with this policy, supporting audit, reviewing results and implementing change where appropriate. Delays in discharge should be monitored and escalated to Operational and Transformation Lead for Hospitals/Discharge hub for support and if necessary improvements made to the process, if delays for failing to meet the EDD are due to non-clinical reasons.

4.5 **The Ward Sister/Charge nurse / Therapy Lead** has responsibility for ensuring that systems are in place to facilitate a safe, timely discharge for all patients under their care in line with the SAFER patient flow bundle. Discharge needs to be coordinated through a multidisciplinary approach by the Ward Sister/Charge nurse or their deputy, to enable discharge by the EDD. The sister should ensure that standards of discharge planning are maintained and that staff report any examples of non- adherence to the policy through the hospital adverse events Ulysses reporting system.

a) Ensuring that every patient has a copy of the 'NHS Hospital Discharge information' given on admission to the ward and a 'Supporting you to leave hospital' Leaflet prior to discharge in line with the Accessible Information standards requirements.

b) Ensuring that medically optimised for discharge status is recorded on SystmOne and that this date has been communicated to the patient, relatives/carer, as appropriate.

c) All information relating to the discharge is recorded on the board round/ discharge profile on SystmOne

d) Ensuring that systems are in place so that patient discharge is co-ordinated and progresses according to plan.

e) Ensuring that where possible all discharges take place before midday.

f) Ensure a Multidisciplinary approach to review patients at daily Board Rounds and later in the day follow up of actions in line with Red2Green principles.

g) Ensuring that information required to plan and manage patient discharges is gathered, and recorded accurately, especially in respect of conversations with the patient, their family and/or carers: including the date and times of those conversations.

h) Continuously monitoring the discharge progress of all patients, ensure positive action is taken to expedite discharges for those who are fit to leave their community bed and have exceeded their EDD.

i) Any delays to patient progress to be reviewed and escalated as per appropriate escalation pathway i.e. through Matron, or the Operational and Transformation Lead.

j) Ensure Home First documents (Appendix 2) are completed on SystmOne in a timely manner using the Home First principles.

The Registered Nurse and Qualified Therapists are responsible for ensuring:

a) The patient and relatives / carers are fully involved in the discharge planning process, their needs and wishes are taken into account and they have at least 24 hours' notice of the discharge date, whenever possible.

b) In the absence of the Senior Nurse /Nurse in Charge jointly work with the multi-disciplinary team to ensure review of patients at daily Board Rounds and later in the day follow up of actions.

c) All information relating to the patients discharge is recorded on the patients discharge care plan and on SystmOne.

d) Consider the need for further assessment on discharge, utilising the Home First form.

e) The patient's medication is ordered 24 hours before the discharge for known next day discharges.

f) The patient has any tests required for discharge e.g. Swabs prior to admission to care homes / community hospitals completed 48 hours before date of discharge.

g) Transport should only be provided for discharge when there are no family or friends to transport the patients and there is a clinical reason.

h) Transport can be booked 24/7 and all staff should access this system to book accordingly to the patient's needs and mobility status. Transport should be made via the On-Line Transport system through the current provider.

i) Appropriate transport arrangements are made and that all pertinent information regarding the patient's condition is given to the ambulance service transporting patients. (E.g. Do Not Resuscitate (DNACPR) status, infections, issues regarding transferring and in respect to manual handling). When arranging transport for discharge it is vital that the discharge address including Post Code is confirmed and checked as correct, as it may differ to the patient's home address. It is equally important to check that the patient can access their destination address e.g. do they have a key, can they manage any steps at the property.

j) Transport for bariatric patients and for property that is difficult to access must be booked 24 to 48hrs prior to discharge in order for the necessary assessments to take place.

k) The receiving hospital, care home or social care facility (or community nurse team, if the patient is returning home) is notified of any known infection and the current infection control practices in place e.g. antibiotic

therapy, dressing regime, barrier nursing. An inter healthcare patient infection prevention transfer form will be completed.

l) The patient has the necessary medication, dressings and relevant information about post discharge care.

m) All arrangements and referrals in relation to discharge planning are clearly documented, signed and dated within the discharge planning documentation.

n) All healthcare professionals involved with the patient are notified of any change in the patient's ward placement and or condition/suitability for discharge with a request for a review as appropriate.

o) Any potential delays in discharge are referred immediately to the MDT as soon as they become known outlining the reasons for the delay or potential delay.

p) Any delays to patient progress to be reviewed and escalated as per appropriate escalation pathway i.e. through Ward Sister, Matron, or the Operational and Transformation Lead

q) All necessary information for discharge/transfer of care and management is gathered, recorded using the discharge checklist/verbal handover form to care home (Appendix 1 and 2), and communicated appropriately.

4.8 **All members of the multidisciplinary team** (MDT) are responsible for

a) Ensuring discharge planning commences within 24 hours of admission and that progress is appropriate to achieve the EDD.

b) Ensuring patients their families and carers are consulted and regularly updated about discharge planning from admission throughout inpatient stay; signposting patients/carers where necessary.

4.9 **The Ward Clerk** is responsible for working in support of the MDT and for arranging outpatient's appointments and ensuring the recording of timely and accurate discharge time within the patient record and the electronic patient information systems.

4.10 **The Allied Health Professionals** (Other allied health professional groups e.g. Dieticians, Podiatry and Speech and Language Therapists) provide holistic functional patient assessment and consider equipment, adaptations and/or goals for rehabilitation, for patients who are expected to improve their functional ability. They will liaise with patients, their carers, families and multidisciplinary teams within LPT and externally to enable the needs of the patient to be met. They work using the principles of trusted assessment, Home first and Discharge to assess. Assessments for long term needs will take place outside of the hospital setting.

4.11 **Pharmacy staff -** A Pharmacist is responsible for clinically screening the discharge prescription, ensuring a safe and complete prescription. The technical team will dispense an appropriate supply, accuracy check and then prepare for transport. The team will provide patient information leaflets for all medicines supplied. If appropriate consent has been obtained, the team will ensure the nominated community Pharmacy for the patient is updated with the latest prescription information, ensuring a safe and effective transition into community.

4.12 **The LPT Flow team working as part of the Discharge Hub** manage the daily flow of patients into and out of the Trust and promote/initiate the use of appropriate

services and schemes to enable safe and early transition to home. They will maintain and communicate accurate information on bed status and liaise with clinical staff to support an overview and understanding of pressures within the service to inform operational and clinical decision making processes. They will work with clinical colleagues to enable morning transition of patients to home whenever possible so that sufficient beds are available to enable patient's timely access to the most appropriate care setting and level of care.

The LPT Flow Team will provide expert clinical leadership in relation to complex and delayed discharges in conjunction with the multidisciplinary teams by:

a) Promoting good practice in discharge planning across Leicester, Leicestershire & Rutland, Health & Social care community.

b) Providing active support to the MDT for discharge of patients with complex needs. Seeking solutions to delays in discharge and pursuing all options for effective discharge in line with 'Home first' and Discharge to Assess principles.

c) Developing strong links within community health services, including other partner agencies to identify and progress delayed discharges.

d) Ensuring that local and national policies and guidelines are used throughout the discharge planning process.

e) Supporting the patient transfer onto discharge pathways as appropriate e.g. Pathway 1, 2 or 3.

f) Ensure the daily required reports are completed.

g) Support the wards with advice as required on complex cases. Escalate any issues that cannot be resolved

4.14 **The System Discharge Lead** has the responsibility for bringing about sustained improvement in discharge planning by working with multidisciplinary teams within LPT and partner agencies by:

a) The development, implementation and evaluation of policies, standards and guidance on discharge planning.

b) The maintenance of an effective inter-agency and multidisciplinary communication strategy, internal and external to LPT.

c) Ensuring that clinical areas have access to information and support in the implementation of local and national policy and legislation relating to discharges and transfer of care.

d) Ensuring a programme of audit to monitor effectiveness of discharge tools and practice and identify areas of improvement.

e) Influencing strategic planning to achieve national and local performance targets.

f) Monitoring the patients experience with discharge planning within the Trust

g) Monitoring and escalation of daily delayed discharge (sitreps) and working in partnership with multidisciplinary teams within LPT and community services to resolve specific issues relating to delays.

h) Ensure escalation of delayed discharges via daily weekday, multi-agency conference calls.

