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Admission, Transfer and Discharge from Inpatient Settings

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Contents

1 Introduction

This Policy supports the delivery of safe and effective care in line with the trust values. It is vital that every person who needs acute mental health care receives timely access to high quality, therapeutic inpatient care, close to home and in the least restrictive setting possible. Care must be personalised, admissions timely and purposeful. Hospital stays should be therapeutic and discharge/transfer of care timely and effective.

This Policy is critical to the delivery of Our Journey to Change and our ambition to co-create safe and personalised care that improves the lives of people with mental health needs, a learning disability or autism. It helps us to deliver our strategic goals as follows:

This policy supports the trust to co-create a great experience for all individuals who use our services, their carer's, and families by ensuring they are:

- Fully involved in the process of admission, transfer, and discharge/transfer of care and able to make informed choices about their care, wherever possible
- Treated in a respectful, professional, and courteous manner.
- Given appropriate and timely information about their treatment and the care they will receive from the service.

Communication between people who use our services, and their families/cares must be effective and timely.

This policy supports the trust to be a great partner, so we will work alongside other health and social care providers and ensure good communication and documentation takes place in relation to all multi-agency working.

2 Why we need this policy

2.1 Purpose

The purpose of this document is to:

- Describe the minimum standards of practice to be followed to support people through their admission to hospital, any transitions/transfers between hospital services, and subsequent discharge/transfer of care /transfer of care from the in-patient service.
- Ensure that people's agreed needs determine the service most appropriate to coordinate their care, not age or diagnosis.
- Set out the overarching principles and standards to support local protocols.

The detailed implementation of the principles and standards within this framework must be incorporated in local clinical operational policies.

2.2 Objectives

- Ensure that all people who use our services have a planned, purposeful inpatient admission, effective treatment, and safe discharge/transfer of care.
- Embed the principle of planning for successful discharge/transfer of care at the point of admission.
- Directly inform practice described in local operational policies in support of clinically effective admission, transfer, and discharge/transfer of care.
- Ensure that the processes facilitate good practice and incorporate joint working arrangements.
- Ensure that TEWV's values are reflected at all stages of a person's journey.

3 Scope

This Policy must be read alongside the Trustwide bed management operational policy.

3.1 Who this policy applies to

- All employees of the Trust, including temporary and bank staff, locums, contractors and volunteers.

3.2 Roles and responsibilities

Role	Responsibility
Chief Executive	• has ultimate responsibility for ensuring that mechanisms are in place for the overall implementation, monitoring and revision of policy.
Director of Therapies, Executive Medical Director, Chief Nurse, Care Group Directors	• Implementing and monitoring the adherence to this policy in their areas of responsibility. • Ensuring that systems and processes are in place and monitored to meet the requirements outlines on this policy.

	• Ensuring that all appropriate employees undertake relevant training with updates as required. • Implementing the systems and processes that are in place to monitor compliance with the policy.
Chief Pharmacist	• Oversight of pharmacy professional implementation and monitoring of policy
Each registered healthcare professional	• Accountable for their own practice and must be aware of their legal and professional responsibilities relating to their competence and work with the Code of Practice of their professional body.
All Trust staff	Are responsible for ensuring that they: • Are familiar with the content of the relevant policy and follow its requirements. • Work within, and do not exceed, their own sphere of competence

4 Admission

All in-patient areas across the Trust have specific admission arrangements to manage the risks associated with national infectious diseases. It is the responsibility of all staff to be aware of their local arrangements and current guidance.

Some of our hospital in-patient areas have adopted the principles of 'Purposeful In-Patient Admission Process' (PIPA) and must refer to those principles when applying this policy.

Secure Inpatient Services and Health & Justice Services must refer to their own operational polices alongside this policy.

Admission to hospital can be a difficult time for both the person being admitted and their family/carer. It is important that individuals feel that they are entering a compassionate, safe, and respectful environment and that they have received personal and individualised care. We must always respect the human rights, diversity, and the needs of individuals throughout their care. Consideration must be given to the needs of individuals with protected characteristics.

Language communication and sensory needs can act as a barrier to accessing Trust services and ensuring that people receive effective and appropriate care and treatment. Staff must refer to Trust 'Interpreting and Translation procedure'. Easy read information in a range of formats including Braille should also be accessible to meet the communication needs of individuals. (NHSE Accessible Information Standard)

4.1 Principles of admission

When considering the most appropriate setting according to the needs of the individual, the least restrictive care option must always be considered first.

Admission to an in-patient ward should always be planned. Even in urgent situations a degree of planning will occur, however quickly the admission takes place. The request for an inpatient bed is preceded by an assessment of a person's presentation and the inability to safely manage an individual's needs, risks, and wellbeing in their home or other community settings. Please refer to the Trust-wide bed management operational policy for the process of requesting a bed.

Multi-Disciplinary Team (MDT) engagement in a pre-admission meeting must take place prior to any admission to secure inpatient services.

When considering admission of a young person aged 16-17 to and adult mental health inpatient setting, please refer to the 'Young people admitted to adult in-patient wards. policy'.

4.1.1 Primary and Secondary Goals of admission

It is important to distinguish between primary and secondary goals of hospital admission.

Primary goals – people are only admitted to inpatient care when they require assessments, interventions or treatment that can only be provided in hospital. If admitted, it is to the most suitable inpatient service provision available for the person's needs and there is a clearly stated purpose for the admission.

Secondary goals – resolving existing housing and welfare/financial problems, social conflicts and social isolation and physical healthcare problems are all secondary goals which may at times be usefully resolved during admission but do not require complete resolution unless they present as immediate impediments to discharge (e.g. absence of appropriate supported housing when such provision is a care plan imperative)

Secondary goals are NOT a reason for admission in the absence of a primary goal.

4.1.2 Joined up partnership working.

Inpatient services that work closely with a range of other services in a collaborative and coordinated way, are more likely to meet people's varied needs, contributing to improved experiences and outcomes from care and reducing avoidable time spent in hospital. It is particularly important that where someone is transferred from another service, that there is strong coordination of care, so that the transition is as supportive as possible.

4.1.3 Trauma informed care

Many individuals accessing mental health services and particularly people requiring an inpatient admission, will have experienced trauma at some point in their lives. Furthermore, when people are admitted to hospital, and particularly when a person is detained under the MHA or is subject to a restrictive intervention, it is often accompanied by feelings of loss of power and control and can be traumatic. It is therefore important that services work to ensure that the support that is offered in hospital is underpinned by a trauma-informed approach, both in terms of the way that care pathways are organised and how care is delivered.

4.1.4 People with a learning disability and autistic people

To improve the support that people with a learning disability and autistic people receive ensure that people who are at risk of admission are included on local Dynamic Support Registers and that they have a Care (Education) and Treatment Review (C(E)TR) in the community pre-admission (or if this is not possible, within 28 days of admission) and that the findings of the C(E)TR inform care planning and delivery. ***Discharge must not be delayed on the basis that a C(E)TR has not been completed.*** Admissions for people with a learning disability and / or autism to adult assessment and treatment wards must also comply with Greenlight protocols.

4.1.5 Alcohol and drug dependence

Alcohol and drug dependence are common among people with mental health problems and are a significant factor in admission and prolonged length of hospital stay. Services should act on the principles of 'no wrong door' and 'everybody's job' so that people can access holistic care for both their mental health and alcohol/drug use problems, delivered by staff working in inpatient settings and/or in partnership with specialist addiction services. Staff must refer to the Mental Disorder and coexisting Substance Misuse (Dual Diagnosis) Clinical Link Pathway (CLiP) and the Management of coexisting mental illness and substance misuse (Dual Diagnosis) Policy Ref: CLIN-0051

4.1.6 Effective care across the inpatient pathway

For people to have the best recovery possible, they need to receive effective care from pre-admission, during their hospital stay and after discharge/transfer of care. This includes ensuring:

- **Admissions are purposeful** – people are only admitted to inpatient care when they require assessments, interventions or treatment that can only be provided in hospital.

