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NHS Trust

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FOI REF: 24/269

26th April 2024

FREEDOM OF INFORMATION ACT

I am responding to your request for information under the Freedom of Information Act. The answers to your specific questions are as follows:

Please could you send me a copy of the discharge policy documentation current at July 2023 or later.

Please see the attached document.

Please note that the names of individuals that are not employed by East Sussex Healthcare NHS Trust have been redacted from the attached document.

I can confirm that we hold this information, but it is exempt under section 40(2) of the Freedom of Information Act 2000 – Personal Information of third parties. This is because this information may allow the identification of these individuals and disclosure would breach the principles of the Data Protection Act.

This is an absolute exemption and there is, therefore, no requirement to consider the public interest.

If I can be of any further assistance, please do not hesitate to contact me.

Should you be dissatisfied with the Trust's response to your request, you have the right to request an internal review. Please write to the Freedom of Information Department (esh-tr.foi@nhs.net), quoting the above reference, within 40 working days. The Trust is not obliged to accept an internal review after this date.

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Should you still be dissatisfied with your FOI request, you have the right of complaint to the Information Commissioner at the following address:

The Information Commissioner's Office
Wycliffe House
Water Lane
Wilmslow
Cheshire SK9 5AF

Telephone: 0303 123 1113

Yours sincerely

Freedom of Information Department
esh-tr.foi@nhs.net

East Sussex Healthcare NHS Trust

Adult Discharge Policy

Document ID Number	2622
Version:	V1
Ratified by:	Clinical Documentation and Policy Ratification Group
Date ratified:	09 April 2024
Name of author and title:	Paul Relf – Assistant Director of Discharge Transformation
Date originally written:	February 2024
Date current version was completed	April 2024
Name of responsible committee/individual:	Professional Advisory Group
Division/Speciality:	Corporate Nursing
Date issued:	23 April 2024
Review date:	April 2027
Target audience:	All staff involved with patient care planning.
Compliance with CQC Fundamental Standard	Regulation 4 Requirements where the service provider is an individual or partnership. Regulation 9 Person centred Care Regulation 12 Safe Care and Treatment Regulation 13 Safeguarding service users from abuse and improper treatment Regulation 17 Good Governance
Compliance with any other external requirements (e.g. Information Governance)	NHS England – Hospital Discharge and community support guidance – March 2022 updated January 2024.
Associated Documents:	Sussex Choice Policy for discharge from NHS hospital and community provision (Link)

Did you print this yourself?
Please be advised the Trust discourages retention of hard copies of the procedural document and can only guarantee that the procedural document on the Trust website is the most up to date version

Version Control Table

Version number and issue number	Date	Author	Reason for Change	Description of Changes Made
V1.0	February 2024	Paul Relf	New Document	New Document

Consultation Table

This document has been developed in consultation with the groups and/or individuals in this table:

Name of Individual or group	Title	Date
Vikki Carruth	Chief Nurse ESHT – Discharge Senior Responsible Officer (SRO)	March 2024
Simon Merrit	Chief Medical Officer ESHT	March 2024
Jane Cadman	Assistant Director of Clinical Governance	March 2024
Angela Colosi	Deputy Chief Nurse (Quality & Policy)	March 2024
Gail Gowland	Head of Safeguarding	March 2024
Sammual Roberts / Cathy O'Callaghan	Heads of Site (EDGH & CQ)	March 2024
Nicola Anslow	Transfer of Care Hub (TOCH) East System Lead	March 2024
	Assistant Directors of Nursing	March 2024
Anne Canby	Assistant Director of AHPs	March 2024
[redacted]	Deputy Director All-Age Continuing Care NHS Sussex	March 2024
[redacted]	Head of Service – Adult Social Care – East Sussex County Council	March 2024

This information may be made available in alternative languages and formats, such as large print, upon request. Please contact the document author to discuss.

Table of Contents

1. Introduction

1.1 Legislative and cultural changes, technological improvements and financial pressures have resulted in significant changes to how care is delivered by the NHS. There is a breadth of viable alternatives to the hospital setting enabling patients to receive significant care and support outside of the hospital environment.

1.2 Effective discharge planning and its execution impact the hospital's capacity to treat acutely ill patients.

1.3 Discharge planning is a crucial part of a patient focused, quality approach to care and care continuity; each clinical area must collaborate fully to ensure that the patient experiences a good quality outcome. Effective hospital discharge can only be achieved when there is cohesive joint working between all concerned.

1.4 This policy excludes Paediatrics and Maternity patients. Please refer to local policies.

1.5 Where patients need continuing health care and /or social care after they have left hospital East Sussex Healthcare NHS Trust (the Trust) is required to work closely with its external partners to communicate each patient's continuing health and social care needs and ensure that suitable care is available for the patient on discharge.

1.6 This policy is intended to assist all staff within the Trust involved in the discharge process.

1.7 Although planned discharges from acute and community beds are between 8am and 10pm, there are rare occasions when discharge will occur outside these times. This policy is to be followed out of the stated hours also.

1.8 This policy is written in accordance with the Department of Health and Social Care (2024) Hospital discharge and community support guidance Delayed Discharges (Continuing Care) Health and Social Care Act, National Framework for NHS Continuing Healthcare and NHS Funded Nursing Care and is based on the guide from the Department of Health "Ready to Go?" promoting "The 10 Steps" essential for safe discharge and transfer of care planning.

1.9 East Sussex Healthcare NHS Trust is committed to the provision of a service that is fair, accessible and meets the needs and expectations of all individuals.

2. Purpose

2.1 This policy has been developed by the Trust to provide guidance to its entire staff who may become involved in supporting the discharge or transfer of care of a patient. It is designed to ensure that patients receive the right care in the right place at the right time, and that Trust staff understand their role and responsibilities when working with external health and social care partners.

2.2 The policy forms the foundation for future development of a protocol with external health and social care partners of common, shared standards that facilitate patient flows through from admission to acute hospital beds, to discharge to any facility within the surrounding areas and beyond.

3. Scope

3.1 The principles of discharge apply to all patients who have stayed, for however long, in the Trust. There are some departments and services such as those for Children,

the Neonatal Unit, Adult Critical Care and Maternity that have specific processes. This policy and procedure will signpost staff to the relevant team and, where appropriate, policy and processes.

3.2 Discharge planning is a multi-professional and often multiagency process. Therefore, this policy applies to all permanent, locum, agency, bank staff and volunteers of the Trust including doctors, nurses, health care professionals and managers involved directly or indirectly in discharge planning. Whilst the policy outlines how the Trust will manage effective discharge implementation, it does not replace the personal responsibilities of staff with regard to issues of professional accountability for governance.

4. Accountabilities and Responsibilities

4.1 The Chief Executive Officer (CEO) is responsible for supporting this policy operationally and financially, in order to fulfil the purpose of the policy.

4.2 The Chief Nurse has a responsibility for ensuring that this policy is implemented, and that staff receive training of an appropriate level that will allow the Trust to comply with this policy.

4.3 The Chief Medical Officer (CMO) has a responsibility for ensuring that this policy is implemented with the medical workforce, and that staff receive training of an appropriate level that will allow the Trust to comply with this policy.

4.4 Divisional, Operational, and other Line Managers: All Managers have a responsibility to implement this policy and to ensure that all reasonable steps are taken to maintain and achieve high standards when discharging or transferring any patient.

4.5 Ward Matrons are responsible for (or delegated actions):

- Ensuring that any ongoing care required to mitigate clinical risk and protect from vulnerability is confirmed to be in place prior to a patient's discharge (supported by the multidisciplinary team).
- Ensuring that staff are aware of this policy and implement it within their area of responsibility.
- Ensuring that staff are educated on the implementation of this policy.
- Acting as role models in the implementation of this policy.
- Challenging staff who do not adhere to this policy.
- Ensuring that there is a named nurse identified for each patient.
- Ensure that patients that require "Pathway 0 (Simple discharges)" discharge are managed effectively by the Ward team.
- Ensure that the Transfer of Care Hub (TOCH) is involved with patients requiring discharge Pathways 1-3.
- Involving the patient and their significant others where appropriate in the planning of their discharge as soon as possible and maintain effective communication.
- Making sure that Expected Date of Discharge (EDD)'s are completed and updated on Ward Boards/Nerceventre within 24 hours of admission.
- Work collaboratively with the TOCH and other partners with complex discharge planning.
- Escalate to Heads of Nursing/Divisional management teams in monitoring patients with "long length of stay", 7, 14 and over 21 days.

4.6 The Multidisciplinary Team is responsible for safe, timely and effective discharge of patients in accordance with the appropriate Trust policies. (A multi-disciplinary team in this context includes nursing and other health and social care professionals, caring for that patient).

4.7 The Consultant or a delegated senior clinician is responsible for the patient's medical care and for determining whether a patient is medically or surgically fit for

discharge and for setting an EDD:

- Within 24 hours of admission for emergency admissions; or
- At the pre-assessment if the patient is admitted for an elective procedure.
- Ensuring in the case of a complex discharge, that the EDD takes into account the time it will take to ensure the patient is safe for discharge from a multidisciplinary perspective and so ensure that the EDD represents an outcome of the assessment for discharge.
- Ensuring there are robust arrangements for keeping the EDD regularly reviewed and where appropriate amended daily ensuring the reasons are clearly recorded using Nervecentre and on the Integrated Patient Documentation (IPD).
- To identify and document patients who are appropriate for Criteria Led Discharge (CLD). See Criteria Led Discharge Policy.

4.7.1 It is the responsibility of the Consultant or their delegated clinician to ensure that their patient's electronic discharge summaries are signed off and verified and communications are sent to the patient's GP within 24hours.

4.7.2 The Consultant responsible for discharge or their delegated clinician must ensure that discharge prescriptions completed in a timely manner

4.8 The Clinical Site Team have an overall remit to ensure efficient patient flow is maintained across the Trust. The Team provides operational responsibility for managing the clinical capacity of the Trust and for patient flow. It must ensure that patient discharges and transfer decisions occur in accordance with this policy and meet the principles that underpin it.