4.15 The LLR Discharge Cell supports the working of this policy and the safe and timely discharge work steam.

5.0. Policy Implementation and Associated Documents – What to do and how to do it

5.1 All Discharges/ Transfers of care. (Going Home Process)

There are a number of key principles, which underpin practice across all aspects of discharge planning:

5.1.1 Each patient's discharge will be planned by the MDT in conjunction with the patient, relatives, and/or carer, and will begin on or before the patient's admission to hospital. It will be an ongoing process that will involve the patient, relatives and carer, and will provide a seamless transfer from hospital to the most appropriate environment using the Home First and Discharge to assess principles.

5.1.2 All patients will receive a Hospital discharge information at pre admission or on admission, which can be formatted and translated into various languages upon request.

5.1.3 All patients must be given an Estimated Date of Discharge (EDD) on admission which will be recorded in SystmOne.

5.1.4 The date of discharge should be confirmed with patients and their families, and care homes giving at least 24 hours' notice where possible.

5.1.5 All patients will have information regarding discharge planning recorded on SystmOne under progress notes and this is commenced on admission.

5.1.6 Ensure up to date record of Discharge planning in care plan, within care records and on SystmOne confirming that the patient has no new care needs and has been assessed as meeting the criteria for discharge.

5.1.7 Adults, including older people, who do not require community support can be discharged without the need of referring to social services but may be given a contact number for the relevant Social Services Department should they require help in the future.

5.1.8 Where patients have capacity to, then they must provide consent to share information with partner agencies, families/ carers for discharge planning. If the patient does not have capacity to consent to information sharing, a best interest decision whether or not to share information, will need to be recorded, following consultation with family/carers.

5.1.9 Patients should be informed to plan their own transport arrangements for discharge. Patients with a clinical need can be referred for ambulance transport or for family to transport if suitable.

5.1.10 On the day of discharge, the discharging nurse must confirm that the patient is fit to leave hospital and check that all arrangements are in place using the discharge checklist (Appendix 3) and communicating with the patient, family/carer. When discharging to a residential/care home, the verbal handover for discharge form must be completed. (Appendix 4). These must be scanned into the electronic patient record.

5.1.11 A copy of the discharge letter (TTO) should be ready 24 hours before discharge/transfer wherever possible. If the patient is being discharged on a treatment initiated by LPT that requires a shared care agreement, please ensure relevant paperwork is completed and sent to the LPT Shared Care Agreement team 24 hours before discharge. See the link below for further information

Home page - Leicester, Leicestershire and Rutland Area Prescribing Committee (areaprescribingcommitteeleicesterleicestershirerutland.nhs.uk)

5.1.12 The discharge/ transfer of care letter must be proof read and checked through and given to the patient/carer at the time of discharge with an opportunity to discuss the content and to ask questions.

a) The letter should be used to confirm the patients/ carers understanding of their condition, treatment, medicines and care needs at the time of discharge.

b) The nurse discharging the patient should also confirm that the patient and/or carer understands the information provided regarding their condition including: expected signs to look for and when and who to contact for help and advice.

5.1.13 The discharging registered nurse is responsible for ensuring the patient and/ or carer understands their medication regime on discharge in line with the accessible information standard and the Trust's Interpretation and Translation policy by discussing the following:

- The name of medication
- The purpose of the medication
- The times the medication is to be administered
- Make note of any special instructions including side effects,

The medications are cross-checked against the TTO list and patient details, ensuring that the label on each box/ container corresponds with the TTO list and contains the correct medication for the correct patient. Check:

- Name
- Medication
- Dose
- Frequency
- Route

For dosette boxes check the labels correspond with the details on the TTO list.

The expiry dates of the medication must also be checked.

Patient's own medication must be checked in the same way as above. If this medication is no longer needed, ask permission from the patient to remove and destroy.

All medicines supplied by LPT must be labelled with instructions for use. Patients must not receive stock or temporary stock items.
If appropriate medications counselling by a pharmacist / medicines administration technician should be considered.
Please refer to the TTO Checking as per LPT policy

5.1.14 The nurse discharging the patient will give the patient details of outpatient appointments or other follow up appointments. If the information is not available by the day of discharge, the patient/ carer will be sent an appointment by post; in these circumstances staff need to confirm with the patient/carer, the address the appointment is sent to and the patient and carer should be given a contact number in case the appointment is not received.

5.1.15 The discharge checklist will be completed by the nurse responsible for discharging the patient on the day of discharge.

5.1.16 Those patients planned for patient discharge will be made ready to leave the ward area as early in the morning as possible.

5.1.17 An electronic discharge summary (TTO) will be sent to the general practitioner (GP) within one working day of discharge.

5.2 Out of hours discharge.

5.2.1 Staff should not routinely discharge patients after 21.00hrs, unless the patient or family request and are happy for discharge after this time.

5.2.2 In the event of patients leaving the hospital after 21.00hrs every effort should be made by the ward nurse discharging the patient to contact the family, carers, unless the patient requests otherwise.

5.2.3 In times of heightened escalation and extreme bed pressures, later discharges and transfers may be necessary and should be discussed and agreed with patients, carers and families and the receiving care facility and noted in the patient record.

5.3 Where Applicable.

5.3.1 The nurse discharging the patient should confirm that the patient and/or carer understands the information provided and, where English is not the patient's first language, staff should request assistance from an interpreter. Interpreters and written translations including Braille can be accessed via a web based portal called Wordski. This also provides telephone, video and British Sign Language Interpreters.

5.3.2 Ensure patients with learning disability/ communication problems are offered the appropriate support to be actively involved and participate with their discharge plans e.g. support from Learning Disability liaison nurse; advice from Speech and language therapy to enhance communication difficulties.

5.3.3 The Consultant/GP/ANP responsible for discharging the patient will provide a medical fit note if the patient is to refrain from work.

5.3.4 An inter healthcare patient infection prevention transfer form will be completed for all patients to identify any infection risks for the receiving care provider and this information should be recorded on the discharge summary (TTO). Contact Infection prevention for advice and support.

5.3.5 If dressings are required:

a) The nurse discharging the patient should ensure that a referral to the practice nurse is made and the patient is well enough to attend the GP surgery.

b) If the patient is not well enough to attend the surgery, then a referral should be made to the Community nursing team via SPA if Pathway 0. For pathway 1-3 this should be made using the Home First Form requesting a home visit by the Community nursing team, this will be triaged in the Discharge Hub and forwarded to the designated team

5.3.6 The patient should be supplied with a transfer letter recording any wounds, pressure ulcers, bruises or skin blemishes and a minimum of 3 days supply of dressings.

5.3.7 Telephone notification to social care / care agencies to restart package of care (if no change and being received prior to admission)

5.3.8 Contact can be made with the LPT Discharge hub/ CHS flow team for assistance contact numbers will be on the daily bed state and flow report.

5.3.9 If an existing care package needs to be restarted, the registered health professional undertaking the assessment will need to confirm this will continue to meet the patient's needs and contact the relevant health or social care provider.

5.3.10 For patients who self-discharge or die whilst in hospital the relevant relatives, carers, agencies and GP should be informed.