If admitted, it is to the most suitable inpatient service provision available for the person's needs and there is a clearly stated purpose for the admission. All services should be available to people based on need not age.

- **Inpatient care delivers therapeutic benefit** – care is planned and regularly reviewed with the person and their chosen carer/s, so that they receive the therapeutic activities, interventions, and treatments they need each day to support their recovery and meet their purpose of admission.

- **Discharge/transfer of care is proactively planned and effective** – the person's discharge/transfer of care is planned with them and their chosen carer/s from the start of their inpatient stay, so that they can leave hospital as soon as they no longer require assessments, interventions or treatments that can only be provided in an inpatient setting, with all planned post-discharge/transfer of care support provided promptly on leaving hospital.

4.2 Sexual safety

Everyone has the right to be safe from sexual harm, and to feel safe and supported on a ward. TEWV use a trauma-informed approach which aims to acknowledge and understand any previous trauma a person may have experienced, and how it has affected them in the past and present.

The outcomes of these conversations may determine which ward environment is identified for admission/transfer. The discussion must be documented and inform the admission and the person's safety summary and safety plan, which will be regularly reviewed during the person's inpatient stay. When admitting to the PICU wards sexual safety is considered as part of the PICU pyramid.

4.3 Safety plan

For those admitted to hospital, it is expected that the safety plan is developed as part of the admission process and continuously reviewed. They must be co-produced whenever possible with the person, and their family/carers when appropriate.

4.4 Admission of a TEWV member of staff

Please refer to the flowchart **Appendix 3** when considering admission of a TEWV member of staff

4.5 At the point of admission

⚠ Each service should have its own admission checklist within its operational process, to ensure that key information is up to date and key processes completed. This should include as a minimum updating Safety Summary, Safety Plan, My Care Plan, My Important Information and Lifestyle factors sections within the EPR. Medication and MHA processes should also be followed.

At the point of admission, the keyworker / care co-ordinator will retain responsibility and continue to be involved in reviews and discharge/transfer of care planning. It is important that the principles contained within the *inpatient and community compact* are followed during the inpatient stay **(see Appendix 4)**

For those previously supported on standard care or unknown to mental health services, a key worker/care co-ordinator will be allocated and will attend ward formulation meetings related to personalised care planning.

On admission, the key worker/care coordinator/ admitting clinician must communicate to the ward:

- The purpose of admission and options exhausted in the community.
- Mental state, any anticipated risks and updated safety summary, safety plan
- Barriers to discharge/transfer of care including homelessness and estimated date of discharge/transfer of care.
- Expected outcome.
- Capacity (this must be recorded in the care documents)
- Any other pertinent information about the admission and /or person
- Consideration must be given to the needs of people with a learning disability or autistic people: a 12-point discharge/transfer of care planning tool should be used.
- The persons GP practice is to be contacted to advise of admission as soon as it practicable. If the person does not have a current Key worker/ Care Coordinator ward staff must take on this responsibility.
- Any paper records must be transferred to the ward and/or retrieved from archive in a timely manner.
- The key worker / Care Coordinator must also identify any carers and establish whether the individual wishes them to be notified of the admission.

⚠ A 72-hour MDT meeting must be arranged immediately following the 24 hour report out on admission (this does not apply to rehabilitation, forensic and some learning disability in-patient areas)

4.6 Patient Photographs

On admission all individuals are to be asked to have a photograph taken. Individuals must be advised that this will be saved in the Electronic Prescribing and Medicines Administration (EPMA) system and is a measure to support the safe administration of their medication. The photo may also be referred to should the person meet the criteria for classification as 'missing' as per the Trust Missing Patients Procedure and the police are contacted. When a person is missing the police may request access to CCTV or images of the individual.

A person's photograph will only be updated and replaced on charts when any changes to physical appearance (hairstyle, facial hair etc) are noted. In some services where individuals may have longer lengths of stay (e.g., secure inpatient services) photos must be reviewed as a minimum every 12 months or when any changes to physical appearance (hairstyle, facial hair etc) are noted. Any old photos must be confidentially disposed of or returned to the service user depending on preference.

If the individual initially declines to have their photograph taken, plans should be put in place to revisit the conversation at an appropriate point after the admission process.

4.7 People detained under the Mental health Act 1983

Refer to the Trust intranet for Mental Health Policies/Procedures and the MHA Code of Practice

5 During the in-patient episode of care

All in-patient stays must include regular MDT review, communication between all involved staff, personalised care plans to support recovery and a successful discharge/transfer of care from in-patient services. Where indicated the individual should be in attendance and should be actively involved in the decision-making process.

All individuals whose length of stay is likely to exceed their estimated date of discharge will be reviewed on a weekly basis at local performance monitoring meetings which flow into meetings with key people from within each appropriate local authority. The purpose of the meetings is for the senior management team to have oversight of longer stay individuals to provide support in determining actions to facilitate safe and timely discharge/transfer of care.

5.1 Privacy and dignity

Privacy and dignity include personal space, modesty, and privacy in personal care. It includes confidentiality and the treatment of medical and personal information relating to an individual. Please refer to the Trust's Privacy and Dignity Policy for detail.

The Trust expects that every person is given individualised care with the least restrictive interventions that meet their needs and enable our service users to maintain the maximum possible level of dignity, independence choice and control.

5.1.1 Transgender

If single or separate sex services are provided for women and men service providers should treat trans people according to the gender role in which they present and identify (Equality Act Code of Practice 13.37) For further guidance on admission into inpatient services the Privacy and Dignity Policy

5.1.2 Gender reassignment definition

The Equality Act 2010, defines gender reassignment as proposing to undergo, undergoing or having undergone a process to reassign your sex. An employment tribunal (M.S R Taylor versus Jaguar Land Rover Ltd, 2018) extended this definition to include non-binary and gender fluid (Privacy and Dignity Policy 4.2.2)

6 Transfer to other hospital services

People can experience any number of transitions during their contact with mental health and learning disability services including transfer between services.

6.1 Principles of transfer

- Wherever possible an MDT discussion will take place involving the individual and carers and they will be provided with clear information regarding the transfer.
- The family will be notified at point of transfer.
- Adequate engagement and communication, including a full handover, will be arranged between services at point of transfer. In particular any information within the 'My important Information' and 'My carer and others' tabs within CITO must be handed over as this contains key information regarding the person, those supporting them and their circumstances.
- Transfer of any persons records must follow the requirements set out within the Moving records and sensitive information procedure
- Transfers to other providers, including independent sector beds, are to be managed via the bed management process as detailed in the Trustwide bed management operational policy, which also identifies the appropriate oversight required for those people who are admitted to an independent sector bed.

6.1.1 Transfers between TEWV and acute hospitals

People who require specialist physical healthcare or intervention should be referred and/or transferred to the appropriate clinician/specialism at the applicable Acute Hospital Trust for assessment, examination, and treatment, and to establish a suitable management plan. If a person is transferred from an Acute Hospital Trust to a TEWV inpatient setting, staff must also follow the Protocol for Hospital Transfers between TEWV NHS FT and Acute Hospitals and complete all required assessment documentation.