4.9 The Head of Site is responsible during core hours for the Clinical Site team and provides direct line management to this team.

4.10 The Transfer of Care Hub Manager is responsible for:

- Leading on the development of a whole systems approach, which promotes continuous improvement in the quality of patient care, and the efficiency of the patient pathway.
- Ensuring all NHS community capacity is utilised to reduced unnecessary hospitalisation of patients.
- Monitoring, reviewing, and reporting performance in relation to discharge and delays at all levels across all dimensions of care and delivery.
- Identifying key blockages to effective discharge and manage a programme of work to ensure that those blockages as they apply across organisation boundaries are addressed.
- Providing senior knowledge and expertise on the management of complex health cases, such that they can be expedited. This includes liaison with senior colleagues in other organisations.
- Reviewing and interpreting revised discharge advice, guideline and best practice from NHS England/Improvement and operationalise for the teams working within the transfer of care hub. This includes any changes in funding guidance as it impacts on the discharge process.

4.11 The Transfer of Care Hub Team are responsible for facilitating the discharge of those patients with the most complex discharge needs from Acute Care (Pathways 1-3). They have a particular focus on implementing and monitoring of the National Service Framework (NSF) for Continuing Health Care (CHC):

- Where requested by the Ward Matron/Manager acting as Discharge Coordinator for a specific patient.
- Identifying critical delays in diagnostics, treatment and care processes and ensuring that these are solved where necessary via escalation to the appropriate staff member.
- In combination with the ward team maintaining Electronic Patient Records (EPR) to make sure that plans are up to date, and that pathways are correct.

- In combination with the ward team ensure that the next of kin are informed of discharge or transfer in a timely manner at least 24 hours in advance.
- Ensuring in the case of a transfer to another care provider that the receiving ward/hospital/care provider has received all appropriate information.
- Ensuring that contact made with external agencies is accurately and fully documented.

4.12 The Integrated Discharge Team (IDT), comprising Occupational Therapists (OT), Physiotherapists (PT), Dieticians and Speech and Language Therapists (SaLT), is responsible for assessing and aiding patient independence, safe mobility and identifying the patient's needs regarding activities of daily living. They have a key role in setting and agreeing rehabilitation plans to enable timely and safe discharge or transfer to non-acute settings with the appropriate aids.

PT and OT Standards for responding to referrals:

- All referrals are accepted by therapy when they are made verbally at board round (or list at nurses station) or picked up by therapist on ward patient action board (process not standardised for each ward) This is not dependant on whether the patient is Medically Ready for Discharge (MRD) or does not meet the Criteria to Reside (NCTR) Referral's will be received and then triaged accordingly.
- Standards are: daily triage (5 days - Mon - Fri -for the majority of our teams) and then:
    - For clinically deteriorating respiratory patients aim to see within 45 mins up to 22.00 pm (7 days a week)
    - All other patients aim to be seen within 24 hours (noting that we do not have capacity to meet this standard and do not have 7-day services for majority of our teams)
    - Patients are prioritised and seen as capacity allows (capacity shared daily on the site calls -Mon - Fri)
    - Priority 1 = Those patients due to be discharged home within 24 hours / New Referrals / Deteriorating patient
    - Priority 2 = Potential Discharge Date (PDD) within 3 days
    - Priority 3 = patients awaiting onward bedded pathway (P2 predominantly) or those without PDD

Standards for responding to referrals for Dietetics / SaLT / Podiatry / Orthotics:

- All referrals sent on e-searcher and accepted.
- Standards are: daily triage (5 days not 7) (except Orthotics) and then prioritised according to need
    - If therapy input is not considered clinically appropriate within the acute setting, the ward will be advised, and the relevant community team will follow-up.

4.13 The Pharmacy team are responsible for:

- Ensuring medicines have been dispensed in accordance with prescriptions or medicine orders.
- Supporting ward areas, when possible, to expedite discharges.
- Helping to identify potential pharmaceutical care problems on discharge and provide expert support to overcome these.
- Supporting a review of patients own medicines at admission to ensure medicines are suitable for inpatient use and subsequent use at discharge.

4.14 Nurse / Midwife responsible for the patient on the day of transfer / discharge:

The ultimate responsibility for ensuring that all necessary action is taken on the day of a patient's discharge or transfer rests with the nurse/midwife responsible for the patient's care on that day. This includes any assessment review to ensure that the patient can be safely discharged or transferred. The nurse/midwife is responsible for ensuring that the relevant

family and/or carers are adequately informed of the patient's discharge or transfer and to ensure that the patient has the necessary medication, equipment, clothing and personal effects and information as appropriate. The nurse/midwife responsible must review the Discharge Checklist in the Integrated Patient Documentation (IPD) or on Nervecentre.

There must be a final check of discharge medication to ensure that the medicines provided at discharge exactly correspond with the inpatient medication record and the discharge letter ("Three-point check"). There must be an adequate supply of medicines; at least 7 days in most cases, but 14 days minimum for Care homes/ Bexhill Irvine unit and Rye Memorial hospital, Virtual Ward patients require at least 28 days supply). Any discrepancies on the discharge letter must be discussed with the prescriber. Extra supplies can be requested from Pharmacy.

4.15 The Discharge Lounge is a safe, comfortable, and friendly environment where patients, when ready on the day of their discharge, may wait for collection by their relatives or by pre-arranged transport. The function of the Discharge Lounge is to enhance patient flow through the hospital. There must be a formal handover of patients between nursing staff and Discharge Lounge Staff.

Exclusion Criteria for the Discharge Lounge:

- Clinically unwell patients at risk of deteriorating
- End stage Palliative care Patients
- Patients with infection requiring isolation
- Patients awaiting transfer via Paramedic transport to an acute setting
- Patients with a cognitive impairment and at-risk absconding or suffering distress.
- Patients with mental health issues whose safety and safety of others is compromised.
- Patients on Oxygen therapy
- Patients with a history of recurrent falls.
- Bariatric patients
- Bedbound needing hoist transfer
- Wheelchair dependent
- Safeguarding concerns
- Patients requiring ongoing IV infusions.
- Patients not referred to ASC/PT/OT as required.

4.16 Adult Social Care (ASC) are responsible for:

ESCC ASC Offer for Acute Inpatients

- Have teams present on site across 7 days a week to undertake assessment activity for inpatients.
- Assess the following cohort of patients:
    - Patients who are ASC funded and have been admitted from a Nursing / Residential Home and require resettlement to another perm care home because of change of need.
    - Patients who would be eligible for a 12-week property disregard subject to a means tested financial assessments and arrange a perm placement
    - Patients who are returning home with a homecare package and not suitable for UCR or JCR due to their needs and/or circumstances e.g. self-neglecting, housing issues
    - Patients who have been identified for a placement but due to their complex needs require a specialist bespoke placement to meet their needs e.g. SPOT contract.
    - We prescribe telecare for P0 and P1 patients.
    - Undertake carers assessments where appropriate.
- The Discharge Nurses who work within the TOCH complete a Trusted Nursing Assessment for patients who have been identified for a placement, the TOCH liaises

directly with the D2A homes and arrange discharge, this process bypasses ASC operations and Brokerage. ASC only become involved with D2A bedded patients if complexities arise as a result of discharge e.g. complex MCA and professional and family conflict around discharge destination.
- Provide information, advice and support for patients who are P0,1,2,3.

4.17 All Age Continuing Healthcare (AACC) are responsible for:

The AACC service will support discharge for individuals who are already NHS Continuing Healthcare funded and supported by the AACC service prior to admission to the hospital. The AACC Case manager will make contact with the ward and will participate in the relevant MDT meeting to facilitate the discharge.

4.18 Other Employees: All employees who are involved directly or indirectly in discharge of patients from hospital have a responsibility to follow this policy and any decisions arising from its implementation. All staff must:

- Adhere to this policy.
- Ensure that the appropriate people are informed about the requirements for the safe discharge of patients.
- Undertake the relevant training and updating as appropriate to the patient group with whom they work regarding the safe discharge of patients.
- Report any incidents or near misses associated with patient discharge and engage fully in any subsequent process of investigation and learning arising from such incidents.

5. Purpose of the Procedure

5.1 Determining patients Criteria to Reside

Every person on every general ward should be reviewed twice daily multidisciplinary ward round to assess their need for continued acute hospitalisation.

If the answer to each of the questions below is ‘no’, active consideration for discharge to a less acute setting must be made.

✓ Requiring Intensive Therapy Unit (ITU) or High Dependency Unit (HDU) care?
✓ Requiring oxygen therapy/Non-Invasive Ventilation (NIV)?
✓ Requiring intravenous fluids?
✓ NEWS2 > 3? (Clinical judgement required in persons with Atrial Flutter and/or chronic respiratory disease)
✓ Diminished level of consciousness where recovery is realistic?
✓ Acute functional impairment in excess of home/community care provision?
✓ Last hours of life?
✓ Requiring intravenous medication more than twice daily. (including analgesia)?
✓ Undergone lower limb surgery within 48hrs?
✓ Undergone thorax-abdominal/pelvic surgery within 72 hrs?
✓ Within 24 hours of an invasive procedure? (With attendant risk of acute life- threatening deterioration)

The outcome of each patient’s daily assessment against the Criteria to Reside must be recorded onto the inpatient Nervecentre, by the ward staff.

It is accepted that clinical exceptions will occur, but they should be warranted and justified within the patient's medical records. Recording the rationale will enable meaningful and time efficient review.

Review questions for the clinical team should include:

Is the patient medically optimised?

What management can be continued via Speciality Same Day Emergency Care (SDEC), or Hot Clinics?

Can the patient have any diagnostics tests as an outpatient? (MRI/CT)

What management can be continued outside the hospital (e.g. intravenous antibiotics) Think Urgent Community Response (UCR), Virtual Ward (VW) or Joint Community Rehab (JCR)?