5.3.11 Risk assessments will be completed prior to ordering any necessary equipment/aids essential for discharge:

a) The Physiotherapist or Occupational Therapist will assess for mobility aids e.g. walking frame/ stick, rotunda or aids to assist transfers eg hoist, bed lever, commode and order as appropriate and arrange further Physiotherapy or Occupational Therapy assessment/support in the community if required.

b) Where appropriate, patients/carers will receive instruction on the use of aids and equipment prior to discharge as a means of encouraging self-management.

c) Referrals for assistive technology can be made via the relevant social service department, patients may be charged for this service.

5.3.12 Where there is an urgent need to discharge a patient prior to the TTO medicines being physically available to ensure placements are not lost due to the delay in discharge, TTO medications will be sent via taxi on the same day of discharge.

5.4 Supported Discharges

5.4.1 Once a patient has been identified by the referring ward as having complex needs this is forwarded to the Discharge hub via the Home First Form, at the earliest opportunity and added to the waiting list, the referral will be triaged and additional conversations and information gained with the MDT involved in the case to support and progress the discharge

5.4.2 Where suspicions or disclosures are made for adults at risk of abuse, prompt adherence to existing safeguarding policy and procedures should be made.

5.4.3 Where it is suspected that patients lack capacity regarding decisions relating to discharge an assessment should be undertaken using the 'Mental capacity and Best Interests assessment' on SystmOne. Additional information e.g MCA assessments/behaviour charts/FIR charts should accompany the home first form where applicable.

5.4.4 Where patients lack capacity regarding decisions relating to discharge the views of family members must be sought and considered. It is the relevant decision makers responsibility to determine the future management of the patient's healthcare needs, in the 'best interests' of the patient, unless there is someone who has authority under a valid and applicable Lasting power of attorney or have been authorised to make decisions as a deputy appointed by the court of protection. (Mental Capacity Act 2005). For further details please refer to the Trust's Mental Capacity Act Policy.

5.4.5 Where patients lack capacity regarding decisions relating to discharge and there are no family or friends the MDT must consider making a referral to an independent mental capacity advocate (IMCA) (Mental Capacity Act 2005). For further details please refer to the Trust's Mental Capacity Act Policy.

5.5 Assessment of on-going care needs/care packages

5.5.1 Carers will be offered a carer's assessment from social services, where disclosures are made regarding their ability or willingness to continue caring or where staff suspect/observe difficulties in meeting the caring role.

5.5.2 Patients will be referred to physiotherapy and occupational therapy, if they have not returned to their pre-hospital functional status to determine whether they have potential for their functional ability to improve. To consider suitability for rehabilitation at home via 'Home First Community services', social care reablement; or admission to the Sovereign unit

5.5.3 The MDT are advised to seek early help and advice from the discharge hub team team or the local Adult Social Care team, with patients who have complex care needs or any issues that could potentially result in a delayed discharge

5.5.4 Patients who require support with care for the end stage of a terminal illness or have a rapidly deteriorating condition should have their care needs clearly documented on a Home First form. The LPT Discharge lead will liaise with Midlands and Lancashire CSU; they will source the appropriate package of care/placement. Midlands and Lancashire CSU will review the patient in the community within 14 days and complete Fast Tack documentation if required.

5.5.5 Patients with on-going healthcare needs should be considered for Discharge to Assess in their own home or a Discharge to Assess placement in a Nursing/Residential Home. Refer the patient via a Home first form.

5.5.6 Before issuing any assessments, i.e. Home First forms the MDT must consult with the patient and, where applicable, the carer to gain consent to referral.

Out of county referrals can be made by contacting the LPT Discharge Lead

5.5.7 Patients with exceptional high levels of care as identified by the referring ward on the HFF, that would also require the care in the community, the LPT flow team will liaise with Midlands and Lancashire team on behalf of the Clinical Commissioning Groups, to arrange the relevant care and further assessment in the community utilising the Discharge to Assess pathways. Completion of appropriate referral forms will be required (Appendix 5)

5.5.8 If the patient requires enteral feeding following discharge referral will need to be made to the HENS team to provide support and training to the patient, family, carer or care providers.

5.5.9 The Multidisciplinary Team (MDT) needs to determine whether the patient will benefit from rehabilitation/medical step down / up:

a) at home with 'Home First' services OR

b) Within a community hospital if the patient is stable a home first referral form is completed and added to system one communications and letter and sent to the LLR hub and the bed management.net account.

c) A placement in the Sovereign Unit for reablement, or at D2A therapy led bed placement or future alternative pathways.

5.5.10 Patients requiring home oxygen will require a Home oxygen form and consent form completing, the home oxygen service can assist with this process.

5.5.11 If the patient requires pressure relieving equipment such as a mattress the ward nurse will need to make a referral to the equipment provider prior to discharge. A referral will be made to the district nursing service to monitor the patient following discharge.

5.5.12 A bed rail risk assessment will be completed by the ward nurse on for patients requiring bed rails on SystmOne. The ward nurse of therapist will order via the ICELS equipment service for provision for discharge.

5.5.13 If the patient is returning home, lives alone and is unable to answer the door to carers - a key safe may be provided by the service commissioning the care (e.g. social care or continuing health care), and the patient may incur a charge.

5.5.14 If the patient has continence problems a continence assessment should be undertaken. Advice is available from the continence nurse specialist. Continence aids should be provided on discharge.

5.5.15 Staff may need to liaise with the Manual Handling team for advice regarding the needs of Bariatric patients – updated policy in place and available on StaffNet

5.5.16 If social services are unable to complete their assessment or arrange a package of care within the agreed timescale, a bridging service or interim placement within a care home should be offered. The social worker should make their offer accompanied by a health representative, to ensure, the patient is suitable for an interim placement (behavioral issues may not be suitable) and also to ensure the patient, family or carer is given an explanation of the benefits of an interim placement and the risks associated with a prolonged hospital stay). The social worker should liaise with the specialist discharge team, before making the offer and consider implementing the choice protocol if this is appropriate.

5.6 Patients who are visiting from abroad or are homeless

5.6.1 Homeless patients frequently have complex health, social and mental health issues. The multidisciplinary team should seek early advice from the Discharge Lead within the Discharge hub. Any complex issues can be raised and discussed at the daily escalation call, weekly discharge, or on an adhoc basis.

5.6.2 Patients visiting from abroad should be raised to the discharge lead to determine eligibility for health care services.

5.6.3 Homeless patients with ongoing care needs following discharge should be referred to the relevant social services by sending a Home first form for a community care assessment.

The patients' previous address will help to identify which local authority is responsible for the patient's care. If the patient wants to reside in Leicester, then a referral should be made to city social services. The patient's consent will be required for the referral.

5.6.4 The multidisciplinary team needs to refer the patient to a housing support officer for a housing assessment or referral for a hostel. If patient is optimised for discharge the patient can be also be directed to: Housing Options Team at Leicester City Council at Customer Service Centre 91 Granby street Tel: 0116 4541008 opening times Monday Tuesday and Thursday 8.30hrs – 17.00hrs Wednesday 9.30hrs – 18.00hrs and Friday 8.30hrs – 16.30hrs or Dawn Centre if out of hours Tel: 0116 2212770. For advice

5.6.5 Patients from abroad who may have no recourse for public funding and want reconnecting to their country of origin should be referred to the outreach team Tel: 0116 2995514. Patients requiring ongoing GP or district nurse can be referred to inclusion health care. A referral letter should be given to the patient, with an explanation of the follow up treatment and care required. The multidisciplinary team could ring the centre 0116 2212780 as there is high risk the letter provided to the patient may get lost. If the patient requires redressing of a wound then the patient should be provided with a 3 day supply of dressings.

5.6.6 The Discharge team may seek assistance with repatriation of overseas patients by contacting the appropriate family members or by seeking advice from the appropriate Embassy or various charitable organisations e.g. Red Cross.

5.7 Patient has long term condition, is frail and /or elderly or at risk of readmission

5.7.1 The multidisciplinary team need to submit the Home First form as early as possible and should contact the LPT Discharge team as early as possible in the patient journey for support.