Urgent medical treatment, (e.g. heart attacks, strokes, serious burns, wounds or fractures) must not be delayed because the individual does not have a signed section 17 form. Leave can be authorised retrospectively by the person's Responsible Clinician (RC) or the duty Approved Clinician (AC) outside regular hours.

Consideration needs to be given to availability of specialist medication for mental health needs (e.g. clozapine). When individuals return from an acute Trust the medicines reconciliation process must be undertaken to review / rewrite the prescription and administration Chart.

Community based Key Workers/Care Coordinators and Lead Professionals must be made aware of all confirmed admission to an acute trust to enable them to contribute to the process.

6.1.2 Transfer within TEWV

The standard access process for flows in and out of the PICUs must be followed, including adherence to the PICU Pyramid.

It is recognised that there may be times when a person must transfer from one ward to another. Good communication and documentation underpin effective transfer processes. A person must only be transferred in response to their individual needs and the transfer process will be initiated following discussion and review with the multi-disciplinary team members, the individual and their identified carers.

If the person is transferring to another TEWV service their paper file must be transferred with them

Appendix 5 contains a transfer document which must be considered alongside local arrangements/guidelines to support good documentation and handover (*does not apply within forensic services)

For *Transfer guidelines from adult mental health services to MHSOP* see **Appendix 6** and for *Assessment of younger service users with cognitive symptoms guidance* see **Appendix 7**

6.1.3 Conflict resolution

It is expected that appropriate transfer between specialist services is agreed based on clinical need at multi-disciplinary team level and with informed consent of the service user and/or carer and that effective communication and CPA / personalised care planning processes will resolve any areas of conflict. If resolution fails at team level the services must follow their agreed resolution escalation processes.

Service users and/or their carer have access to the Trust Complaints Policy.

All outcomes should be based on good practice and the involvement of the service user and/or their carer.

7 Discharge from inpatients / transfer of care to the community.

7.1 Key principles of discharge/transfer of care

- Individuals must be regarded as partners in their own care throughout the discharge/transfer of care process and their choice and autonomy must be respected.
- Chosen carers (including family and young carers) should be involved in the discharge/transfer of care process as early as possible.
- Discharge/transfer of care planning should start on admission or before and take place while the person is in hospital.
- There must be ongoing communication between hospital teams and community services involved in onward care during admission and post discharge/transfer of care.
- Information must be shared effectively across relevant health and care teams and organisations across the system to support the best outcomes for the person.

(Discharge from mental health inpatient settings DHSC 26th January 2024)

7.2 Clinically ready for Discharge (CRFD)

In this policy a distinction is made between the point at which a person is 'clinically ready for discharge (CRFD) and the actual point at which it is possible to discharge/transfer care the person (i.e. when the ongoing care and treatment that they need in the community or less restrictive setting is also available). (Acute inpatient mental health care for adults and older adults NHS England July 2023)

The point at which someone is CRFD is reached when the MDT conclude that the person does not require any further assessments, interventions and/or treatments, which can only be provided in an inpatient setting.

There are three key criteria, which need to be met, before the MDT can make this decision:

1. There must be a clear plan for the ongoing care and support that the person requires after discharge/transfer of care, which covers their pharmacological, psychological, physical health, social, cultural, housing, and financial needs, and any other individual needs or wishes.
2. The MDT must have explicitly considered the person and their chosen carer/s' views and needs about discharge/transfer of care and involved them in co-developing a discharge/transfer of care plan.
3. The MDT must have involved any services external to the provider in their decision-making, where these services will play a key role in the person's ongoing care, e.g. social care teams and housing teams.

A good question for the bed management and clinical teams to ask is:

- *Would this person be admitted to hospital today with their current symptoms / risks / problems / distress.*
- *How do existing inpatients compare with service users on awaiting admission in terms of their current symptoms/risks/problems/distress?*

However, it does not necessarily mean the person can be discharged, for example, if the right support is not available in the community at that time.

All teams will follow their local escalation processes where the MDT are not able to reach a consensus that someone is CRFD, or partner services may not agree with the MDT's decision.

7.3 Planned discharge / transfer of care

The point at which it is possible to discharge/transfer care of someone is reached when the person is considered CRFD and the ongoing care and support agreed in the person's discharge/transfer

of care plan can be delivered according to the agreed timescales following discharge/transfer of care .

- A discharge/transfer of care plan is to be formulated based on the safety summary and safety plan to support recovery.

- Medicines management needs post discharge/transfer of care must be considered, download.cfm (tewv.nhs.uk) this will include ongoing supply of medication e.g. arrangements for 'red' hospital only medicines e.g. clozapine and re-instating or arranging supply of controlled drugs for substance misuse – please refer to Prescribing and initiation of treatment procedure - supporting adherence e.g. compliance aids and managing risk by supplying a safe and appropriate supply of medication for up to 28 days.

- Ensure safe transfer of care by providing comprehensive information to services in the community, including GPs.

- Discharge/transfer of care cannot be deferred simply because relevant professionals are unable to attend.

- Resolving existing housing and welfare/financial problems, social conflicts and social isolation and physical healthcare problems are all secondary goals which may at times be usefully resolved during admission but do not require complete resolution unless they present as immediate impediments to discharge/transfer of care. (e.g., absence of appropriate supported housing when such provision is a care-plan imperative.)

- Provisional discharge/transfer of care dates are to be agreed on admission as targets to work towards and will be reviewed regularly in report out and the AMH/MHSOP bed flow meeting.

  Report out occurs:

  Weekly – SIS, LD, rehabilitation

  Daily AMH, MHSOP

- Ideally all planned discharges will take place before 10 am each day.

- In AMH and MHSOP the professionals required as a minimum to agree a discharge, are a registered nurse and a medical representative.

7.3.1 On discharge / transfer of care

Once the final decision has been made that it is possible to discharge/transfer care of someone:

- Timely follow up has been highlighted as a priority form patient groups and the National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH), due to the increased risk of suicide following discharge from hospital. All individuals who have had a period of TEWV in-patient admission, excepting respite care, must include follow up within 72 hours of hospital discharge/transfer of care by the person identified on the care plan.

- Care plans must be reviewed on discharge/transfer of care from hospital, including at 72 hour follow up; the written agreed care plan will identify the key worker/ care coordinator and set out the care and ongoing recovery interventions to be provided including identifying potential relapse triggers to reduce the possibility of readmission and any physical healthcare needs.

- If a person is clinically ready for discharge/transfer of care but does not have accommodation identified a duty to refer is to be completed and discharge/transfer of care from the ward facilitated in a timely manner following local homeless procedure.

- Individuals who are clinically ready for discharge/transfer of care will not remain on the ward if they are homeless unless they have additional care needs identified. If discharge to homelessness needs to be considered this will routinely involve senior clinicians and management. Please refer to the *Discharge/Transfer of Care Homelessness Guidance* in **Appendix 8**

- Individuals will receive a written copy of their agreed after care plan.

- Individuals, carers and relevant others must be informed of a named contact including a telephone number as appropriate, in the event of experiencing any difficulties following discharge/transfer of care. Other communication methods such as texting must be considered for deaf service users.

- Ensure the individual receives all the medication required at discharge/transfer of care and knows the arrangements in place for getting further supplies. If they are to be looking after their medication themselves, make sure the individual/carer/family knows how to take the medication safely.

- GP discharge/transfer of care letter must be sent within 24 hours of discharge/transfer of care from in-patient services to the person's GP and other involved agencies. A copy should be given to the person and to their carer(s) where appropriate.