People with a low NEWS score (0-4) - Can they be discharged with a suitable follow-up? For example:

- If not scoring 3 on any one parameter
- If their oxygen needs can be met at home
- Stable and not needing frequent observations (i.e. less than four hourly)
- Not needing any nursing or medical input after 8pm
  People waiting for results:
  Can they come back?
  Can they be phoned through?
- Repeat bloods:
  Can they be done after discharge in an alternate setting?
- People waiting for investigations:
  Can they go home and come back as outpatients, but with the same prioritisation as inpatients?

Discharge planning is a continuous process that commences on or before admission. The need for support on discharge must be clearly identified and arrangements made from as early as possible in the patient's stay or from the decision to admit and clearly documented in the patients notes.

5.2 When starting to plan for a patient's discharge, the following factors must be considered:

- Complexity, stability, and predictability of the patient's physical and mental condition
- Previous care needs
- Changing medication needs
- Likely changes as a result of admission
- Eligibility for Continuing Health Care post discharge
- Transport needs
- Social needs
- Possible vulnerability of patient
- Infection prevention and control issues and the possible need for consultation with the infection prevention and control team
- Equipment needs.
- Environmental considerations – will the patient be able to return to their place of residence, taking into consideration any changes in ability or dependency they may have undergone.
- Level of support required – whether the patient's care needs changed and, if so, whether carers/relatives will be able to provide an appropriate level of support.

5.3 Principles of safe discharge

5.3.1 The principles of effective and safe discharge are enshrined in the “10 Steps” outlined in “Ready to Go?” (DH 2010) and must be followed when discharging all adult patients.

The 10 Essential Steps to Effective Discharge are:

1. Start planning for discharge or transfer before or on admission.
2. Identify whether the patient has simple or complex discharge and transfer planning needs, involving the patient and / or carer in your decision.
3. Develop a clinical management plan for every patient within 24 hours of admission.
4. Co-ordinate the discharge or transfer of care process through effective leadership and handover of responsibilities at ward level.
5. Set an expected date of discharge (EDD) or transfer within 24 hours of admission and discuss with the patient and carer.
6. Review the clinical management plan with the patient each day, take any necessary action and update progress towards the discharge or transfer date.
7. Involve patients and carers so that they can make informed decisions and choices that deliver a personalised care pathway and maximise their independence.
8. Plan discharges and transfers to take place over seven days to deliver continuity of care for the patient.
9. Use a discharge checklist 24–48 hours prior to transfer.
10. Make decisions to discharge and transfer patients each day.

Patients should remain in hospital only as long as their condition requires acute inpatient services and facilities: An unnecessary prolonged stay in a busy acute care environment can impact on a patient’s wellbeing and may not be in their best interests. In such circumstances patients may experience boredom, low mood, or depression. It can also increase the risk of infection and impact a patient’s mobility and independence.

Why am I going home? Its ok to ask.

We know that it’s much better for a patient’s physical and mental wellbeing to leave hospital as soon as they are medically ready to do so.

That’s why we’re doing everything we can to reduce prolonged hospital stays and help our patients continue their recovery at home or, for those that can’t go straight home, within a care location most suited to their needs.

Launched in February 2022 the ‘When am I going home?’ campaign is designed to empower and encourage patients and their families to feel confident in asking questions about their care and recovery beyond the hospital setting.

https://www.england.nhs.uk/urgent-emergency-care/reducing-length-of-stay/reducing-long-stays-empowering-patients-campaign/

We recognise it can sometimes be hard for patients to ask questions about where their care is up to, especially if they’re unsure about their illness or they can see staff are busy; but encouraging them to ask key questions can help them feel more in control of their recovery.

The campaign is centred around these four questions that patients can ask so they understand everything they need to know about their care and recovery plan:

1. **What is wrong with me?**
2. **What is going to happen next?**
3. **What can I do to help myself get better?**
4. **When am I likely to go home?**

5.3.2 The patient and their carer (where appropriate) will be at the centre of discharge and transfer planning and involved fully at each stage. Opportunities for them to discuss and contribute to planning, and to raise concerns (including any financial ones) must occur and the resulting conversations must be documented in the patient notes and on Nervecentre.

5.3.3 Timely referral to appropriate services will take place to ensure all necessary support is fully available.

5.3.4 Liaison with internal/external health and social care providers must be timely, in an accepted format and must be clearly recorded.

5.3.5 Matron is responsible for ensuring that there is a Nurse in charge responsible for coordinating each discharge and for ensuring that the patient / carer are aware of who that person is.

5.3.6 The Mental Capacity Act 2005 provides legal framework for acting and making decisions on behalf of patients aged 16 and over, who lack the mental capacity, either permanently or temporarily, to make particular decisions for themselves. This includes decisions relating to discharge. This Act also provides a best interest checklist which must be used when staff make a best interest decision on behalf of a patient. The principles of this Act require Trust staff:

- To assume a patient has capacity unless it is established that they lack capacity.
- Not to treat patients as unable to make decisions until all practical steps have been taken to help the patient to make their own decision.
- Not to treat patients as unable to make a decision merely because they make an unwise or eccentric decision.
- To carry out actions or make decision in the best interests of the patient who lacks capacity.
- To ensure that before the action is carried out, or the decision is made, regard is given to whether the purpose for which it is needed can be effectively achieved in a way that is less restrictive of the person's rights and freedom of action.

5.3.6 Where consent of the patient cannot be obtained, through incapacity, then decisions about their personal welfare, which includes discharge planning, must be determined in accordance with the Mental Capacity Act 2005 and the accompanying Code of Practice. This Act is designed to protect the rights of individuals and empower vulnerable people.

5.3.7 Patients requiring health and social care services will not be discharged until it has been confirmed to the ward staff that the agreed package of care is in place.

5.3.8 Discharge prescriptions (TTAs) where required must be available for the patient to take with them and completed electronic discharge summaries and any other necessary communications sent to the patient's GP in a timely manner (within 24hours). If relevant-arrangements with the patients GP and community pharmacy if the patient has an existing Medication Compliance Aid (MCA) or Monitored Dosage System (MDS). These usually take at least 1-2 working days to arrange. The pharmacy team can support and advise.

Further support for patients and their medicines can also be arranged via the Discharge Medicines Service (DMS). This allows use of the ICE Discharge system and eSearcher to authorise an automatic community referral so that patients can discuss any changes or new medicines with their chosen community pharmacy after they have been discharged. This is a patient safety benefit as it can improve understanding and compliance with medicines. The pharmacy team can advise on the process for setting this up if staff have not had training.

5.3.9 Patients and their carers must have sufficient information (written where appropriate) to participate in the successful discharge/transfer of care.

5.3.10 Staff should liaise with the ESHT Safeguarding team where there is a safeguarding concern such as domestic abuse and self-neglect. It may be appropriate to further liaise with Adult Social Care and arrange an MDT to ensure a safe discharge.

6. Planning Discharge for Elective

6.1 For elective admissions the discharge planning process commences prior to admission when information can be gathered from the patient and primary and community services (e.g. support plans from care homes, with or without nursing, and documentation) regarding the patient's needs. Screening patients through the process of pre-assessment appointments effectively will identify potential risk factors which could lead to a delay in discharge. Patients must be advised to have a supply of their normal analgesia at home ready for discharge.

The pre-assessment for elective patients (this includes pre op check lists, optimising health outcomes, MDT assessments such as nutrition screening) must include the following discharge planning elements:

- Home circumstances: whether the patient lives alone, who will collect them / stay with them on discharge.
- Whether the patient lives in supported accommodation or care home, with or without nursing; arrangements for transport to / from hospital.
- Current and previous relevant medical history.
- Mobility check.
- Existing Social care support arrangements and those post discharge.
- Existing support from district nurse or community-based nursing teams and services.
- Arrangements for ensuring effective liaison with post discharge community-based care and social support colleagues involved in supporting the patients.
- Personal effects and equipment for use on discharge including full set of outdoor clothing including coat and shoes appropriate to the season, front door keys, and contact numbers.
- Has suitable pain relief at home if required.

6.2 Planning discharge for patients originally admitted via the Emergency Department

6.2.1 When a patient is admitted as an emergency the process of assessing home circumstances and any anticipated needs in relation to discharge can be supported by information provided by ambulance crews, accompanying carers, documentation from community services/GP and the patient's next of kin.

6.2.2 Discharge plans must assess and document the following:

- Capacity assessment
- Discussion with the patient and family
- Home circumstances: whether the patient lives alone, who will collect them / stay with them on discharge if required.
- Whether the patient lives in supported accommodation or care home, with or without nursing, Arrangements for transport from hospital.
- Current and previous relevant medical history
- Mobility.
- Pre-existing Social care support arrangements and those post discharge.
- Pre-existing support from district nurse or community-based nursing teams and services.
- Arrangements for ensuring effective liaison with post discharge community-based care and social support colleagues involved in supporting the patients.
- Personal effects required for discharge including full set of outdoor clothing including coat and shoes appropriate to the season, front door keys, contact numbers / access codes.

7. The Simple Discharge Pathway and Process

7.1 Pathway 0 (Simple Discharge): Patients with simple discharge needs usually make up the majority (roughly 80%) of all discharges: They are defined as; Patients who will usually return to their own home or usual place of residence and have simple on-going care needs which do not require complex planning and delivery or have support packages in place that do not require adjustment.

7.2 Time in hospital does not determine whether a patient has simple discharge needs. The key decision factor is the level of ongoing care / support required and whether this has altered since the patient's admission.

7.3 An initial assessment and discharge plan must be completed within 24 hours of admission, or directly from a pre–admissions clinic. The recording of 'simple' or 'complex' discharge must be documented on the patient 'Discharge and transfer plan'.

Issues that must be considered as part of a discharge plan include:

- Previous care needs.
- Changing medication needs including compliance aids (the pharmacy team can advise whether compliance aids are suitable).
- Likely changes as a result of this admission.
- Transport needs.
- Social needs.
- Eligibility for Continuing Health Care.
- Possible vulnerability of patients, e.g. frail, elderly, terminally ill, learning disability, mental health problems.
- Infection prevention and control issues and the possible need for consultation with the infection prevention and control team.
- Equipment needs.
- Home circumstances: whether the patient lives alone, who will collect them / stay with them on discharge if required.
- Whether the patient lives in supported accommodation or care home, with or without nursing, Arrangements for transport from hospital.
- Current and previous relevant medical history.
- Mobility.
- Pre-existing Social care support arrangements / involvement and those required post discharge.
- Pre-existing support from district nurse or community-based nursing teams and services and those required post discharge.
- Arrangements for ensuring effective liaison with post discharge community-based care and social support colleagues involved in supporting patients.
- Personal effects required for discharge including full set of outdoor clothing including coat and shoes appropriate to the season, front door keys, contact numbers / access codes.

