1. Introduction and purpose

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

BSW partners recognises

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

4. MANAGING EXPECTATIONS OF PATIENTS

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

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

4.3

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

5.3 multi-disciplinary hospital discharge teams and transfer of care hubs, comprising professionals from all relevant services across sectors (such as health, social care, housing, and the voluntary sector), will work together so that, other than in exceptional

24-hour nursing care and support to talk through the patients wishes and preferences. Everyone’s care journey should be anticipated and mapped out, including advanced care

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

10 Equality and diversity

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

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

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

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