- The individuals paper notes must follow them to their new team (if within TEWV)

- Ensure continuity of therapeutic interventions begun in the in-patient environment if appropriate

Crisis Resolution Home Treatment Team

Where they exist an integral role of the Crisis Resolution Home Treatment Team (CRHTT) is to facilitate discharge/transfer of care from acute In-patient wards for people who continue to experience distress, but no longer require continued hospitalisation. This may involve joint working with community intervention teams and other relevant teams along with the provision of a follow up within 72 hours in line with national guidance.

- **CRHTT's should have daily links with respective wards to identify individuals that no longer require continued hospitalisation but may benefit from IHT.**

⚠ Secure Inpatient Services must also refer to the Process for promoting timely discharge of care from Secure Inpatient Services and Forensic Rehabilitation wards Procedure.

7.4 Unplanned discharge/discharge against medical advice

If an informal person requests discharge/transfer of care against medical advice the consultant psychiatrist or their deputy will:

- Discuss the request with the individual and review their risk documents.
- Consider using Mental Health Act powers if appropriate.
- Consider facilitating early discharge/transfer of care with Crisis Team

Following discussion with the multi-disciplinary team, the consultant psychiatrist may decide to implement the discharge/transfer of care planning process, considering the availability of resources at short notice. This must be fully documented in the electronic clinical record. In this case:

- Advise the individual's relatives/carer and relevant others of the decision to leave, where appropriate, as soon as possible

- Complete GP discharge/transfer of care documents within 24 hours of discharge/transfer of care and inform the individual's General Practitioner and Key Worker/Care Coordinator of the person's decision to leave against medical advice as soon as possible.

- The appropriate key worker/ Care Co-Ordinator/ professionals / carers / agencies involved must be informed as above and a care plan implemented as necessary and as soon as possible in the absence of the individual/carer.

7.5 Delayed discharge/transfer of care

Patients who have met the aims of admission but are unable to be discharged/transfer of care due to secondary goals must be escalated through the clinically ready for discharge/transfer of care process. The person must continue receiving interventions, activities, and other support in hospital, so that they remain CRFD and can be discharged/transfer of care as soon as the appropriate support has been put in place for them.

Please refer to Delayed transfers of care in the non-acute and mental health sector protocol.

In the event of a person being absent without leave procedures refer to the Missing Patients Procedure

8 Definitions

Term	Definition
Care Programme Approach (CPA)	• Care Programme Approach describes the approach used in secondary mental health and learning disability services to; assess, plan, review, and co-ordinate; care, treatment and support for people with complex needs, relating to their mental health or learning disabilities. The current services still required to operate according to the CPA framework are: • Secure Inpatient Services (Adults) • Health and Justice Services • Body Dysmorphia Services • Perinatal Services • Obsessive Compulsive Disorder Services • Mental Health Services for the Deaf
Personalised care planning	• A flexible, responsive and personalised approach following a high-quality and comprehensive assessment means that the level of planning and co-ordination of care can be tailored and amended, depending on: • the complexity of a person's needs and circumstances at any given time. • the assessed and identified intervention required to meet personalised needs. • what matters to them and the choices they make.

	• the views of carers and family members • professional judgment and evidenced based practice.
Key worker / coordinator of care	• The offer of a Keyworker is not an intervention in and of itself but will assess, identify needs and coproduce a care plan with the person, overseeing its coordination. • Have the requisite competence, experience and training to assess and coordinate the care of the person. • To have a meaningful and productive therapeutic relationship with the person. • May deliver interventions where applicable. **Please see Personalised Care Planning Policy** for more information
PIPA	• Purposeful In-patient Admission – many of our inpatient areas have adopted this as a process to be followed to ensure that all in-patient admissions incorporate purposeful intervention plans to support recovery and ultimately a successful discharge/transfer of care from inpatient services
24 hour report out	• A multi-disciplinary meeting which must take place every 24 hours to discuss service user progress. Time is allocated for new admissions to agree initial assessment and plans for treatment and discharge/transfer of care. Attendees should include Community representative whenever possible
72 hour CPA / personalised care plan review/ Formulation meeting	• A multi-disciplinary meeting which should take place within 72 hours of a service user's admission to agree Formulation / CPA / personalised care documentation and outcome plans. (Up to 4 weeks within SIS)
Clinically ready for discharge/transfer of care	• The MDT conclude that the person does not require any further assessments, interventions and/or treatments, which can only be provided in an inpatient setting.
Care, Education and Treatment Reviews.	• C(E)TR's or sometimes CTR's, if the person is no longer in Education. Used alongside the Dynamic Support Register, ensure that local health and care services support people with a learning disability and autistic people, so they only go to hospital if they really need to.

9 Related documents

This policy should be read in conjunction with the following Trust policies and procedures:

- Personalised Care Planning Policy
- Safety and Risk Management Policy
- Trustwide bed management operational policy
- Privacy and Dignity Policy
- Mental Health Act Code of Practice
- Individuals who decline treatment or disengage with services.
- Crisis Operational Policy
- Interpreting and Translation procedure
- Safeguarding Children Policy
- Safeguarding Adults Policy
- Process for Promoting Timely Discharge from Secure Inpatient Services and Forensic Rehabilitation Wards
- Missing Patients Procedure
- Child Visiting Policy.
- Section 132/132A MHA – providing information to patients and patients nearest relatives.
- Protocol for Hospital Transfers between TEWV NHS FT and Acute Hospitals
- Delayed transfers of care in the non-acute and mental health sectors Protocol
- Prescribing and initiation of treatment procedure
- Medicines – Multi Compartment Compliance Aids
- Medicines Optimisation – Interactive Guide
- Transitions Procedure Child & Adolescent to Adult Services/Primary Care
- Young people admitted to adult in-patient wards.
- Physical Health and Wellbeing Policy
- Delayed transfers of care in the non-acute and mental health sector protocol.
- Joint Working Protocol for Adults with Learning Disabilities and Mental Health Problems
- Process for promoting timely discharge of care from Secure Inpatient Services and Forensic Rehabilitation Wards Procedure

10 How this policy will be implemented

10.1 Training needs analysis

Staff/Professional Group	Type of Training	Duration	Frequency of Training

All clinical staff	In house via induction processes or via preceptorship	Variable	On commencing in inpatient areas/transferring between wards/specialties
All clinical staff	Pathway updates via briefings	Variable	As clinical pathways are updated

11 How the implementation of this policy will be monitored

Number	Auditable Standard/Key Performance Indicators	Frequency/Method/Person Responsible	Where results and any Associate Action Plan will be reported to, implemented and monitored; (this will usually be via the relevant Governance Group).
1	Quality assurance schedule asks where the patient is ready for discharge within the next 14 days is there evidence of multi-agency involvement in discharge planning within the pre-discharge i.e. MDT/formulation	Monthly audit via ward managers	Via Fundamental standards, QUAIGS and Quality Assurance Committee
2	The yearly audit schedule will include elements of admission / transfer and discharge/transfer of care within the central audit programme	Yearly audit programme, Clinical Audit & Effectiveness team	Specialty Level Improvement and Delivery Groups (IDGs) with red compliance audits escalated to Care Group Board (CGB) and Quality Assurance Committee (QUAC)
3	Compliance with policy	Review of incidents and complaints	Trust organisational learning group will identify any themes in relation to admission/transfer and discharge/transfer of care

12 References

NHS E. Dynamic Support Register (DSR) and Care, Education and Treatment Reviews (C(E)TR)Policy and Guidance.
NHS E. Brick by brick: Resources to support mental health hospital-to-home discharge planning for autistic people and people with a learning disability.

NICE Guideline 53: Transition between inpatient mental health settings and community or care home settings.