7.4 All patients must have an Estimated Date of Discharge (EDD) within 24 hours of admission. This must be documented in the patient's notes and on Nervecentre set by the patients Consultant.

7.5 The Consultant or their delegated representative and the Ward Sister/Manager must ensure robust arrangements are in place for EDDs to be reviewed and updated on a daily basis.

7.6 Once a patient has been assessed as appropriate for discharge using the simple discharge pathway the Ward matron / Manager will, whilst remaining involved with the provision of advice and support related to simple discharges must:

7.7 Identify a named nurse from their team to lead the patient's discharge.

7.8 Ensure that the patient and/ or carers agree the discharge plan and that this is documented on the Multi-Disciplinary Discharge Communication Sheet and on Nervecentre.

7.9 Any additional equipment needs must be identified early involving early referral to the Therapy Team: Occupational Therapy; Physiotherapy; and Adult Speech and Language Therapy, orthotics, podiatry and Dieticians, as needed, and the necessary community arrangements made for their provision.

7.10 If there is an existing package of care that needs to be restarted and where no change to the patient's care needs are identified as a result of their hospital treatment or care, contact must be made with the relevant Adult and Social Care Department. N.B. Social Services can require 48 hours' notice depending on the length of admission before a care package can be restarted so this needs to be done in good time.

7.11 Medical staff must review and document their consent for the patient to be discharged and must ensure timely prescribing of any discharge medication and completion of discharge summaries.

8. Complex Patient Management

8.1 Ward Responsibility

- Have oversight on all patients on their ward area in all pathways.
- Link in with the Clinical Site Management Team around potential and confirmed discharges.
- Aim to discharge patients early in the day.
- Use the discharge lounge where appropriate.
- Early escalation in the discharge pathway of complex cases.
- Ward Matron to escalate complex patients at their divisional length of stay reviews to Head of Nursing or Assistant Director of Nursing.

8.2 Divisional Responsibility

- Assistant Director of Nursing to hold weekly length of stay reviews of their ward-based areas.
- Escalate complex patients at weekly TOCH System Escalation meeting where system escalation is required i.e. Continuing Healthcare, Adult Social Care, Discharge to assess pathways.

8.3 TOCH Responsibility

- To have overall view of system delays and pressures.
- To support the wards in completion of documents such as Trusted Nurse Assessor (TNA's) and Continuing Healthcare (CHC)Fastrack paperwork.
- To provide training to Matrons/Sisters/Charge Nurses around completing necessary discharge paperwork.
- Discharge Co-ordinators to support with discharge pathways 1-3.
- Discharge Co-ordinators to support Wards with referrals such as Personal Health Grants (PHG's), voluntary service referrals etc.

8.4 Choice Policy

8.4.1 Patients do not have the right to remain in hospital longer than required.

8.4.2 There is an NHS Sussex Choice Policy which has been adapted by ESHT. This policy can be found by searching policies on the ESHT intranet page

http://nww.esht.nhs.uk/wp-content/uploads/2023/10/02568_P.pdf

8.4.3 If a patient is a self-funder and arranging their own package of care, this should be done within 3 days of being discharge ready.

8.4.4 If a patient requires an Intermediate Care Unit bed for rehabilitation, this bed will be arranged by ESHT. This bed will be in an available bed available to the organisation and preference cannot always be adhered to.

8.4.5 A patient requiring a new placement which is being arrange by either the patient/family and or friends this must be done within 7 days of becoming discharge ready.

8.4.6 An MDT meeting will be held if delays exceed stated times above. A formal letter will be submitted to the patient/or family from the Divisional Assistant Director of Nursing or nominated Head of Nursing.

8.4.7 If a patient or family refuse options provided or do not find somewhere in a timely way, then ESHT will seek legal advice for next steps.

8.4.8 Once legal advice has been taken, then a final notice letter will be completed by the Director of Nursing/ or Medical Director informing the patient/family that we will be discharging to an appropriate place with a confirmed timescale.

8.5 Learning Disability Service User Consideration

8.5.1 ESHT has an Acute Learning Disability Liaison Nurse who covers both acute hospital sites who can be contacted to assist with support to ward/department areas.

8.5.2 Please refer to the ESHT Policy “Policy for the care of People with Learning Disability in the Acute NHS Trust”.

http://nww.esht.nhs.uk/wp-content/uploads/2018/08/01409_P.pdf

8.5.3 Throughout a person’s inpatient stay:

- ensure that the clinical care and treatment plans are based on a holistic assessment of need and have a plan for discharge from the point of admission.
- have a continued focus on the person’s mental, physical, and emotional wellbeing.
- ensure that discharge planning properly considers any support needed through the transition from hospital to life in their local community.

8.5.4 Demonstrate that in decision-making about the person’s physical and mental health care in hospital, their discharge plans (including transition arrangements and life planning), and their options for community care, support and housing or accommodation when they leave hospital, you have co-produced this with the full involvement of the person, their family (as appropriate), and the person’s advocate.

8.6 Mental Health

8.6.1 The MDT need to contact the TOCH as early as possible for support, advice or assistance with discharge planning.

8.6.2 If the patient has no previous history of mental health problems, the medical staff need to rule out organic cause e.g. infections, side effects from medication, urinary tract infection. A referral to mental health services can be made.

8.6.3 If the patient is already known to mental health services the multidisciplinary team should contact the community mental health practitioner or relevant psychiatrist to ascertain background information/ patient baseline.

8.6.4 The patient mental health case worker should be informed of the patient's date of discharge and discharge destination for future follow up.

8.7 Safeguarding

8.7.1 All actions in respect of Safeguarding Adults should be in accordance with the Care Act.

8.7.2 All patients should be assumed to have mental capacity to make a decision about their ongoing care, including as regards discharge. A capacity assessment should be undertaken at any point during the process if their capacity, in relation to the discussions and decisions on discharge, is in doubt.

8.7.3 If a patient is the subject of a Safeguarding Adults referral/investigation, or it is felt that discharging the patient may put him at risk, the Adult Social Care Team will agree how they will support discharge arrangements in the best interests of the patient.

http://nww.esht.nhs.uk/wp-content/uploads/2018/12/Safeguarding-Adults-Guidance-on-Raising-Concerns-about-Abuse-and-Neglect.pdf

8.8 Self Discharge against medical advice

8.8.1 All staff should remember that patients do have a right to self-discharge (assuming they have capacity to do so). In these situations, staff must consider the following in order to facilitate self-discharge to achieve the best outcome possible.

- Does patient have capacity?
- Has this been evidenced by completion of an assessment under the Mental Capacity Act as appropriate?
- Has a Deprivation of Liberty checklist been completed?
- Inform and discuss with medical staff, Matron, or Head of Nursing as required.
- If out of hours, liaise with Clinical Site Manager.
- Inform and discuss with GP and any other relevant agency.
- Patients are able to take any medicines which they have brought in with them and a risk/ benefit decision made on whether other medicines can be provided at discharge, particularly if the discharge letter has not been completed.
- Inform next of kin, if known and appropriate.
- Self-discharge form should be completed.
- Document clearly within medical and nursing notes all actions taken.

8.8.2 Unless it is assessed and documented that a patient lacks the mental capacity to make this decision at this particular time for themselves. If this is the case a 'best interest decision' will need to be made with regards to what is the least restrictive intervention. The patients' safety must be maintained.

8.8.3 It must be ensured that the patient has all their belongings, relevant documents, medications, and dressings prior to their discharge plus information leaflets.

01540_P.pdf (esht.nhs.uk)

8.9 Patients approaching end of life

8.9.1 Patients are 'approaching the end of life' when they are likely to die within the next 12 months. It is important to identify and understand what the patient's wishes are regarding discharge from hospital and exploring the most appropriate discharge pathway to use.

8.9.2 This Trust uses 4 pathways and provides checklists to ensure safe discharge from hospital.

They are:

- Pathway A – Patients identified as being (or likely to be) in their last year of life (this may include weeks to months) but who are not rapidly deteriorating.
- Pathway B – Patients who are rapidly deteriorating and are felt to be in the last weeks / short months of life with increased care needs, but do not have complex symptoms.
- Pathway C – Patients with complex symptom control needs requiring admission to a hospice for symptom control.
- Pathway D - Patients requesting immediate discharge home to die within hours or short days.

Definitions Fast Track discharge can be considered when:

- The patient is recognised to be 'rapidly deteriorating' and in the last days or short weeks of life.
- The patient's care needs have changed.
- The patient's physical condition has significantly deteriorated.
- The patient is not requiring any further in-patient intervention.
- Options for future care have been discussed and an agreed discharge destination has been identified.

Complex Symptom Control is when physical or psychological symptoms continue despite the intervention and support of the Supportive and Palliative Care Team and require more frequent reviews by hospice teams. This may include needing the intervention of other healthcare professionals and services that cannot be provided in the acute setting but are available within the hospice setting.

http://nww.esht.nhs.uk/wp-content/uploads/2015/05/Discharge-pathways-and-Checklists-for-adult-patients-in-their-last-year-of-life.pdf

8.10 ReSPECT (Recommended Summary Plan for Emergency Care and Treatment) Documentation

- ReSPECT has been developed under the supervision of the Resuscitation Council (UK), by a working group comprising representatives from the Medical Royal Colleges, the Royal College of Nursing, Ambulance Services, Patient Representative Groups and others.
- ReSPECT is not just a form it is a process. The process undertaken before the form is completed, including conversations with the person, family members and other representatives, is central.
- This process entails reaching a shared understanding of the person's state of health, likely prognosis and the potential for deterioration and acute crises. Options for treatment in an emergency must be explained realistically, including the prospects of success and the likelihood of unwanted effects (including pain). Discussions about CPR should include the probability of successful resuscitation (often very low for people with advanced disease).