5.7.2 A Multidisciplinary meeting needs to be arranged to discuss discharge planning, this will vary depending on the problem e.g. ward medical and nursing staff, social worker; OT, physiotherapist; community matron; care home staff if the patient is resident in a care home; CPN or psychiatrist if patient has mental health needs, GP or frequent attender nurse.

5.7.3 The aim of the meeting will be to determine the patients pre hospital functional status prior to admission, including the community social and health care support the patient was receiving and to discuss the patients current ongoing health and social care needs following discharge to enable a medical management plan and appropriate package of care can be commissioned that meets the patient's needs.

5.7.4 The Occupational therapist and Physiotherapist may need to consider any equipment, adaptations or assisted technology the patient may require that can help to support the patient in the community.

5.7.5 The patient, family/carer will be provided with a full explanation of their illness, prognosis, likely setbacks to expect and contact numbers of who to contact if concerned or requiring further assistance.

5.7.6 Staff may need to consider a contingency plan if the package of care/ care plan, is likely to breakdown, to prevent the patient from being unnecessarily admitted to acute care e.g. care home placement/ respite care; medical step down in community hospital.

5.8 Patients with mental health/ behavioural issues

5.8.1 The MDT need to submit the home first form and contact the Discharge team as early as possible for support, advice or assistance with discharge planning, again this could be a discussion at the daily escalation call.

5.8.2 If the patient is already known to mental health services the multidisciplinary team should contact the community psychiatric nurse (CPN) or relevant psychiatrist to ascertain background information/ patient baseline (0116 2255911).

5.8.3 The CPN should be informed of the patient's date of discharge and discharge destination for future follow up.

5.9 Patients with a learning disability

5.9.1 Establish if patient has known health or social key worker by contacting the GP or social work department (city 0116 454 1004, county 0116 3050013)

5.9.2 Refer to learning disability team for support with discharge planning, if the patient has ongoing care needs or issues relating to discharge. Also make them aware of any admission to our services.

5.9.3 Determine whether the patient has mental capacity to make decisions regarding discharge, if this is unclear and an assessment is required, ensure the patient receives appropriate support with communication e.g. learning disability nurse, friend, family, speech & language therapist.

5.10 Patients with End of Life care needs (Rapid Discharge/Fast Track)

5.10.1 Establish that the patient is not for further active treatment and that this is documented in SystmOne.

5.10.2 Ensure the patient and the family are aware that the patient is approaching end of life.

5.10.3 Establish preferred place of death.

5.10.4 Ensure RESPECT form & End of Life medication is prescribed via TTO letter for district nurse or specialist palliative care nurse.

5.10.5 For same day discharge make an urgent referral via the appropriate form to the Integrated Specialist Palliative Care Team (ICSPC). (Appendix 6)

5.10.6 Discharge Team will contact ISPCT to ensure that there is capacity to accept patient. Referrals Mon- Fri before midday, discharge can be arranged on the same day; referrals after midday can be arranged for the next working day.

5.10.7 Referring ward nurses will determine and order relevant equipment for discharge e.g. hospital bed, slide sheets, pressure relieving mattress, and notify ISPCT who will organise urgent delivery on the same day of discharge if required. To support rapid discharge, ICSPC coordination centre can order required equipment on the wards behalf to speed up discharge.

5.10.8 Fourteen days supply of End of life drugs to be prescribed by medical staff

5.10.9 Complete ReSPECT form, notify patient and carer and GP. Patients to be given original on discharge. Patients transferring to a new care home will be registered with a new GP. It is good practice to make advanced contact with the GP and advise that the patient is being discharged and that they may need to undertake a symptom review at an early stage.

5.10.10 Refer to home oxygen service if palliative oxygen is required and mark as urgent. ICSPC nurses have access to order home oxygen at end of life if support is needed.

5.10.11 Arrange ambulance online or by telephone - ensuring end of life is entered onto booking to ensure maximum 2 hour wait.

5.10.12 Notify GP and Integrated Community Specialist Palliative Care of actual time of discharge, 0300 5555255. Out of hours remains as SPA but the ICSPC will automatically transfer to SPA 18.00-08.00hrs. After 1800hrs SPA have the direct number of the SPCN on duty to support any discharges after 18.00-20.00hrs.

5.10.13 Ensure patient has copy of GP letter; ReSPECT form; transfer letter; nursing documentation; TTO letter and relevant medicines/water for injection & syringe driver. Inform the ISPCT form on the referral form when syringe driver has been sent with patient, so that they can arrange for it to be returned.

5.11 Self-Discharge against medical advice

5.11.1 Self discharge against medical advice may be a significant risk to both the patient and the Trust and on occasions to the public. Patients are under no obligation to follow the medical advice but it is crucial that they understand the implications of a decision to self-discharge and whether they have the capacity to refuse treatment.

5.11.2 Patients or families wishing to take their own/ their loved ones discharge will be advised by nursing staff initially to stay. The ANP should also be involved in encouraging the patient/ family to stay, informing them of the risks associated with self-discharge. If they believe leaving hospital is not in the patient's best interest medically a Consultant/GP/ANP should make a decision as to whether this constitutes a safeguarding issue.

5.11.3 If capacity is questioned the Consultant, GP or ANP should assess capacity in relation to the patients' ability to make a decision to self-discharge and this should be recorded on the 'Discharge against medical advice form' and filled in the medical notes.

5.11.4 If the patient has capacity and is adamant that they wish to leave hospital by their own means. The most senior doctor available who should provide an explanation of the clinical problem and suggested management plan. Furthermore, any discussion of treatment should mention of not only the complications of treatment, but also the potential consequences of declining treatment. The patient should be asked to sign the discharge against medical advice form, which should be countersigned by the ANP present. This should then be scanned on to SystmOne.

5.11.5 If the patient does not have capacity the Consultant, ANP and Lead Therapist need to make a best interest's decision whether the patient needs to be detained in hospital and consider whether an urgent DoLS application is required. For further details refer to the Trust's Deprivation of Liberty Safeguards Policy.

5.11.6 Patients will be offered a prescription for relevant medication. If the patient is unwilling to wait for the medication to be dispensed this should be recorded in the notes and the GP informed.

5.11.7 If the patient requires a district nurse this should be discussed with the patient to be established if the Trust should contact the DN service or if the patient wishes to make their own arrangements. If this is the case, the relevant contact number should be given to the patient. The decision and action should be documented in the patient's medical records.

5.12 Delayed Transfers of Care

5.12.1 A delayed transfer of care occurs when a patient is ready for transfer from an acute hospital bed but is still occupying such a bed.

5.12.2 Monitoring of delayed transfers of care takes place daily with LLR system partners and through daily escalation calls.

5.12.3 The System Discharge Hub Administration Team coordinate the daily discharge sitrep report will ensuring that delays are accurately assigned on the Strategic Data Collection Service

5.13 Patients who Refuse Discharge

5.13.1 On occasions a person fit for discharge, may refuse to leave hospital. In these circumstances the person refusing should be evaluated by the MDT to establish medical/psych/social basis for that patient's refusal. If no resolution from the MDT the ward staff may contact the Matron for support then provide the 'Patient Choice' procedure.

6.0. Education and Training Requirements

6.1 LPT is committed to raising awareness of effective discharge planning by the provision of discharge training for all staff within the Trust and partner agencies.

6.2 The Trusts Flow team is responsible for the development, implementation and evaluation of Trust Discharge Training events.

6.3 Ward Sisters, ANPs, Matrons, Head and Deputy Head of Nursing, Operational and Transformation Lead for Hospitals and Clinical Directors will ensure that all staff have access to training and education to maintain up to date knowledge of local and national policies relating to discharge planning.