Discharge of care from mental health inpatient settings DHSC 26th January 2024

Acute inpatient mental health care for adults and older adults NHS England July 2023

13 Document control (external)

To be recorded on the policy register by Policy Coordinator

Required information type	Information
Date of approval	21 January 2025
Next review date	21 January 2028
This document replaces	CLIN-0012-v8 Admission, Transfer and Discharge Policy
This document was approved by	Executive Clinical Leaders Sub-Group
This document was approved	15 January 2025
This document was ratified by	Management Group
This document was ratified	21 January 2025
An equality analysis was completed on this policy on	08 January 2025
Document type	Public
FOI Clause (Private documents only)	n/a

Change record

Version	Date	Amendment details	Status

6.1	March 2016	Section 4.1.1 added re the privacy and dignity of transgender service users Section 7 Discharge process amended to reflect key findings from the 2014 National Confidential Inquiry into Suicide and Homicide by People with Mental Illness Annual Report	Withdrawn
7	November 2016	Section 3.1 Guidance added regarding planned admissions. Section 3.1.4 Pre admission time frame for none urgent cases corrected to 28 days. Sections 3.1, 3.3, 3.4 and 7.1.2 Requirement for easy read information to be given to those who require it identified. Section 3. Care Coordinator to advise GP practice of admission as soon as practicable and ward staff to take on this responsibility if no Care Coordinator allocated Section 6. Need for all Community Care Coordinators and Lead Professionals to be made aware of transfers to other hospital services identified. Section 7.1.1 Need for consideration of service users' medication information needs on discharge identified. Section 7.1.1 Principle added regarding ensuring safe transfer of care by providing comprehensive information to community services, including GPs.	Withdrawn
7.1	October 2017	Appendices 1 and 2 added	Withdrawn
7.2	March 2018	Minor amendment to wording in section 6	Withdrawn
7.3	June 2018	Appendix 4 – approved for Trust-wide use (no longer restricted to Durham and Darlington locality)	Withdrawn
7.4	September 2018	Title amended from Admission, Transfer and Discharge of service users within hospital and residential settings Footer amended from Admission, Transfer and Discharge Policy	Withdrawn
7.5	July 2019	Amended section 6 'Transfer to other hospital services' and added section 7 'Transfer Summary - within the Trust'	Withdrawn

8	26 January 2022	Full Review with major updates Section 1 Introduction – reworded Section 2 Objectives – reviewed and changed Section 3.3 Admission, Discharge and Transfer House removed. Section 4 reviewed and numbers of sub headings changed: Section 4.1 Admission – reworded and titled Admission: introduction Section 4.2 Preadmission title removed replaced by Admission process Section 4.2.1 Safety Plan added Section 4.2.2 – Adult Admissions new title. Section 4.2.3 CAMHS Admissions Section 4.2.4 Unplanned admission of children Section 4.2.5 MHSOP Admissions and age appropriate services Section 4.2.6 Admission of people with a Learning Disability Section 4.2. Forensic Admissions. Content reviewed and reworded. Section 4.3 Out of Locality Admissions and Managing Local beds Section 4.3.1 Admitting Trust service users within Trust but out of Locality Section 4.3.2 Admitting service users from outside of the Trust. Harrogate and Northallerton and Sandwell Park removed and Foss Park added. Section 4.3.3 Admitting service users outside the Trust Section 4.4 At the point of admission. Reviewed and reworded. Section 4.5 After admission. Reviewed and reworded. Sentence added to check that correct carer has been identified and establish if the service user is happy for communication to take place. Section 4.6 Service users detained under the Mental Health Act. Reviewed and reworded Section 5 During the episode of care. Reviewed and reworded. Section 7 Transfer to other hospital services. Reviewed and reworded.	Withdrawn

		Section 8 Transfer Summary- Within Trust. Reviewed and reworded Section 9 Discharge from Hospital. Reviewed and reworded. Section 9.1 Forensic services. Reviewed and reworded. Section 9.1.3 Follow up. Reviewed and reworded. Section 10 Definitions. MDT, Hospital, Admission, Discharge, Carer/Family and Ward team removed. Appendix 1 removed. Appendices ~~3~~ 5, ~~4~~ 6 and ~~5~~ 7 have been added. Note – amended to current template and appendices reordered and numbered to trust standard. References to appendices corrected through body of document. Heading styles and numbering corrected.	
9	21 Jan 2025	Full Review with major updates: Section 1 renumbered and reworded Section 2 renumbered and Objectives reviewed and changed Section 3 renumbered and Scope now refers to Trust wide Bed Management Operational Policy Section 3.2 Roles and responsibilities updated Section 4 renumbered and reworded – now Admission section which has had complete review and updated to set of key principles, inclusion of sexual safety considerations, removal of speciality sections, inclusion of patient photographs Section 5 renumbered and reviewed - now includes updated privacy and dignity considerations Section 6 removed ref to child visiting policy, now Transfer to other hospital services reviewed and updated to include principles of transfer Section 7 renumbered and reworded. Now Discharge from hospital/transfer to community – includes key principles and inclusion of clinically ready for discharge.	Ratified

		Section 8 Renumbered now Definitions – updated to include CPA and personalised care planning/key worker/ clinically ready for discharge / CETR Section 9 Renumbered now related documents – updated Section 10 Training Needs analysis updated Section 11 How this policy will be monitored updated Section 12 References and document control updated Appendix 3 PIPA principles removed and replaced with Admission of TEWV member of staff flowchart Appendix 4 Managing age discrimination removed and conflict resolution moved to main body of the policy. Appendix now Inpatient and Community Compact Appendix 5– Out of Trust referral and admission checklist removed and replaced with Transfer considerations Appendix 6 Process for formal and informal adult service users who require medical assessment and or treatment while on leave from a mental health ward removed and now transfer guidelines from AMH to MHSOP Appendix 7 Transfer Summary checklist removed and now in appendix 5. Appendix 7 now Assessment of younger service users with cognitive symptoms Appendix 8 Now updated Discharge from Homeless guidance Appendix 9 removed and now Appendix 7	

Appendix 1 - Equality Impact Assessment Screening Form

Please note: The Equality Impact Assessment Policy and Equality Impact Assessment Guidance can be found on the policy pages of the intranet

Section 1	Scope
Name of service area/directorate/department	Trustwide
Title	Admission Transfer and Discharge Policy
Type	Policy
Geographical area covered	Trustwide
Aims and objectives	To ensure that all people who use our services have a planned, purposeful inpatient admission, effective treatment, and safe discharge/transfer of care.
Start date of Equality Analysis Screening	17th May 2024
End date of Equality Analysis Screening	30th September 2024