For any patient that is made DNACPR, it is a legal requirement to inform the patient of this decision.

- ReSPECT emphasises the views of the person themselves in setting goals for treatment. What is most important to the patient: sustaining life, even if that will entail discomfort; or ensuring comfort, even if that may shorten life. This does not mean that the patient is being asked to decide their own treatment plan.
- Following these discussions, a set of clinical recommendations, for use in an emergency, can be written. These should reflect both the wishes of the person, and the professional opinion of the clinician. Unlike DNACPR orders, there is emphasis on treatments to be considered, as well as those which are not wanted or which are unlikely to be successful. Decisions relating to CPR are made in the wider context of what can and cannot, realistically, be achieved.
- Conversation should be led by a clinician of sufficient experience and seniority, who has knowledge of the patient. This may be a GP, consultant, trainee, nurse of other healthcare professional. Involving another member of the healthcare team may help by providing another perspective, maintaining consistency and supporting reflection. It may also be useful to involve other professionals with relevant expertise – specialist doctors, Critical Care, End-of-life Care etc.
- Talk to the patient and, if possible, to family or other representatives. A person with mental capacity must be involved in the decision-making process. If asked to speak to someone else alone, you should seek the patient's permission.
- If possible, conduct the conversation at a time when the person is relatively well and is able to participate. This may be done in an outpatient or community setting, or on a ward, and more than one meeting may be necessary. However, a patient may present with an acute illness, necessitating a more urgent conversation. In such cases, if the ReSPECT process is appropriate, the conversation should take place as soon as possible.
- The ReSPECT conversation should be adapted to circumstances. Someone presenting in the community or an outpatient clinic, with long-term health problems, might need quite a long discussion and more than one meeting. Discussion would include their long-term expectations and wishes, and whether or not they would wish to be admitted to hospital. A patient presenting acutely to A&E may require a much briefer conversation. Initially, this may be restricted to whether or not they should be admitted to ICU and whether or not CPR should be attempted. Depending on the response to treatment, the conversation may be continued and developed at a later time, and the recommendations may be altered.
- Gather as much information as possible before starting the conversation: past and current medical history, normal function, any history of deteriorating health over time. If time allows, seek advice from relevant specialists on appropriate treatment.
- Use plain language during conversation and when completing the form (the ReSPECT form is kept by the patient, in the long term). Avoid jargon, and check that you have been understood by asking the patient to repeat what has been said in their own words.

ReSPECT Live Forms:

- The form should be at the front of the patients working notes and should accompany the patient everywhere whilst under ESHT's care.
- Ensure that the section relating to ReSPECT is completed on the discharge letter to inform the GP.
- ReSPECT form to be scanned and added onto E-Searcher by ward or area.
- The form should be given to the patient to take home with them and make sure you provide advice on how to care for the form.
- Scan and email a copy to the Ambulance Service who will update their system respect@secamb.nhs.uk

9. Patients requiring home oxygen.

If your patient potentially needs home oxygen, then please contact the Regional East Sussex Pulmonary Service (RESPS).

Contact information

Ext: 735317
Tel: 0300 131 5317
esh-tr.RESPS-TEAM@nhs.net

Working hours:
Monday to Friday – 8am to 6pm
Weekends and bank holidays – 9am to 5pm

Home oxygen can be provided for a patient with confirmed long term respiratory/cardia condition i.e. COPD, bronchiectasis, Intestinal lung disease, hypoxemic heart failure, pulmonary hypertension.

1. Please complete the RESPS checklist

2. If checklist advises, please complete the Oxygen Risk Mitigation Form (IHORM), the patient agreement to sharing information form, and the Oxygen Safety Agreement.

3. Complete a Part A HOOF form and fax and email.

http://nww.esht.nhs.uk/task/resps-regional-east-sussex-pulmonary-service/

10. Transport

10.1.1 Ensure that you have asked the patient about transport on discharge in good time, preferably at least two days prior to their EDD. In most cases relatives, carers or friends will be more than happy to help if they are given adequate notice. Preplanning is essential especially for more complex discharges and for bariatric patients requiring addition crew and specialised equipment. Patients are only permitted to take 1 piece of equipment and 1 bag. All other belongings must be planned to be taken by friends/family.

10.1.2 If the patient doesn't qualify for ambulance or Non-Emergency Patient Transport (NEPT), and they have no friend or family to take them home, consider the use of voluntary transport, e.g., Age Concern. Any potential costs to patients must be explained in advance.

10.1.3 Patients generally make their own arrangements for transport from hospital unless they meet the medical or social eligibility criteria for hospital transport. The service currently is provided under contract to the Trust by South Central Ambulance Service (SCAS).

10.1.4 The Nurse in Charge of the patient, with support from the ward clerk and Transport Team, is responsible for executing this process. Arrangements for discharge and possible transport requirements must be considered at the earliest opportunity and at least 24 hours prior to discharge. Ambulance and Non-Emergency Patient Transport (NEPT) must only be used in the event of clinical need. Transport must be booked from the discharge lounge, unless there are circumstances where the discharge lounge is not appropriate.

10.1.5 NEPT can convey patients that require assistance for mobility reasons but do not require medical interventions during the course of a journey. To pre book patient transport ward

staff must complete an electronic request form 24 hours in advance of expected discharge and must ensure that transport personnel taking the patient home, are aware of any particular requirements, such as Zimmer frames or bulky luggage, and that they are aware of any specific clinical instructions for the individual's care e.g. oxygen requirements, together with requirements for their physical movement such as a chair or trolley.

10.1.6 Specialist Patient Transport i.e. for bariatric patients; must be booked as soon as EDD is known. Requirements must be discussed with the transport team at the earliest opportunity. A risk assessment would be required a minimum of 24 hours' notice is required.

10.1.7 In some circumstances when SCAS are busy or there are concerns that a journey cannot be met by SCAS, then alternative transport can be arranged, but this must be arranged via the Clinical Site Management team.

11. The Day of Discharge

11.1 The ward staff in charge of the patient's care on the day of discharge must review, complete, and sign the discharge checklist with the patient (In the IPD or Nervecentre).

11.2 The nurse in charge of the ward, must communicate and inform the Clinical Site Manager of the potential/confirmed discharge and update Nervecentre. They must also liaise with the discharge lounge and ideally discharges should be in the discharge lounges before 11 am daily where possible.

11.3 On the day of discharge the named nurse in charge of the patient's care on that day must ensure that the patient leaves with:

- An outpatient appointment, if required.
- TTAs and an explanation on how they are to be taken, how many days medication has been supplied and when they need to get more from their GP. Check medicines are labelled correctly, and remove those not on the discharge letter (unless patient's own where agreement will be needed before removal)
- Information on any further procedures/investigations required e.g. blood test.
- Details of who to contact if they are anxious or worried.
- A supply of continence items, consumables for intravenous administration or dressings that may be required.
- Any valuables and personal items.
- Contact details for any of the following services that may have been arranged for their discharge.
- If the patient has a RESPECT form, has this been given to the patient to take home or taken with the patient to be given to the necessary care setting post hospital stay.

11.4 The ward staff in charge of the patient's care on the day of discharge must check that:

- The patient is fully clothed in appropriate day attire suitable for the season before discharge.
- (Patients must not be discharged in their night clothes unless the patient declines the offer of clothes in which case this must be recorded on the multi-disciplinary communication sheet and transport personnel advised).
- The patient has keys to their property or knows how to gain access.
- Any cannula that is not required has been removed.

11.5 If the patient is employed, they may require a Fit Note if they have been off sick for 7 days or more.

11.6 If you are handing care over to another organisation/provider/service then please complete a transfer of care form. Please see section below for advice.

11.7 The discharge letter must be given to the patient. An electronic discharge summary may also be sent to the patient and or GP. Include any other relevant medicines related documentation e.g. community MAR chart / palliative care chart.

12. Transfer of Care Document

The trust has an internal document called the “Transfer of Care Document” which can be used as part of the discharge process to support handover to other ongoing care providers i.e. care agencies/care or nursing homes. This gives additional information to the medical discharge letter and a verbal handover.

The expectation is that ward staff complete these as part of discharge process.

13. Document Monitoring Table

Element to be Monitored	Lead	Tool for Monitoring	Frequency	Responsible Individual/Group/ Committee for review of results/report	Responsible individual/ group/ committee for acting on recommendations/action plan	Responsible individual/group/ committee for ensuring action plan/lessons learnt are Implemented
Patient Safety Incidents	Assistant Director Clinical Governance	Patient Safety Incident Framework	Ongoing	Divisional and/or Specialism Governance Meetings/IPR.	Divisional Leadership team Chief/DDO/ADN	Divisional Leadership team Chief/DDO/ADN

Appendix A: Pathway Zero - Simple Discharges

Simple discharge home (to usual place of residence or temporary accommodation) co-ordinated by the ward without involvement of the care transfer hub.

British Red Cross – Assisted Discharge Service

Service Hours Monday – Friday 10.00 a.m. – 22.00 p.m. Saturday and Sunday 10.00 a.m. to 18.00 p.m.

Contact 07872 839884

Service users must be over the age of 18 yrs., mobile and be able to transfer into a car.

Using Redcross vehicles and a one-person crew we collect patients from the hospital and take them home.

Once home we ensure that they are comfortable, safe and supported.

Tasks carried out in the home may include:

➢ Testing the Lifeline and complete a test call
➢ Preparation of a light meal and drink
➢ Ensuring the kitchen is stocked with essential items (either from onboard food pack or purchase items from a local shop if patient can provide cash and a list of what is required)
➢ Clean the fridge and remove any out-of-date items.
➢ Ensure heating is on if required.
➢ Transport equipment.
➢ Contact with any relevant parties to inform them of patient's return home
➢ Make a referral for further support including the Red Cross Home from Hospital and Carers Crisis Response Service

Appendix B: Pathway One Discharges

Urgent Community Response (UCR) – HomeFirst

Urgent community response teams provide urgent responsive care within two hours to people in their homes which helps to facilitate hospital discharges and avoid hospital admissions.