6.4 All staff have responsibility to attend an update of the Trust Discharge Training organised by the LPT Flow team if a training need or gaps in knowledge are identified at appraisal.

7.0 Monitoring Compliance and Effectiveness

To understand if a discharge or transfer of care is safe, timely and effective the following key performance metrics/indicators will be monitored:

a) Evidence of a discharge care plan; including EDD, patient/ carer awareness. Completion of discharge / transfer of care letter/TTO.

b) Readmission report from LPT completed monthly.

c) Daily Discharge Sitrep reporting to the Strategic Data Collection Service (SDCS). Electronic incident forms relating to discharge

d) Complaint trends and themes where discharge is the key theme.

e) Patient satisfaction in relation to the specific national patient experience questions in relation to discharge.

Page/Section	Minimum Requirements to monitor	Process for Monitoring	Responsible Individual /Group	Frequency of monitoring
Section 5	Evidence of a discharge care plan; including EDD, patient/ carer awareness	Report pulled from SystmOne/ documentation audit	CHS Flow Group	Annual

Page/Section	Minimum Requirements to monitor	Process for Monitoring	Responsible Individual /Group	Frequency of monitoring
Section 5.1	Completion of discharge / transfer of care letter/TTO/Home First Form	Report pulled from SystmOne/ICE	CHS Flow Group	Annual
Section 3.6	Daily Discharge Sitrep reporting to the Strategic Data Collection Service (SDCS).	Report pulled from SystmOne	LLR Discharge Cell	Quarterly
Section 4.5	Ulysses incidents/complaints relating to discharge	Report relating to incidents by /ward for the trust	CHS Flow Group	Monthly with quarterly review
Section 7	Patient satisfaction in relation to the specific national patient experience questions in relation to discharge	Report pulled from national patient satisfaction survey.	CHS Flow Group	Monthly with quarterly review

8.0 References and Bibliography

8.1 This document has been developed in conjunction with hospital staff, local LLR Health and social care partners and is consistent with the UHL Going Home Policy (for Adults).

8.2 The documents listed below have been used in the formulation of this policy:

a) NHS COVID-19 Hospital Discharge Service Requirements Published 19th March 2020 and updated 16th September 2020.

b) National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care. October 2018 (Revised) Published March 2018.

c) NHS Improvement ‘A brief guide to developing Criteria led discharge’ (2017).

d) Discharging older patients from hospital. National Audit Office 20th May 2016.

e) Transition between inpatient hospital settings and community or care home settings for adults with social care needs. NICE guidelines December 2016. nice.org.uk/guidance/qs136.

f) A report of investigations into unsafe discharge form hospital. Parliamentary & Health Ombudsman. May 2016.

g) Healthwatch England Special Enquiry Findings July 2015, ‘Safely home: What happens when people leave hospital and care settings. July 2015.

h) NHS Commitment to carers (NHS England 2014).

i) Testing the bed blocking hypothesis. Does higher supply of nursing and care homes reduce delayed discharge? ESHCRV CHE Research paper. University of York August 2014.

j) National Framework for NHS Continuing Health Care and NHS Funded Nursing Care. Department of Health revised November 2012.

k) Lees, L. (2012) “Timely Discharge from Hospital”, M&K Publishing, United Kingdom.

l) External Ready to go? - Department of Health, 2010.

m) Transforming Social Care - Department of Health, 2008.

n) Local Authority circular LAC (DH) (2009) 1 - Department of Health, 2009.

o) User-led Organisations Project Policy - Department of Health, 2007.

p) Urgent Care Pathway for Older People with Complex Needs - Best practice guidelines. Department of Health, 2007.

q) Safeguarding Adults Policy and Procedures. Trust reference B26/2011 UHL Mental Capacity Act Policy. Trust reference B23/2007.

r) Carers (Equal Opportunities) Act 2004. Office of Public Sector Information.

s) Achieving timely "simple" discharge from hospital - Department of Health, 2004, t) Supporting people with long term conditions - Department of Health, 2005.

t) Discharge from hospital: pathway, process and practice (DoH 2003)

9.0 Fraud, Bribery and Corruption consideration

The Trust has a zero-tolerance approach to fraud, bribery and corruption in all areas of our work and it is important that this is reflected through all policies and procedures to mitigate these risks.

- Fraud relates to a dishonest representation, failure to disclose information or abuse of position in order to make a gain or cause a loss. Bribery involves the giving or receiving of gifts or money in return for improper performance. Corruption relates to dishonest or fraudulent conduct by those in power.
- Any procedure incurring costs or fees or involving the procurement or provision of goods or service, may be susceptible to fraud, bribery, or corruption so provision should be made within the policy to safeguard against these.

- If there is a potential that the policy being written, amended or updated controls a procedure for which there is a potential of fraud, bribery, or corruption to occur you should contact the Trusts Local Counter Fraud Specialist (LCFS) for assistance.

Appendix 1 Supporting patient choice

Appendix 1 Supporting patient choice

Supporting 'Patient Choices' to avoid Long Hospital Stays

University Hospitals of Leicester NHS Trust

Leicestershire Partnership NHS Trust


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?

What might I expect?

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?

Step 1. Hospital Admission

Provide information leaflets


NHS University Hospitals of Leicester and Leicestershire Partnership NHS Trusts ...Working together to provide better healthcare

Supporting you to leave hospital when you may need ongoing care

Information for Patients

Name:

Estimated date of discharge:

Step 2. Assessing and preparing for discharge. If additional needs on discharge

Complete Home First Form


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?

What might I expect?

Why can't I stay in hospital?

Who can I contact?

Step 3. Discharge Destination Confirmed by LLR Discharge Hub

Provide information leaflets


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?

What might I expect?

Why can't I stay in hospital?

Who can I contact?

Step 4. Escalation

To Matron / Discharge Specialist Team

If Patient refuses

Step 5. Seek Legal Advice

Appendix 1 Supporting patient choice

Supporting 'Patient Choices' to avoid Long Hospital Stays

NHS University Hospitals of Leicester NHS Trust

NHS Leicestershire Partnership NHS Trust

Patient Addressograph	Ward: Site:

The completed Checklist is to be placed in the Patients Medical Records

1. Has the Patient been given a copy of the **'Planning together: leaving hospital when the time is right leaflet**'?	YES	NO
2. Has the patient been given a copy of the **'You are leaving hospital: returning home / moving or returning to another place of care leaflet'**?	**YES**	**NO**
3. Have you/ senior nurse explained to the patient it is not in their best interests to remain in hospital?	**YES**	**NO**
If No to any of the above – please have a conversation about discharge with the patient/ family/ carers		
4. What are the Patients and or Families concerns about the planned discharge destination? What are they most worried about?		
Name: **Date:** **Signature:**		
Escalate to Matron or Discharge Specialist Nurse if no resolution.		
Actions taken by Matron/ Discharge Specialist Nurse:		
Name: **Date:** **Signature:**		
Outcome:		

Appendix 2 Home First form

Appendix 2 Home First form

Patient Name: NHS No

LLR Discharge Hub Referral: Home First Form

Please 'describe the current care needs', not prescribe the care for discharge

<table>
<tr><th colspan="3">PATIENT DEMOGRAPHICS</th></tr>
<tr><td rowspan="3">Patient Name:

NHS No:

D.O.B:
Address:

Tel no:

Gender:</td><td rowspan="3">Date of Admission:
Reason for Admission:

Current diagnosis:

Past Medical History:

Estimated Date of Discharge:</td><td>Referring Hospital:

Referring Ward:

Ward contact no:</td></tr>
<tr><td>GP Practice (including OOA):

Postcode:

County ☐ City ☐ Rutland ☐</td></tr>
<tr><td>Next of Kin/Preferred Contact Name:

Relationship:

Address:

Contact No:</td></tr>
<tr><td>Consultant/Speciality:</td><td rowspan="3">ReSPECT (DNACPR) in place?
Yes ☐ No ☐