Section 2	Impacts
Who does the Policy, Procedure, Service, Function, Strategy, Code of practice, Guidance, Project or Business plan benefit?	The policy will benefit all those who access our services, their families and carers by ensuring a personalise and collaborative approach to care is taken throughout any admission, transfer and discharge/transfer of care journey. The policy will benefit staff by providing them with a framework that will support the to offer personalised approach to any admission, transfer, discharge/transfer of care
Will the Policy, Procedure, Service, Function, Strategy, Code of practice, Guidance, Project or Business plan impact negatively on any of the protected characteristic groups? Are there any Human Rights implications?	• **Race** (including Gypsy and Traveller) **NO** • **Disability** (includes physical, learning, mental health, sensory and medical disabilities) **NO** • **Sex** (Men and women) **NO** • **Gender reassignment** (Transgender and gender identity) **NO** • **Sexual Orientation** (Lesbian, Gay, Bisexual, Heterosexual, Pansexual and Asexual etc.) **NO** • **Age** (includes, young people, older people – people of all ages) **NO** • **Religion or Belief** (includes faith groups, atheism and philosophical beliefs) **NO** • **Pregnancy and Maternity** (includes pregnancy, women / people who are breastfeeding, women / people accessing perinatal services, women / people on maternity leave) **NO** • **Marriage and Civil Partnership** (includes opposite and same sex couples who are married or civil partners) **NO** • **Armed Forces** (includes serving armed forces personnel, reservists, veterans and their families) **NO** • **Human Rights Implications YES** (Human Rights - easy read)
Describe any negative impacts / Human Rights Implications	When people are very unwell and where they may need detention under the Mental Health Act or deprivation under the Mental Capacity Act then decision making can be complex. We know that for some people admission itself can impact negatively on the person being admitted and that discharge/transfer of care can also evoke feelings of

	loss/abandonment. As the procedure outlines, care is personalised, admissions timely and purposeful. Hospital stays aim to be therapeutic and discharge/transfer of care timely and effective to ensure that any possible negative impact is reduced or removed for patients.
Describe any positive impacts / Human Rights Implications	The policy provides a framework and set of principles for those complex conversations that need to take place between staff and people using our services and their families/carers. With a Human Rights approach decisions ae made collaboratively: Respect/ what we do to prevent the use of restrictions, and admission to the most appropriate environment. Protect/ the safeguarding elements we have in place. Fulfil / procedural ways we review practice

Section 3	Research and involvement
What sources of information have you considered? (e.g. legislation, codes of practice, best practice, nice guidelines, CQC reports or feedback etc.)	Research and national policy guidance. NICE guidance MHA, MCA, Equalities Act Human Rights
Have you engaged or consulted with service users, carers, staff and other stakeholders including people from the protected groups?	Yes.
If you answered Yes above, describe the engagement and involvement that has taken place	Wide range of staff involved in policy development. Consultation includes peer workers and service users
If you answered No above, describe future plans that you may have to engage and involve people from different groups	

Section 4	Training needs
As part of this equality impact assessment have any training needs/service needs been identified?	No
Describe any training needs for Trust staff	None identified – induction processes will update staff as to requirements and clinical pathways will reflect requirements
Describe any training needs for patients	None identified
Describe any training needs for contractors or other outside agencies	None identified

Check the information you have provided and ensure additional evidence can be provided if asked.

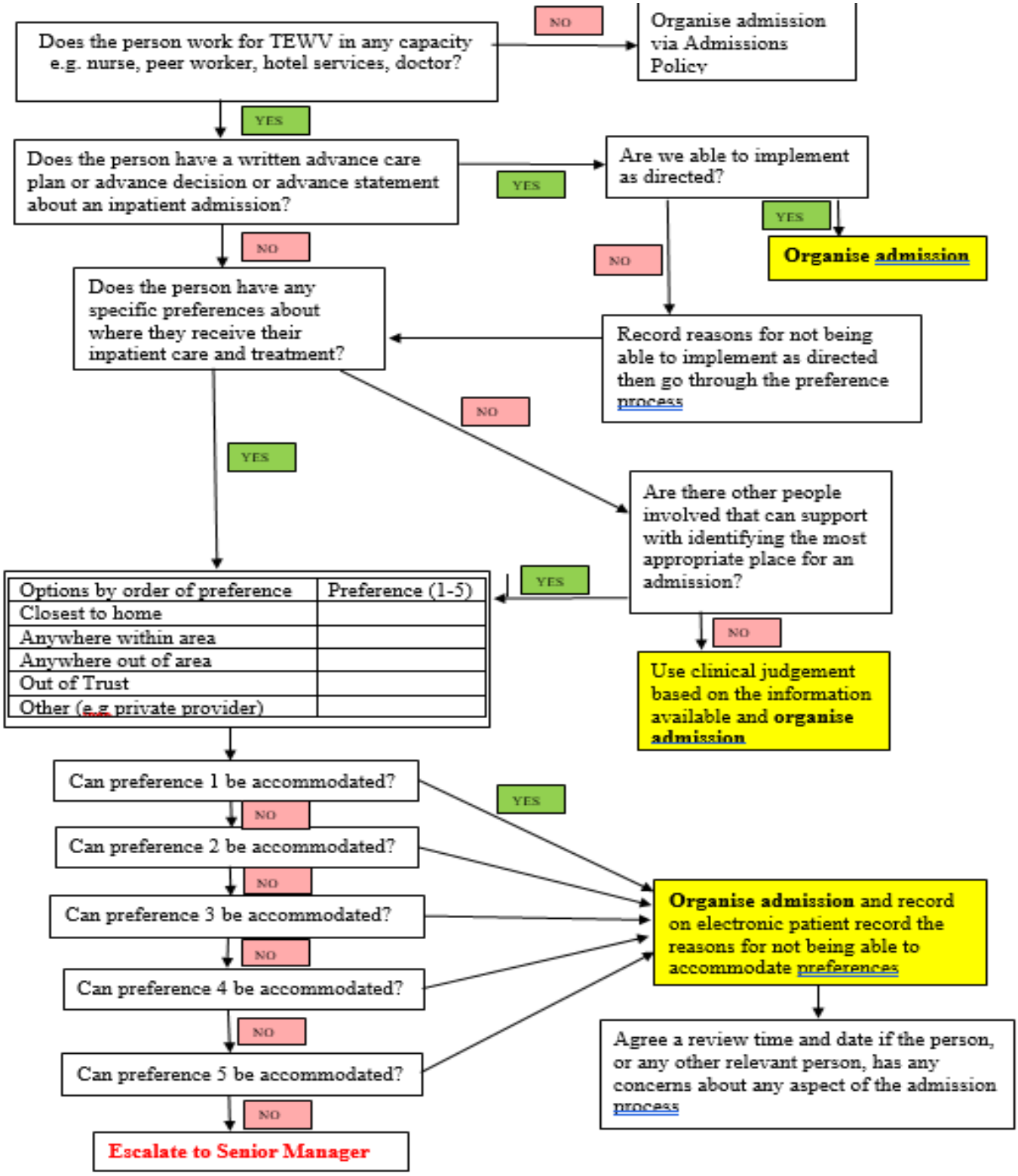
Appendix 2 – Approval checklist

To be completed by lead and attached to any document which guides practice when submitted to the appropriate committee/group for consideration and approval.

Title of document being reviewed:	Yes / No / Not applicable	Comments
1. Title		
Is the title clear and unambiguous?	Y	
Is it clear whether the document is a guideline, policy, protocol or standard?	Y	
2. Rationale		
Are reasons for development of the document stated?	Y	
3. Development Process		
Are people involved in the development identified?	Y	
Has relevant expertise has been sought/used?	Y	
Is there evidence of consultation with stakeholders and users?	Y	
Have any related documents or documents that are impacted by this change been identified and updated?	Y	
4. Content		
Is the objective of the document clear?	Y	
Is the target population clear and unambiguous?	Y	
Are the intended outcomes described?	Y	
Are the statements clear and unambiguous?	Y	
5. Evidence Base		
Is the type of evidence to support the document identified explicitly?	Y	
Are key references cited?	Y	

Are supporting documents referenced?	Y	
6. Training		
Have training needs been considered?	Y	
Are training needs included in the document?	Y	
7. Implementation and monitoring		
Does the document identify how it will be implemented and monitored?	Y	
8. Equality analysis		
Has an equality analysis been completed for the document?	Y	
Have Equality and Diversity reviewed and approved the equality analysis?	y	AH 30/09/2024
9. Approval		
Does the document identify which committee/group will approve it?	Y	
10. Publication		
Has the policy been reviewed for harm?	Y	
Does the document identify whether it is private or public?	Y	
If private, does the document identify which clause of the Freedom of Information Act 2000 applies?	N/A	
11. Accessibility (See intranet accessibility page for more information)		
Have you run the Microsoft Word Accessibility Checker? (Under the review tab, 'check accessibility'. You must remove all errors)	Y	
Do all pictures and tables have meaningful alternative text?	Y	
Do all hyperlinks have a meaningful description? (do not use something generic like 'click here')	Y	