These are common clinical conditions or needs that may lead to a patient requiring a two-hour response in a crisis, but this list is not exhaustive:

- Urgent equipment provision to support a person experiencing a crisis/at risk of hospital admission.
- To facilitate a hospital discharge
- Decompensation of frailty
- Fall without serious injury or fracture.
- Urgent catheter care
- Reduced function/ deconditioning/ reduced mobility
- Unpaid carer breakdown which, if not resolved, will result in a healthcare crisis for the person they care for
- Palliative/end-of-life crisis support
- Urgent support for management/treatment/medicines administration for patients with diabetes
- Urgent catheter care
- Confusion / Delirium

Referral criteria

UCR is a busy service receiving referrals from a range of acute, community and primary care teams. These include:

- GPs
- District Nurses
- Nursing and Rest Homes
- Hospice
- South East Coast Ambulance Service (SECAMB)
- Adult Social Care (ASC) inc. Older Peoples Mental Health (OPMH)
- Hospital wards and gateway areas,
- Specialist Nurses,
- Joint Community Rehabilitation
- Allied Health Care Professionals within acute or community settings

UCR have a self-referral pathway for patient experiencing difficulties with their catheter.

This list is not exhaustive. Patients can be referred by anyone into the UCR service providing they have an urgent need and met the criteria below:

Note: if a patient meets the top two exclusion criteria but a treatment escalation plan, advance care plan or advance decision to refuse treatment is in place which states the person wishes for treatment to be delivered in their usual place of residence; or family

have a lasting power of attorney for health and welfare, the patient no longer has capacity to make decisions and the family wish for treatment at home. Then please include this information in the referral and it can be considered for acceptance.

Inclusion Criteria

- Over 18 years
- Is living in their own home or a residential/care home setting.
- Is in a crisis (some guidance above) and needs intervention within two hours to stay safely at home/usual place of residence and avoid admission to hospital.
- Is living with dementia – best practice is to share responsibility for care with older people's mental health teams.
- Needs short term support for hospital discharge.

Exclusion Criteria

- Is acutely unwell or injured, requiring emergency care intervention and admission into an acute hospital bed.
- Needs acute/complex diagnostics and clinical intervention for patient safety in hospital.
- Is experiencing a functional mental health crisis with no co-occurring urgent physical needs and requires referral/assessment by a specialist mental health team.

How to refer to UCR

Catheter Care Line: Patients with a catheter needing urgent assessment can self-refer on:

- Eastbourne, Hailsham and Seaford – Tel: 0300 131 4711
- Hastings and Rother – Tel: 0300 131 5603

To refer to UCR please use the HSCC (Health and Social Care Connect) Referral Form which can be found in on E-searcher → Patient documents → Electronic Referrals → Select from drop down menu → complete document → send.

Virtual Ward (VW)

Virtual wards can accept patients with ongoing treatment or clinical review requirements to support an early discharge to the place they call home. The VW team can provide package of care support, physiotherapy, occupational therapy, SALT, dietetics and pharmacy reviews. The patient must give consent and the doctor overseeing the care must agree for the patient to be discharged home for the remainder of the treatment. As well as a General Ward that will support a wide spectrum of patients, the VW has specialist wards available for those with Respiratory, Heart Failure or Frailty needs.

The doctor must ensure a clear treatment and escalation plan is in place and this must be handed over on referral to the virtual ward, so that a decision can be reached by the senior clinical decision maker for the relevant ward. Once the referral has been accepted the virtual ward staff are required to inform the pharmacy team that the patient is being discharged onto a virtual ward and require 28-days' supply of all medications. They should

then continue the discharge process as normal, ensuring the discharge letter has been completed.

The patients we can support:

- Patients receiving IVABS up to QDS.
- Patients that require digital monitoring / repeat bloods
- Monitoring output from in dwelling drains
- Nebulisers / Peak flow / Spirometry readings / O2 Therapy

Referral:

Call the Virtual Wards team:
Ext: 734455 Tel: 0300 131 4455

Service hours
8am to 10pm – 7 days a week **(no referrals after 4pm)**

Joint Community Rehab (JCR)

The Joint Community Rehabilitation and Falls Service (JCR) is a joint East Sussex Healthcare Trust and Adult Social Care service which can provide both reablement short term care packages and/or rehabilitation in a person's own residence or community settings.

Our aims are to promote rehabilitation through activity, exercise and equipment and to prevent unnecessary hospital admission. The staff within the JCR Service are multi-disciplinary and aim to provide a person-centered approach, working with both other services and organisations.

The JCR service covers Hastings and Rother, Eastbourne, Hailsham and Seaford and the High Weald, Lewes and Havens areas.

The service works mostly with clients within their own homes.

Referral criteria

We accept referrals from both our Health and Social care colleagues in other services, most commonly via Health and Social Care Connect (HSCC), for people who have experienced a decline in their function and independence.

How to refer

Direct client referrals via Health and Social Care Connect or
email: HSCC@eastsussex.gov.uk

Adult Social Care – Homecare

East Sussex County Council employees who are based in the Acute Hospitals (EDGH and Conquest Hospital) and work as part of a Multi-Disciplinary Team to support patients who are ready for discharge, this includes some P0 patients, but mainly P1 and P3.

Adult Social Care, will:

- Undertake a statutory assessment for a person who has an appearance of need.
- We assess needs and the mental capacity of patients for a specific decision who have been referred to us by ward staff or the discharge hub.
- We have a legal duty to safeguard adults at risk of harm and/or abuse and arrange a plan to safeguard the adult at risk and other adults.
- We arrange services (homecare, telecare, care homes, direct payment) for people open to us.
- We work with all partners to achieve a person's desired outcomes as part of discharge planning and facilitation.

ESCC ASC Offer for Acute Inpatients

- We have teams present on site across 7 days a week to undertake assessment activity for inpatients.
- We assess the following cohort of patients:
    - Patients who are ASC funded and have been admitted from a Nursing / Residential Home and require resettlement to another perm care home because of change of need.
    - Patients who would be eligible for a 12-week property disregard subject to a means tested financial assessments and arrange a perm placement.
    - Patients who are returning home with a homecare package and not suitable for UCR or JCR due to their needs and/or circumstances e.g. self-neglecting, housing issues
    - Patients who have been identified for a placement but due to their complex needs require a specialist bespoke placement to meet their needs e.g. SPOT contract.
    - We prescribe telecare for P0 and P1 patients.
    - Undertake carers assessments where appropriate.
- The Discharge Nurses who are part of the TOCH complete a Trusted Nursing Assessment for patients who have been identified for a placement, the discharge hub liaises directly with the D2A homes and arrange discharge, this process bypasses ASC Ops and Brokerage. ASC only become involved with D2A bedded patients if complexities arise as a result of discharge e.g. complex MCA and professional and family conflict around discharge destination.
- Provide information, advice and support for patients who are P0,1,2,3.

How to refer

Direct client referrals via Health and Social Care Connect or
Email: HSCC@eastsussex.gov.uk

Housing and Rough Sleepers

ESHT staff will establish whether a person may be homeless or threatened with homelessness when:

- a person attends A&E
- at any point during hospital admission whereby it is identified that a person has no accommodation or has accommodation, but it would not be suitable/reasonable for them to return to e.g. due to a medical condition or domestic abuse.

Once this has been identified, ESHT staff will complete the duty to refer form and send to the relevant housing authority duty to refer inbox. The form should include the reason for admission and brief background/diagnosis, including formulation of risk.

ESHT staff will inform housing staff of known risks to service providers and the public. This information will be included in the formulation of risk.

The duty to refer information will be completed and sent through to the housing team at the earliest opportunity – this can be done either by the ward or area the patient is in, or the TOCH.

In instances when the person is ready for discharge with no significant medical issues it may be appropriate for ESHT staff to advise the person to call the housing teams themselves to book an emergency appointment. The ESHT staff will follow up with a duty to refer email with information on the person's reason for admission and medical information.

Rough sleepers

In addition to following the duty to refer process, where it is identified that a person is, or may be, a rough sleeper ESHT staff will also contact the Rough Sleepers Initiative (RSI). ESHT staff will ensure the RSI nurse is involved in all aspects of patient management. The RSI nurse will ensure relevant RSI specialists such as Change Grow Live (CGL), Adult Social Care and Mental Health are involved as appropriate. This will include notification of admission and discharge planning.

Personal Health Grants

Personal Health Grants (PHGs) (Single Payment Discharge Grants) are one-off payments in the form of grants for patients/families/carers, aimed at removing some of the practical barriers that delay discharge by funding solutions that remove them. They are not intended to fund direct care as this would be a duplication of existing services.

Scope

- The grants are open to East Sussex Residents.
- PHG funding per patient is up to £1000 (amounts over £1,000 will be considered as exceptions with the named Identified ICB -Place based point of contact.
- Facilitate discharges sooner from Acute and Community settings; these include Pathway. 1- HomeFirst and facilitates discharges sooner from community bedded units and overall, helping patients to maintain independence at home and overall, supporting flow within the wider system.
- Preventing failed discharge that could result in extended length of stay in Acute or Community settings.
- Referral by health / social care professional (i.e. community nurse, OT, paramedic), social work teams, carers, families, the patient, and voluntary sector will be considered.
- Approval is determined on a case-by-case basis and aligned to the core principles. Should a person have multiple admissions to hospital, each referral will be reviewed/approved on a case-by-case basis.
- Teams are encouraged to be creative to support informal care and one-off solutions that will support individuals and meet their needs; however, it is able to support discharge sooner by at least 2 acute bed days.
- Although the offer does not fund formal domiciliary care provision it can provide funding for associated tasks.
- Ensure that the grant supports spend that is sustainable, or with an onwards plan to support independence once a patient has been discharged.
- They should also not be used as a default – if the patient or friends/carers have access to resources these should NOT replace anything they were already planning to undertake/purchase.