Advanced Care Plan in place?
Yes ☐ No ☐</td><td rowspan="3"></td></tr>
<tr><td>Ethnicity:

Religion:</td></tr>
<tr><td>Spoken/Understood Languages:

Interpreter required: Yes ☐ No ☐</td></tr>
<tr><th colspan="3">END OF LIFE DISCHARGE</th></tr>
<tr><td colspan="3">EOL prognosis is 7 days or less: Yes ☐ No ☐

If yes for a patient in UHL please call the UHL Discharge Team immediately.
If yes for a patient in LPT please call the LLR Integrated Community Specialist Palliative Care Service (ICSPC)

EOL prognosis is longer than 7 days: Yes ☐
Timeframe of prognosis:
EOL diagnosis: Patient/NOK aware: Yes ☐ No ☐</td></tr>
</table>

Appendix 2 Home First form

INFECTION RISK & RESULTS		
Covid-19 Date of last Covid test: Result: If result positive/exposed to covid needs isolation until date: If available (not mandatory): Date first vaccine: Date second vaccine given /due:	MRSA +ve Yes ☐ No ☐ Date: C/Difficile +ve Yes ☐ No ☐ Date: CRO +ve Yes ☐ No ☐ Date: Any other infections? Yes ☐ No ☐ Details:	Any evidence of infective diarrhoea? Yes ☐ No ☐ Diarrhoea in last 48 hours? Yes ☐ No ☐ Date bowels last opened:
Please describe Infection / bowel management plan, if applicable:		

SOCIAL CIRCUMSTANCE AND ABILITY PRIOR TO ADMISSION	
Accommodation Type i.e. a house, Residential Home or Nursing Home, Assisted Living: Owner of accommodation: Detail of any known housing issues/environmental barriers to discharge i.e. hording and access issues:	
Social History (prior to admission) i.e. ability with ADL's, formal and informal care in place, and equip already insitu at property Known night time needs – detail: Falls History: Yes ☐ No ☐ Detail:	
Keysafe insitu: Yes ☐ No ☐ Keysafe number: Contact details for keysafe:	Keysafe required? Yes ☐ No ☐ Essential for discharge? Yes ☐ No ☐ Patient/NOK preferred number for keysafe: (four different digits but not DOB. No zeros)
Pendant Alarm in situ? Yes ☐ No ☐ Pendant Alarm required? Yes ☐ No ☐ Essential for discharge? Yes ☐ No ☐ Detail:	Assistive Technology insitu: Yes ☐ No ☐ Detail: Assistive Technology required: Yes ☐ No ☐ Detail: Essential for discharge: Yes ☐ No ☐

CURRENT COMMUNICATION AND COGNITION	
Communication difficulties? Yes ☐ No ☐	Please describe ability and difficulties:
Cognitive impairment? Yes ☐ No ☐	Please describe ability and difficulties:

Appendix 2 Home First form

Display of challenging or at risk behaviour? Yes ☐ No ☐ If yes – have behaviour charts been completed? Yes ☐ No ☐ (please submit Behaviour Charts with Home First Form referral)	Please describe and include description of how this is managed:

CURRENT ABILITY/NEED WITH WASHING & DRESSING		
Independent: Yes ☐	Prompting/Supervision: Yes ☐	Assistance x 1: Yes ☐
Assistance x 2: Yes ☐	Non-compliant? Yes ☐ No ☐ Details if No:	
Additional comments:		
Re-ablement potential: Yes ☐ No ☐	Detail:	

CURRENT MOBILITY & TRANSFERS		
Transfers: *(state level of ability)*	Chair:	Bed:
	Toilet:	Commode:
	Equipment used for transfer:	
Mobility	Detail:	
Stairs	Detail:	
Falls	Detail of falls whilst inpatient:	
Weight bearing status	Detail: Cast/POP insitu: Yes ☐ No ☐ Detail/when to be removed: Prescribed timeframe of weight baring status, if applicable: Date/time of Fracture Clinic OPA, if applicable:	
Additional comments: Re-ablement potential: Yes ☐ No ☐ Detail:		

EQUIPMENT ORDERED FOR DISCHARGE
Equipment ordered for discharge and delivery date:
Essential for discharge: Yes ☐ No ☐
If yes, why:
Patient/NOK aware of equipment ordered/being delivered: Yes ☐ No ☐

Appendix 2 Home First form

NUTRITION & HYDRATION			
MUST score: Or NST score:	Weight:	Height:	BMI:
TPN prescribed? Yes ☐ No ☐ Detail:		Dentures in situ? Yes ☐ No ☐	
PEG/RIG Feeding? Yes ☐ No ☐ Detail:			
Is patient at risk of dehydration and/or malnutrition? Yes ☐ No ☐ If yes, please give details:			
SALT input? Yes ☐ No ☐		Feed at Risk: Yes ☐ No ☐ Feed at Risk plan in place: Yes ☐ No ☐ Detail:	
Modified Diet? Yes ☐ No ☐		If modified - what texture?	
Fluids: Normal- Yes ☐ Thickened-Yes ☐		If thickened – what level?	

CURRENT ABILITY/NEED FOR EATING		
Independent:	Supervision/Prompting:	Full Assistance:
Re-ablement potential: Yes ☐ No ☐	Detail:	

CURRENT ABILITY/NEED FOR DRINKING		
Independent:	Supervision/Prompting:	Full Assistance:
Re-ablement potential: Yes ☐ No ☐	Detail:	

CURRENT MEAL PREPARATION NEED		
Hot drink: Independent: ☐ Supervision/Prompting: ☐ Full Assistance: ☐	Snack: Independent: ☐ Supervision/Prompting: ☐ Full Assistance: ☐	Hot Meal: Independent: ☐ Supervision/Prompting: ☐ Full Assistance: ☐
Comments?		

CURRENT CONTINENCE/TOILETING NEEDS	
Continent of Urine? Yes ☐ No ☐ Management plan: Aids/equipment trialled: Aids/equipment used:	Continent of Bowels? Yes ☐ No ☐ Management plan: Aids/equipment trialled: Aids/equipment used:
Night-time continence management:	

Appendix 2 Home First form

CAPACITY & CONSENT	
Does the patient have capacity to consent to this referral? Yes ☐ No ☐ Unsure ☐	If yes, do they consent to this referral? Yes ☐ No ☐ Do they consent to record sharing? Yes ☐ No ☐
Has a Mental Capacity Assessment been completed? Yes ☐ No ☐ N/A ☐ If yes, for what decision? Outcome: Has Capacity Yes ☐ No ☐ (please submit MCA with Home First Form referral) If patient does not have capacity, have NOK/preferred contact been consulted for a best interest decision? Yes ☐ No ☐ Outcome:	Name/role of person completing the Mental Capacity Assessment: Date Completed:
Is there a DoLS in place? Yes ☐ No ☐ N/A☐ If yes, please give details as to why in place:	
Is there a Power of Attorney in place for: Health & Welfare? Yes ☐ No ☐ Finances? Yes ☐ No ☐ If yes, please give details: Has formal evidence been provided and viewed: Yes ☐ No ☐	
Are there any live safeguarding concerns? Yes ☐ No ☐ If yes, who is involved: UHL Safeguarding Team: Yes ☐ No ☐ Adult Social Care Safeguarding Team: Yes ☐ No ☐ LPT Safeguarding Team: Yes ☐ No ☐ Please provide details of safeguarding investigation:	

CURRENT MEDICAL MANAGEMENT	
Is there a medical management plan to support discharge? Yes ☐ No ☐ If yes, please describe this plan:	Follow up treatment/appointments post discharge? Yes ☐ No ☐ N/A ☐ If yes, please provide details:
Any controlled drugs? Yes ☐ No ☐ *(Please provide details including how often)*	Can patient self-administer? Yes ☐ No ☐ If no, state who will provide support?