Appendix 3 - Admission of a TEWV staff member



Appendix 4 - Inpatient and Community Compact

Theme	Inpatient Teams Role and Responsibilities	Community Teams Role and Responsibilities
Formulation Meeting Attendance **Key Principles:** - Formulation meetings should take place within 72 (working) hours of admission to hospital - It is preferable all participants attend in person. Exceptions may include when a service user has been admitted out of area - All key partners involved in someone's care in the community, including key workers, should be invited to attend a persons formulation meeting	• Inpatient teams will reserve protected diary slots specifically for formulation meetings • Inpatient teams will communicate plans to arrange a formulation at the earliest opportunity with community colleagues, families, carers and other support agencies • This should be arranged following the first 24-hour report meeting • Team secretaries will communicate formulation dates to community colleagues by telephone and e-mail to generic e-mail addresses following a patients first 24 hour report out • Where a request is made for Early Intervention Psychosis (EIP) to attend a formulation meeting and the service is not currently open to the service, a registered practitioner from the ward will call the team to provide a verbal handover/referral (see document **Helpful info for EIP referrals** which is found here - "T:\Intranet Published Documents\Policies procedures and legislation\Policy resources\Helpful info for Eip referrals.docx")	For people open to community services: • Key Workers and other involved staff will prioritise attendance at Inpatient Formulation meetings within 72 hours of admission • If required, leadership team members within community services will support key workers with re-allocation of work to prioritise formulation attendance **For people not currently open to community services:** • Community Intervention teams will identify a representative to attend the initial formulation meeting **EIP:** • Efforts must be made to commence/complete EIP specific assessment prior to the formulation meeting • A member of the team will be allocated to attend the formulation meeting
Allocation of Key Worker **Key Principles:** - Key Workers must be allocated as soon as possible post formulation - A named Key Worker is required to ensure a	• An estimated date of discharge is to be confirmed in the formulation, this should be agreed with the service user and community colleagues where practicable	**Community Intervention Teams:** • Where a Key Worker has been requested the Community Intervention Team will allocate a Key Worker to oversee the patients care and treatment whilst an inpatient

primary point of contact for the service user and inpatient MDT		• If prior to discharge it is felt the community hub would be better placed to support someone post discharge, the key worker allocated will arrange for this transition of care to take place • Allocations will be made the same week as the formulation meeting • Same day allocation will be made when a same day/week formulation and discharge is anticipated **EIP:** • If the outcome of the assessment is to enter into an EIP pathway then a Key Worker must be allocated with the same principles above • If EIP is not appropriate a discussion between the Inpatient MDT and appropriate community intervention team is to be arranged to identify the most appropriate Key Worker
In-Reach	• Changes to leave status and plans for extended time away from the ward must be communicated to Key Workers in a timely manner	• A weekly in-reach contact should occur for all in-patients from their allocated key worker or a community team representative involved in their care. Exceptions may include when a service user has been admitted out of area • Huddle boards have a designated column used to monitor ward in-reach

Appendix 5 - Transfer Considerations

All transfers will be in line with the Personalised Care Planning Policy and the accepting ward will ensure that they understand the information within the 'My important Information' and 'My carer and others' tabs within CITO as this contains key information regarding the person, those supporting them and their circumstances. Each area / speciality will have their own guidelines for transfer but the following should be considered and documented in the EPR by the transferring nurse in the EPR. For those wards using PIPA the accepting ward will review on arrival so they have a formal handover of PIPA. This summary does not replace the verbal the handover of the patient.

Patient Name:
Date and time of transfer:
Named Nurse:
Responsible Clinician:
Reason for Transfer:

MHA Status:
MHA office informed (who informed and when if applicable):

Agreed Aim of Admission:

Progress:

Safeguarding issues or risks:

Significant Physical Health Needs:

Plan from Formulation (admission meeting in MHSOP):

Medication on transfer and items issued to transferring ward:

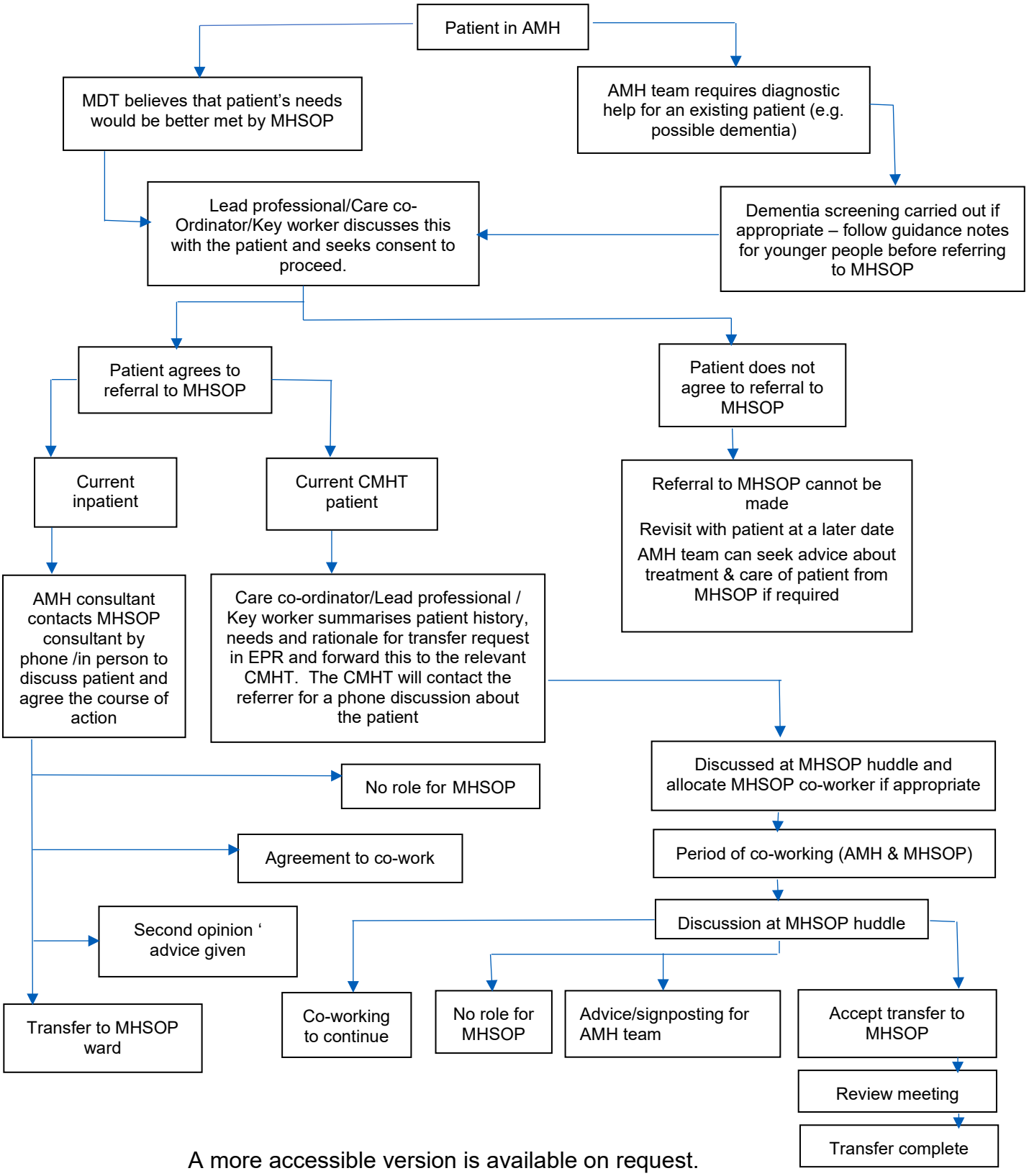
Medication transfer book process complete as per Appendix 2b Medicines – Ordering, storage, transfer, security and disposal procedure

Family/carers informed:
Patient property transfer (valuables):

Suggestions and Outstanding Tasks:

PLEASE NOTE A COPY OF THE CURRENT VISUAL CONTROL BOARD MUST ALSO BE SENT TO THE ACCEPTING WARD HIGHLIGHTING COMPLETED AND OUTSTANDING TASKS

Appendix 6 - Transfer guidelines from AMH to MHSOP



A more accessible version is available on request.