Referral process

- Identify eligible patient:
    - Patients identified as being on discharge pathways 0,1,2 or 3 where appropriate.
    - Patients identified within an acute, community or home setting.
    - No formal care required.
    - Unable to facilitate discharge for practical reasons/barriers.
    - Lack of funding prevents resolution of problem.
- Complete all fields in the referral form.
- Referrer to email completed referral form within 2 hours of receipt to the ICB Lead at: sxicb.ccgphg@nhs.net
- ICB lead will liaise with the Referrer within 2 hours of receipt of referral on a working day and by 11am on a Monday for weekend requests.
- Notification of ICB decision outcome within 4 hours of receipt of referral
- Approved referrals emailed to providers within 2 hours of receipt of approval ICB lead to liaise with referrer and provider.
- Referrer to confirm the date referred patient discharged to the ICB Lead

Appendix C: Pathway Two Discharges

Pathway 2
Discharge coordinated through the care transfer hub to a community bedded setting with dedicated health and/or social care and support, including bed-based intermediate care on a time-limited, short-term basis for rehabilitation, reablement and recovery in a community bedded setting (bed in care home, community hospital or other bed-based rehabilitation facility).

ESHT Intermediate Care Beds

Intermediate Care is focussed on rehab, that is provided in a community hospital. Sometimes community hospitals are known as Inpatient Rehab Units.

The rehab journey will involve the support of a team of health professionals known as a Multidisciplinary Team (MDT).

An MDT may include Doctors, Nurses, Occupational Therapists (OTs), Physiotherapists (PTs), Speech and Language Therapists (SLTs), Dieticians, Rehab Support Workers (RSWs), Healthcare Assistants (HCAs) and colleagues working in Adult Social Care.

The patient must be aware of an agreement for a referral and be made aware that they are agreeing to a service in any one of the six rehab units listed below.

East Sussex HealthCare NHS Trust:

- **Bexhill Irvine Unit, Holliers Hill Bexhill-On-Sea, TN402DZ**
- **Rye Memorial Hospital, Peasmarsh Road, Rye, TN317UD**

Sussex Community Foundation NHS Trust:

- **Crowborough War Memorial Hospital Southview Rd, Crowborough, TN61HB**
- **Lewes Victoria Hospital Neville Rd, Lewes, BN71PE**
- **Uckfield Community Hospital Framfield Rd, Uckfield, TN225AW**

East Sussex County Council:

- **Milton Grange (Eastbourne) Milton Rd, Eastbourne, BN211SL**

We aim to provide inpatient rehab close to the patient's home, but this is not always possible due to the high demand for rehab beds.

The most important outcome is that the patient receives rehab as quickly as possible to progress your ability to prevent deconditioning.

Referral process

- The integrated discharge team attend the Board Rounds on the acute hospital wards. If a patient is identified as having rehabilitation goals, a referral is made from E-Searcher to HSCC, these referrals are then screened by the team in Intermediate Care and once accepted will go onto the waiting list. Our Therapy Pathway Co-ordinators will then liaise with the ward and teams once the bed is available and an agreed transfer date.
- Patients can also be referred from other hospitals, again a referral to HSCC is required and acceptance onto the transfer list.

Discharge to Assess Beds (D2A)

- Introduced as best practice in 2016 by NHS England, the discharge to assess (or D2A) model involved providing short-term care, rehabilitation and reablement, where needed, and then assessing people's longer-term needs for care and support once they've reached a point of optimal recovery.

- This pathway of patient discharge should be used for patients who have been admitted to hospital and had a significant life changing event meaning that they cannot return to their existing home and will require either a care or nursing home placement.

- All other options will need to be considered before the patient is allocated to this pathway**.**

- This pathway will be managed by the TOCH where a decision will be made if this is the correct pathway, a Trusted Nurse Assessor document will be completed by a TOCH Integrated Discharge Sister/Charge Nurse and submitted to an appropriate D2A bed. The home will review the paper and make the TOCH know if they are able to manage the patients needs. This process can happen 3 times, before we have exhausted the D2A bed option, and move to a spot purchase request.

Appendix D: Pathway Three Discharges

Pathway 3

In rare circumstances, for those with the highest level of complex needs, discharge to a care home placement co-ordinated through the care transfer hub, including:

- care home placement for assessment of long-term or ongoing needs and facilitation of patient choice in relation to the permanent placement
- long-term care and support in a care home following a period of intermediate care in the community.

Spot Purchase Beds

- When a patient has been referred to a D2A bed and has been declined by 3 homes due to their care needs are too high for those homes, then a spot purchase request will be made to NHS Sussex.

- Once agreed, the Adult Social Care Brokerage Team will source a placement which will be able to manage the care needs of the patient.

- This process will be overseen by the TOCH and the TOCH will feed back to the relevant ward and keep Nervecentre up to date.

Appendix E: Equality and Human Rights Statement
Equality and Health Inequalities Impact Assessment (EHIA) template

Undertaking EHIA helps us to make sure that our services and polices do not inadvertently benefit some groups more than others, ensuring that we meet everyone's needs, and our legal and professional duties.

This is important because:

- Assessing the potential for services and policies to impact differently on some groups compared with others is a legal requirement.
- People who find it harder to access healthcare services are more likely to present later when their disease may be more progressed, have poorer outcomes from treatment, and need more services than other groups who have better access.

The Equality Act 2010 legally protects people from discrimination in the workplace and in wider society. It is against the law to discriminate against anyone because of:

- age
- gender reassignment
- being married or in a civil partnership
- being pregnant or on maternity leave
- disability
- race including colour, nationality, ethnic or national origin
- religion or belief
- sex
- sexual orientation.

These are called 'protected characteristics'. The Act requires that public sector organisations meet specific equality duties in respect of these protected characteristics. This is known as the public sector equality duty.

Public Sector Equality Duty
Public bodies have to consider all individuals when carrying out their day-to-day work – in shaping policy, in delivering services and in relation to their own employees.

Public bodies must have due regard to the need to:

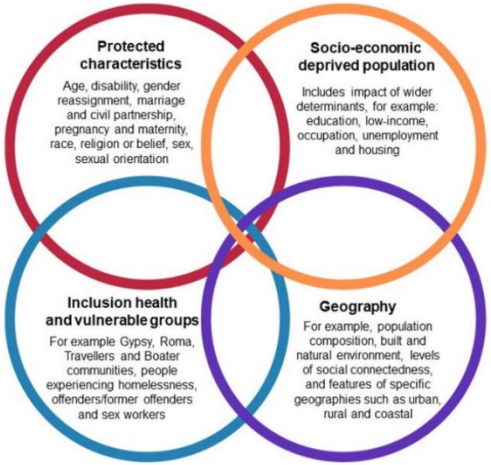
- eliminate discrimination
- advance equality of opportunity
- foster good relations.

Armed Forces Covenant Duty
The new Covenant Duty raises awareness of how Service life can impact on the Armed Forces community, and how disadvantages can arise due to Service when members of that community seek to access key local services. The Duty requires organisations to pay due regard to the Covenant principles when exercising functions in healthcare. "Due regard" means that we need to consciously consider the unique obligations and sacrifices made by the Armed Forces; that it is desirable to remove disadvantages faced by the Armed Forces community; and that special provision may be justified in some circumstances.

Health Inequalities Duties- Equity for all
In addition to our legal duties in relation to Protected Characteristics, the Health and Social Care Act and other legislation, NHS Planning Guidance and sector specific recommendations require the NHS to have regard to the need to address health inequalities (or differences in access to or outcomes from healthcare) and take specific action to address them.

Figure 1 shows the different population groups, factors associated with where we live, or our individual circumstances, which separately, or when combined, influence access to and outcomes from health care.

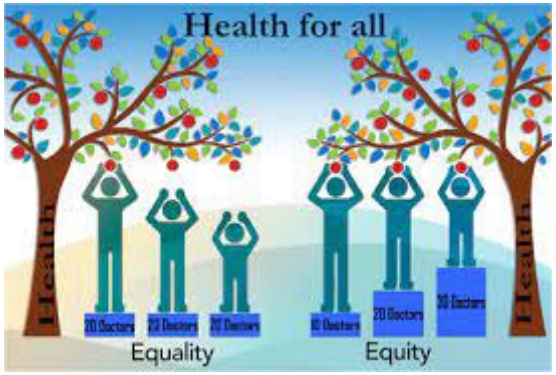
Getting equal outcomes may require different inputs (or services). In completing an EHIA its important to think about whether a one size fits all approach will generate the same good outcomes for everyone, or whether we might need to make some tweaks or adjustments to enable everyone to benefit equally. The health tree diagram shows that unless we think about the needs of different people, equal services might generate unequal outcomes.



The Health Tree[1]

The following principles, drawn from case law, explain what we must do to fulfil our duties under the Equality Act:

- **Knowledge:** everyone working for the Trust must be aware of our equality duties and apply them appropriately in their work.
- **Timeliness:** the duty applies at the time of considering policy options and/or before a final decision is taken – not afterwards.
- **Real Consideration:** the duty must be an integral and rigorous part of your decision-making and influence the process.



[1] https://www.researchgate.net/figure/Equality-and-equity-of-medical-resources-distribution_fig2_323266914

- **Sufficient Information:** you must assess what information you have and what is needed to give proper consideration.
- **No delegation:** the Trust is responsible for ensuring that any contracted services which provide services on our behalf can comply with the duty, are required in contracts to comply with it, and do comply in practice. It is a duty that cannot be delegated.
- **Review:** the equality duty is a continuing duty. It applies when a policy/process is developed/agreed, and when it is implemented/reviewed.
- **Proper Record Keeping:** to show that we have fulfilled our duties we must keep records of the process and the impacts identified.

NB: Filling out this EHIA in itself does not meet the requirements of the equality and health inequalities duties. All the requirements above must be fulfilled or the EHIA (and any decision based on it) may be open to challenge. Properly used, an EHIA can be a tool to help us comply with our equality and health inequalities duty and as a record that to demonstrate that we have done so. It is advised that you complete the short EHIA training session on MyLearn before completing this EHIA.