Appendix 2 Home First form

Any time critical medications? Yes ☐ No ☐ *(Please provide details including how often)*		Can patient self-administer? Yes ☐ No ☐ If no, state who will provide support?
Warfarin/Anticoagulation? Yes ☐ No ☐ *(Please provide details including how often)*		Can patient self-administer? Yes ☐ No ☐ If no, state who will provide support?
Insulin dependent? Yes ☐ No ☐ *(Please provide details including how often)*		Can patient self-administer? Yes ☐ No ☐ If no, state who will provide support?
Use of inhaler? Yes ☐ No ☐ *(Please provide details including how often)*		Can patient self-administer? Yes ☐ No ☐ If no, state who will provide support?
Use of nebulisers? Yes ☐ No ☐ *(Please provide details including how often)*		Can patient self-administer? Yes ☐ No ☐ If no, state who will provide support?
Is the patient on eye drops? Yes ☐ No ☐ *(Please provide details including how often)*		Can patient self-administer? Yes ☐ No ☐ If no, state who will provide support?
Does the patient have any allergies? Yes ☐ No ☐ If yes, please provide details:	Describe any breathing concerns:	Home oxygen? Yes ☐ No ☐ Litres: Frequency: In place for discharge: Yes ☐ No ☐ Delivery date:
Is medication supplied in: Dosset Box ☐ Blister Pack ☐	PICC Line in-situ: Yes ☐ No ☐ Please provide details:	IVAB's at home: Yes ☐ No ☐ OPAT referral made: Yes ☐ No ☐
WOUND CARE		
Are pressure areas intact? Yes ☐ No ☐ If no: Location: Grade:		Any wounds? Yes ☐ No ☐ Please provide details: Current Waterlow score:
Please describe management plan for wound care on discharge: Community Nurse referral already made: Yes ☐ No ☐		
NURSING NEEDS *(Bullet Point Summary of Needs)*		
•		
Referrer: Designation: Contact Number:		Contributors: Designation: Contact Number:
Date/time of referral:		

Insert sticker here

Appendix 3 Discharge Planning Checklist

Discharge Planning Checklist

For Day of Discharge

Date of discharge……

	YES	NO	N/A	Insert date if appropriate
Is your multidisciplinary team in agreement your patient is fit for discharge?				
Is your patient aware of their discharge plans?				
Is the appropriate family, next of kin/carer aware of the discharge plan?				
Is a package of care and start date in place and documented?				
If family are supporting with care, have they received support and education e.g., changing catheters?				
Is all nursing/therapy essential equipment in place e.g., bedrails/seating, key safe?				
Are the patients TTO's on the ward e.g., blister pack/dosset box/CDs?				
Have the TTO medication been checked by 2 RNs, with the patient?				
Is an authorisation required for Community Nurse Administration?				
Has the authorisation been completed?				
Is your patient taking warfarin?				
If so, is an anticoagulation referral competed? (plus 4 day dose prescribed)				
Is your patient on insulin?				
Will you require a Community Nurse referral for administration of Insulin?				
Have you made referrals to Community Services, DN's etc?				
Will Family be collecting? If not has transport been booked? (online)				
Have you confirmed a discharge date with community services/care home? Has a verbal handover been completed?				
Does your patient have access to their property?				
Do they have their keys / key safe number?				
Have the patient's possessions been returned to them, including those in the Safe?				
Does the patient have suitable attire for discharge (preferably their own clothes?				
Check therapy equipment is discharged with the patient?				
Are you sending the patient with appropriate nursing supplies? continence products, sharps bin, dressings, stoma care?				
Is the ICE discharge letter completed by all MDT participants?				
Have you documented in the progress notes to reflect that the patient is ready for discharge?				
Has the ANP reviewed the TTO's? Are the TTO's correct and up to date?				

Discharging Nurse Print Name …… Signature ……

Insert sticker here

Verbal Handover for Discharge of Patient into Residential / Nursing Care

Date of discharge: …… Name of Care Home ……..

Person Completing the Handover

Print Name: ……..…… Signature: …….

Person Receiving the Handover

Print Name: ……..……

Diagnosis PMH	Is the patient diabetic? On insulin?
Is the patient on O2? Has O2 been ordered?	
Date of COVID swab and result	
Patients IPC Status	
RESPECT Form	
Weight and Waterlow	
Patients mobility Equipment used for mobility	
Does the patient use a call bell? Does the patient require 1:1?	
Are pressure areas intact? Any other wounds?	Dressing used
Continent of urine/faeces? Catheter in place? Catheter passport?	Any samples sent and results
Communication needs	
Type of diet and fluids Does the patient require assistance? NG/PEG?	
Is the patient a falls risk? Bed rails in use?	
Equipment ordered on discharge and details	Company and telephone number

Appendix 5 High Dependency Criteria

High Dependency Patients – Criteria

(June 2021)

- **The patient is a County and or City LA resident (not Rutland). Use Gov link if not certain:** https://www.gov.uk/find-local-council
- **Is registered with a Leicester or Leicestershire GP**
- **Hospital setting inpatient:** no longer requires an acute hospital bed and is medically optimised for discharge
- **Patient may have cognitive impairment, known delirium, or a non-acute mental health diagnosis, that is impacting upon behaviour and/or resulting in wandering and risk taking. 1:1 support is recommended following triage/DC Team review. The patient only responds to skilled intervention, that requires 24hr assessment, monitoring, medication administration and input via trained professionals**
- **May be able return home but would require a 24 hr care, as above**
- **If can't return home, needs may be met in Residential Home with additional staffing and core commissioned Community Health Services**
- **Needs can't be met in a Residential Home with additional staffing and Community Health Services, so requires a Nursing Home placement**
- **'Home First' is the goal, but if a placement is required the MDT aim for discharge home through ongoing assessment in the community within 2-4 weeks. This will involve a system partner MDT approach**

The 'High Dependency' cohort of patients are managed by the High Dependency Case Managers via MLCSU. This cohort is managed separately to the patients referred for a D2A NH Framework bed, also managed by MLCSU. High Dependency patients have high level health and social care needs that may trigger on a CHC Checklist, after 7-14 days recovery post discharge from the hospital setting and would therefore require a DST assessment for CHC funding eligibility. It is anticipated that the cohort of patients referred for the D2A NH Framework beds, without high dependency health needs, will not trigger on a CHC checklist, nor require a DST after a period of recovery. It is important to add that CHC assessments will not occur in hospital and will be carried out in the community, if appropriate.

Prior to discharge planning acute health colleagues (DC Team) will need to provide clear feedback about: what the 1:1 is required for and, if being discharged home/to a Residential Home, the community health service referrals made, with contact details for such services. The High Dependency Case Manager will be supported by a Health Care Professional (HCP) in the community, to jointly case mange the patient at home/in a Residential Home. The community HCP will liaise with and chase core community health colleagues regarding the health referrals made, so information is available to support the D2A Needs Assessment Meeting in the community.

Appendix 6 End of life Rapid Discharge Form

Leicestershire Partnership NHS
NHS Trust

LOROS
Hospice Care for Leicester, Leicestershire & Rutland

Integrated Community Specialist Palliative Care Team

Email: llr.icspc@nhs.net **Telephone: 0300 555 5255**

End of Life Rapid Discharge Referral Form – v4 June 2021

ELIGIBLE CRITERIA:

PATIENT NEEDS TO HAVE AN END OF LIFE DIAGNOSIS, WITH A PROGNOSIS OF NO MORE THAN 1 WEEK WITH DOCUMENTED EVIDENCE OF THEIR PREFERRED PLACE OF DEATH AS HOME.