Appendix 7 - Assessment of younger service users with cognitive symptoms – guidance notes

Please note ages mentioned are for guidance and are in keeping with commissioning arrangements. Also, they reflect likelihood of having dementia diagnosis and are not intended to discriminate, but instead to point towards the most appropriate initial assessment for the service user.

Most of those younger people referred, whether from primary or secondary care; do not have a dementia but a significant proportion have a functional illness. It potentially disadvantages those service users if seen by memory team first as those services have not been designed to manage large numbers of functionally ill younger service users. If there is evidence of other symptoms (that potentially could cause cognitive symptoms) such as depression or anxiety, then the initial assessment should be undertaken by Adult Mental Health Services.

If aetiology is thought to be alcohol related, Adult Mental Health Services must undertake the initial assessment. Service users with a history of excess alcohol use may have multitude potential aetiologies (delirium, intoxication, sub-dural haematoma, Wernicke's encephalopathy (a medical emergency), Korsakoff's psychosis (which is a static injury). For alcohol related dementia the key to management is achieving abstinence and managing risk via supportive measures such as a care package.

In the very young (under 45 years of age), consideration should be given to making a neurology referral in the first instance. This is because very young service users are more likely to require other investigations such as lumbar puncture.

Younger people with static (non-progressive) cognitive impairment are not usually appropriate for transfer to MHSOP. This would include people with:

- Korsakoff's, traumatic brain injury, static damage due to e.g. brain infection, hypoxia or neurotoxin.
- Acute onset large vessel stroke or brain haemorrhage.

Referrals from AMH to MHSOP must follow the flow chart. MHSOP consultants are also available to have case-based discussions with AMH colleagues prior to consideration of transfer.

Prior to referral of a younger person with suspected dementia it is expected that the following will usually have been completed:

- An entry detailing the nature of the symptoms and a description of their onset and progression.
- MRI (or CT) head scan, (most younger service users will require MRI)

- bloods, (fbc, U&Es, LFTs, bone, B12, folate, thyroid, ESR, glucose, lipid profile and consider if thought to be at risk HIV and syphilis)
- EEG if relevant
- ACE-III (AMH have psychologists who are competent to do this)
- OT assessment
- ECG if there are cardiac symptoms or history.
- If a service user's usual mental disorder is unstable, they should have treatment and symptoms optimised prior to referral (many will have improvement in their cognition).
- If referral is considered urgent, then consultant to consultant discussion (phone or in person) is necessary.

For both in-patient and out-patient services, the service user must remain open to adult services up until such a time as determined appropriate by MHSOP team to take over as very few of these referrals conclude with a dementia diagnosis.

Appendix 8 - Discharge Homeless Guidance

This guidance has been developed in collaboration with clinical colleagues including safeguarding and social care leads. It aims to set out a list of considerations and key actions for Multi-Disciplinary Teams to consider when caring for someone in an inpatient setting who has no fixed abode. Our primary aim is to support people through holistic care planning to improve their overall mental health and wellbeing, although it is recognised that optimal accommodation status may not always be secured during an inpatient admission due to a variety of barriers and circumstance.

This guidance offers practical advice to ensure support related to accommodation status is readily available throughout a person's admission and if discharge/transfer of care with no-fixed abode is required; appropriate follow up support from the relevant statutory agencies is arranged.

Key Considerations:

These considerations are specific to someone's housing and accommodation status and must be considered at the point someone is deemed to require an emergency admission to hospital (if not before as part of their care plan) and revisited at appropriate junctures during their inpatient journey.

Duty to Refer:

The Homelessness Reduction Act 2017 places duties on local housing authorities to intervene at earlier stages to prevent homelessness in their areas, and to provide homelessness services to all those who are eligible. Additionally, the Act introduced a **duty on specified public authorities to refer service users who they think may be homeless or threatened with homelessness to local authority homelessness/housing options teams. TEWV have a duty to refer under this Act.**

- Accommodation status should be identified prior to admission and if appropriate a referral to local homelessness/housing options services must be made by the appropriate admitting team.
- Ward MDT's should consider if a referral to local housing options/homelessness teams is required at the 24 hour report out, if this has not already been made then a referral is to be facilitated as a priority, the status of this referral must be revisited as part of a person's formulation meeting.
- If accommodation status changes throughout a person's admission and they become homeless during their stay then a referral must be made at the point this information is received

Key Working and Follow Up:

- Where available third sector support agencies are working as part of Inpatient MDT's to support people with sub-optimal accommodation status. These colleagues must be notified of homeless individuals and urgent support requested.

- Other key teams involved including Key workers and social care teams must be involved in accommodation discussions and key leads identified for priority actions.
- Accessing appropriate accommodation should be part of a person's overarching care plan and both community and inpatient colleagues must be aware of plans and included in their creation.
- Family or loved ones should be involved in discussions throughout in discussion with the individual.

Strength Based Discussions:

National Homeless charities recommend a strength-based focus when working with people facing homelessness and supporting the development of support plans. Three conversations the strengths-based model suggests including:

- Explore the persons needs and identify their sources of personal, family and community support.
- Assess risk and any crisis interventions that may be needed and establish a plan.
- Discuss long-term outcomes and planning based on a client's vision of a good life and how to mobilise the resources needed, including budgetary needs, and drawing on personal and community strengths.

These discussions must take place as part of a person's overarching care plan development however revisited as part of discharge/transfer of care planning.

Discharge/transfer of care Actions:

Where aims of admission have been met and a person is deemed clinically ready for discharge/transfer of care, but does not have accommodation, the following actions should be considered:

- Principles of the Trust Safety and Risk Management Policy must be adhered to considering the long- and short-term risks and benefits of the decision to discharge/transfer of care from the ward.
- Safeguarding advice can be sought from TEWV Safeguarding Teams in relation to the decision to discharge/transfer of care from hospital, this advice can be included in the risk assessment and care plan.
- Liaison must take place with the appropriate homelessness/housing options team to make them aware of plans to discharge/transfer of care a person at the earliest opportunity.

- If a person is being discharged/transfer of care, then it would be recommended this takes place as early in the day as possible and the person is supported to (where possible) a planned appointment with a local homeless team to secure temporary accommodation.

- Discharge/transfer of care follow up appointments should be arranged for the most appropriate Trust base and the appointment details must be provided to the person user prior to leaving the ward. We must also check that we have the most up to date telephone number for someone before they leave and support them to charge their phone.

- Key family and involved people/professionals must be made aware of discharge/transfer of care plans where appropriate.

- Outputs of the above actions must be translated into a discharge/transfer of care, care plan and shared with the person prior to leaving the ward.