SECTION A ADMINISTRATIVE INFORMATION

This form is a central part of how the Trust makes sure and can demonstrate to others that we are meeting our legal duties; and how we can assure ourselves that all patients will get the best outcome for them from our services.

A completed copy of this form must be provided to the decision-makers in relation to your proposal. The decision-makers must consider the results of this assessment when they make their decision about your proposal. **Function/policy/service name and number:**	Hospital Discharge Policy.		
Main aims and intended outcomes of the function/policy/service and summary of the changes you are making (if existing policy/service):	To provide staff with information around roles and responsibilities and current discharge practice within the organisation to support safe discharge of patients out of the organisation.		
How will the function/policy/service change be put into practice?	Shared with Divisional Leadership and Governance teams and discussed at Safety huddles		
Who will be affected/benefit from the policy?	This policy will benefit patients and support patients around stages in the process and support staff in understanding.		
State type of policy/service	✓ Policy	Service ☐	
	Business Case ☐	Function ☐	Existing
Is an EHIA required? NB :Most policies/functions will require an EA with few exceptions	✓ Yes		

such as routine procedures	No ☐ (If no state reasons)
Accountable Director: (Job Title)	Vikki Carruth – Director of Nursing and Discharge SRO
Assessment Carried out by:	Name: Paul Relf
Contact Details:	Paul.relf@nhs.net
Date Completed:	09/02/2024

SECTION B ANALYSIS AND EVIDENCE

Analysis of the potential impact – Equality and Health Inequalities Duties
For this section you will need to think about all the different groups of people who are more likely to experience poorer access or have poorer outcomes from health and care services. For each group please describe in the first column the potential impact you have identified, in the second column explain how you have arrived at this conclusion and what information you used to identify the potential impact, and in the third column say what you are going to do to prevent it from happening, or which elements of a service or policy specifically address the potential impact. Key things to remember.

- Everyone has protected characteristics but some groups who share one or more protected characteristics may be more likely to have poorer outcomes or access compared with others – and it is this potential that the EHIA process seeks to identify and address.
- The information included here should be proportionate to the type and size of the policy/service/change.
- An update to a policy should demonstrate that you have considered the potential for the policy to impact differently on different groups and taken steps to address that.
- A minor policy update is likely to need to be much less comprehensive than an EHIA for a major service change.
- You will need to know information about who uses or could use your service/policy will apply to (the population). You can use information about current patients or staff, and about the general population the Trust serves.

3. PROTECTED CHARACTERISTICS - Main potential positive or negative impact of the proposal for protected characteristic groups summarised
Please write in the box below a brief summary of the main potential impact (positive or negative) Please state **N/A if your proposal will not impact adversely or positively on the protected characteristic groups listed below, but make sure you include information on how you know there will be no impact.**

This guidance provides a positive impact on supporting patients who are Medically Fit for Discharge regardless of protected characteristic groups.

Protected characteristic	Summary explanation of the *potential* verse impact of your proposal	How do you know this? (include here a brief f what information you have used to identify erse impact e.g. NICE guidance, local data, ews, stakeholder or patient feedback	Action that will be taken to address or negative impact.
Age: older people; middle years; early years; children and young people.	This policy protects patients from all age groups no matter what age they are as outlined in the Equality Act 2010	Acute care is provided in ESHT to all patients regardless of age. Some specific acute needs may need to be referred to other providers such as paediatrics who offer more specialized care.	No negative impact anticipated
Disability: physical, sensory and learning impairment; mental health condition; long-term conditions.	This policy has a positive impact on all patients that have a disability or long-term health condition.	This guidance supports those patients with both physical and mental health needs to access effective safe care	Monitored through weekly patient safety meeting and shared learning from patient safety incident framework
Gender Reassignment and/or people who identify as Transgender	This policy protects all patients regardless of gender	Acute care is provided in ESHT to all patients regardless of gender	No negative impact anticipated
Marriage & Civil Partnership: people married or in a civil partnership.	This policy does not have a negative impact on a patients marital or civil partnership status	Acute care is provided in ESHT to all patients regardless of marital or civil partnership status	No negative impact anticipated
Pregnancy and Maternity: before and after childbirth and who are breastfeeding.	This policy does not have a negative impact on patients who are pregnant/parent	Acute care is provided in ESHT to all patients regardless of whether they are a parent or pregnant	No negative impact anticipated
Race:	This policy has a positive impact for all patients regardless of their race or ethnicity	Acute care is provided in ESHT to all patients regardless of race	No negative impact anticipated
Religion and belief: people with different religions/faiths or beliefs, or none.	This policy has a positive impact for all patients regardless of their religion or belief	Acute care is provided in ESHT to all patients regardless of religion or belief	No negative impact anticipated

Protected characteristic	Summary explanation of the *potential* verse impact of your proposal	How do you know this? (include here a brief f what information you have used to identify rse impact e.g. NICE guidance, local data, ews, stakeholder or patient feedback	Action that will be taken to address or negative impact.
Sex:	This policy has a positive impact for all patients regardless of their sex	Acute care is provided in ESHT to all patients regardless of gender	No negative impact anticipated
Sexual orientation	This policy has a positive impact on patients no matter what their sexual orientation is	Acute care is provided in ESHT to all patients regardless of gender	No negative impact anticipated
Veterans/Armed Forces Communities	This policy ensures 'due regard' is considered for veterans and the armed forces community	Acute care is provided in ESHT to all patients regardless of gender	No negative impact anticipated

4. HEALTH INEQUALITIES -Potential positive or adverse impact for people who experience health inequalities summarised

Please briefly summarise the main potential impact (positive or negative) on people at particular risk of health inequalities (as listed below). **If the policy/procedure is unrelated to patients, this sections does not require completion.**

Please state none if you have assessed that there is not an impact, but please make sure you complete the 'how do you know this' column to demonstrate that you have considered the potential for impact**. If you identify the potential for impact for one or more of these groups please complete the full assessment in Appendix A**

Groups who face health	Summary explanation of the potential positive pact of your proposal	How do you know this? (include here a ion of what information you have used to tial adverse impact e.g. NICE guidance, idence reviews, stakeholder or patient	Action that will be taken to otential for negative impact.

Groups who face health	Summary explanation of the potential positive pact of your proposal	How do you know this? (include here a ion of what information you have used to tial adverse impact e.g. NICE guidance, idence reviews, stakeholder or patient	Action that will be taken to otential for negative impact.
This includes all groups of people who may have poorer access to or outcomes from healthcare services. It includes: People who have experienced the care system; carers; homeless people; people involved in the criminal justice system; people who experience substance misuse or addiction; people who experience income or other deprivation; people with poor health literacy; people living in rural areas with limited access to services; refugees or asylum seekers; people in or who have been in the armed force; other groups who you identify as potentially having poorer access and outcomes.	None	Acute care is provided in ESHT to all patients	No negative impact anticipated

SECTION C ENGAGEMENT

5. Engagement and consultation

a. Talking to patients, families and local communities can be a rich source of information to inform health care services. If you are making substantial changes it's likely that you'll have to undertake specific engagement with patients. For smaller changes and policies your may have undertaken some engagement with patient groups, gained insight from routine sources e.g. patient surveys, PALS or Complaints information or information from Healthwatch, you may also have looked at relevant engagement that others have undertaken in the Trust, or locally

Have any engagement or consultative activities been undertaken that considered how to address equalities issues or reduce health inequalities? Please place an x in the appropriate box below.

Yes	✓ **No**

b. If yes, please ensure all stakeholders are listed in the consultation table at the beginning of the policy.

SECTION D SUMMARY OF FINDINGS

Reflecting on all of the information included in your review-

6. EQUALITY DUTIES: Is your assessment that your proposal will support compliance with the Public Sector Equality Duty? Please **add an x** to the relevant box below.

	Tackling discrimination	Advancing equality of opportunity	Fostering good relations
The proposal will support?	x	x	x
The proposal may support?			
Uncertain whether the proposal will support?			

7. HEALTH INEQUALITIES: Is your assessment that your proposal will support reducing health inequalities faced by patients? Please add an x to the relevant box below.

	Reducing inequalities in access to health care	Reducing inequalities in health outcomes
The proposal will support?		*x*
The proposal may support?		
Uncertain if the proposal will support?		

8. Outstanding key issues/questions that may require further consultation, research or additional evidence. Please list your top 3 in order of priority or state N/A

Key issue or question to be answered		Type of consultation, research or other evidence that would address the issue and/or answer the question
1	N/A	
2		

3		

9. EHIA sign-off: (this section must be signed)

Person completing the EHIA:	**Paul Relf – Assistant Director of Discharge Transformation**	**Date:**
Line Manager of person completing:	**Vikki Carruth – Chief Nurse**	**Date:**

Appendix A

Breakdown of Groups who are more likely to experience health inequalities:

Groups who face health	Summary explanation of the tive or adverse impact of your	How do you know this? (include here ation of what information you have fy potential adverse impact e.g. NICE al data, evidence reviews, stakeholder dback	Action that will be taken to address the egative impact.
Looked after children and young people			
Carers of patients			
Homeless people. People on the street; staying temporarily with friends /family; in hostels or B&Bs.			
People involved in the criminal justice system: offenders in prison/on			

Groups who face health	Summary explanation of the tive or adverse impact of your	How do you know this? (include here ation of what information you have fy potential adverse impact e.g. NICE al data, evidence reviews, stakeholder dback	Action that will be taken to address the egative impact.
probation, ex-offenders.			
People with addictions and/or substance misuse issues			
People or families on a low income			
People with poor literacy or health Literacy: (e.g. poor understanding of health services poor language skills).			
People living in deprived areas			
People living in remote, rural and island locations			
Refugees, asylum seekers or those experiencing modern slavery			
People who have served in the Armed Forces			
Other groups experiencing health inequalities (please describe)			

Appendix B – EHIA Resources
Sources of Information on the East Sussex population and sources of community or patient insight.

Population Data
State of the County 2021 Focus on East Sussex

East Sussex JSNA

Community Insight

Further Reading on Equality and Health Inequalities

Training