Date of Referral:		**Time of Referral:**
Discharger:		**Tel No.:**
Hospital Site:	**Ward:**	**Tel No.:**
The Discharger (or nominated person) **MUST** call the ICSPC Service on 0300 555 5255 to confirm when the patient has left hospital (not when they are waiting for transport). This is to ensure the service delivers the patient care, following discharge from hospital, in a timely manner.		
Patient Name:		
NHS No.:		**D.O.B:**
Address:		
Post code:		**Keycode:**
Telephone Number:		
Next of Kin: **Relationship:**		**Contact No.(s):**
GP Name/Base:		**Contact No.:** **Last Visit:**
RESPECT Form in situ with DNAR? : YES / NO **Received? : YES / NO** ***Please email with this Referral form***		**Authorisations in situ?: YES / NO** **Received?: YES / NO** ***Please email with this Referral Form***
Has Equipment been ordered by hospital?: YES / NO **Weight:** **Height:** **(If no, what equipment needs to be ordered by the ICSPC Service)?**		
Current Medication Regime: **Transdermal Patch: YES / NO** **Dose:** **Pre-Emptive Meds: YES / NO**		**Syringe Driver in situ? : YES / NO** **Contents:** **O_2 in situ? : YES / NO**

Diagnosis: **COVID-19 STATUS:** **Patient Aware? : YES / NO** **Family aware? : YES / NO**	**Prognosis:** needs to be last days of life): where one or more of the following apply: ○ The patient is having difficulty moving and bed-bound ○ The patient is spending more time asleep than awake -semi-comatose ○ The patient is taking sips of fluid only ○ The patient is having difficulty swallowing or taking oral medication **Patient Aware? : YES / NO Family aware? : YES / NO**
Medical History:	**Are there any pressure areas? : YES / NO** **Details:** **Waterlow Score:** **Is Patient Bedbound? : YES / NO**
IS THE PATIENT AT RISK OF A CATASTROPHIC BLEED:	**YES -** If so, please consider prescribing/authorising crisis medications. **NO**
Does the patient need Marie Curie overnight? : YES / NO Have family agreed?: YES / NO	
Environmental Factors: **(Access, parking, concealed entrance etc.)** **Any pets? : YES / NO** **Smokers in house? : YES / NO**	**Consent to access data? : YES / NO** **Consent to Share data? : YES / NO**

Additional Nursing/Care Requirements:

- Catheter **YES / NO**
- Any other (please list):

Please email this completed form to llr.icspc@nhs.net. When you have emailed the form, please contact the team on 0300 555 5255 to ensure the email has been received and acknowledged.

Appendix 7 Training Requirements

Training Needs Analysis

Training topic:	Discharge
Type of training: (see study leave policy)	☐ Mandatory (must be on mandatory training register) ☐ Role specific X☐ Personal development
Directorate to which the training is applicable:	☐ Mental Health X☐ Community Health Services ☐ Enabling Services ☐ Families Young People Children / Learning Disability Services Autism ☐ Hosted Services
Staff groups who require the training:	*Community Hospital Inpatient Team*
Regularity of Update requirement:	3 Yearly
Who is responsible for delivery of this training?	Capacity and Flow Lead
Have resources been identified?	Within Service Line
Has a training plan been agreed?	In Development
Where will completion of this training be recorded?	☐ ULearn X☐ Other (please specify)
How is this training going to be monitored?	Service Line Governance Meeting

Appendix 8 The NHS Constitution

- The NHS will provide a universal service for all based on clinical need, not ability to pay.
- The NHS will provide a comprehensive range of services.

Shape its services around the needs and preferences of individual patients, their families and their carers	☐
Respond to different needs of different sectors of the population	☐
Work continuously to improve quality services and to minimise errors	☐
Support and value its staff	☐
Work together with others to ensure a seamless service for patients	☐
Help keep people healthy and work to reduce health inequalities	☐
Respect the confidentiality of individual patients and provide open access to information about services, treatment and performance	☐

Appendix 9 Due Regard Screening Template

Section 1	
Name of activity/proposal	Discharge
Date Screening commenced	17.05.23
Directorate / Service carrying out the assessment	CHS
Name and role of person undertaking this Due Regard (Equality Analysis)	Sarah Latham HON
Give an overview of the aims, objectives and purpose of the proposal:	
AIMS: This document sets out the Community Health Services (CHS) Leicestershire Partnership NHS Trust (LPT) Policy and Procedures for the safe and timely discharge and transfer of care of adults admitted to the trust.	
OBJECTIVES: To provide a framework that enables the delivery of safe, effective and timely discharge or transfer of care for all adult inpatients. The core principles and processes are the same for all CHS inpatient wards.	

Section 2	
Protected Characteristic	If the proposal/s have a positive or negative impact please give brief details
Age	
Disability	
Gender reassignment	
Marriage & Civil Partnership	
Pregnancy & Maternity	
Race	
Religion and Belief	
Sex	
Sexual Orientation	
Other equality groups?	

Section 3	
Does this activity propose major changes in terms of scale or significance for LPT? For example, is there a clear indication that, although the proposal is minor it is likely to have a major affect for people from an equality group/s? Please tick appropriate box below.	
Yes	No
High risk: Complete a full EIA starting click here to proceed to Part B	Low risk: Go to Section 4. x

Section 4			
If this proposal is low risk please give evidence or justification for how you reached this decision:			
Following and compliant with national guidance as detailed by NHSE All individuals admitted to community hospitals will follow the same policy for discharge. Discharge destination and time to discharge may be impacted due to protected characteristics however process to discharge will not be affected			
Signed by reviewer/assessor	S Latham	Date	17.05.23
Sign off that this proposal is low risk and does not require a full Equality Analysis			
Head of Service Signed	Nikki Beacher	Date	18.05.23

Appendix 10 Data Privacy Impact Assessment Screening

Data Privacy impact assessment (DPIAs) are a tool which can help organisations identify the most effective way to comply with their data protection obligations and meet Individual's expectations of privacy. The following screening questions will help the Trust determine if there are any privacy issues associated with the implementation of the Policy. Answering 'yes' to any of these questions is an indication that a DPIA may be a useful exercise. An explanation for the answers will assist with the determination as to whether a full DPIA is required which will require senior management support, at this stage the Head of Data Privacy must be involved.

Name of Document:	**Discharge and Transfer of Care Policy (Going Home Policy) for Community Health Services (CHS) For Adults Leaving Community Hospitals**	
Completed by:	**Sarah Latham**	
Job title	**CHS Head of Nursing**	**Date 17.05.23**

Screening Questions	**Yes / No**	**Explanatory Note**
1. Will the process described in the document involve the collection of new information about individuals? This is information in excess of what is required to carry out the process described within the document.	No	
2. Will the process described in the document compel individuals to provide information about them? This is information in excess of what is required to carry out the process described within the document.	No	
3. Will information about individuals be disclosed to organisations or people who have not previously had routine access to the information as part of the process described in this document?	No	
4. Are you using information about individuals for a purpose it is not currently used for, or in a way it is not currently used?	**No**	
5. Does the process outlined in this document involve the use of new technology which might be perceived as being privacy intrusive? For example, the use of biometrics.	No	
6. Will the process outlined in this document result in decisions being made or action taken against individuals in ways which can have a significant impact on them?	No	
7. As part of the process outlined in this document, is the information about individuals of a kind particularly likely to raise privacy concerns or expectations? For examples, health records, criminal records or other information that people would consider to be particularly private.	No	
8. Will the process require you to contact individuals in ways which they may find intrusive?	**No**	

If the answer to any of these questions is 'Yes' please contact the Data Privacy Team via Lpt-dataprivacy@leicspart.secure.nhs.uk
In this case, ratification of a procedural document will not take place until review by the Head of Data Privacy.

Data Privacy approval name:	**Sarah Latham**
Date of approval	**September 2023**

Acknowledgement: This is based on the work of Princess Alexandra Hospital NHS Trust