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Cardiff and Vale University Health Board Hospital Discharge Policy (integrated with Cardiff and Vale Local Authorities)

Introduction

This policy outlines the procedures for the safe and effective discharge of patients from Cardiff and Vale University Health Board hospitals, in collaboration with Cardiff and Vale Local Authorities. It is based on the Welsh Government's Hospital Discharge Guidance (September 2024)

Objectives

- To inform all staff working in Cardiff and Vale University Health Board of the correct process to ensure timely and safe discharge of patients in adult in patient settings
- To ensure all staff are aware of their responsibilities regarding the discharge process
- To improve processes to reduce the length of time patients spend in hospital
- To improve outcomes for patients and carers and reduce the risk of avoidable harm

Scope

This policy applies to all staff involved in the discharge process, including hospital and community teams, Local Authority partners, housing teams, and other relevant partners.

This policy covers adult in patient areas only. Although the discharge principles align, this policy does not cover Mental Health Inpatients.

Equality and Health Impact Assessment	An Equality Health Impact Assessment (EHIA) has been completed and found there to be a positive impact
Documents to read alongside this Procedure (not exhaustive)	• Mental Capacity Act (2005) • Deprivation of Liberty Safeguards (2008) • Code of Practice for Mental Capacity Act and Deprivation of Liberty Safeguards. • All Wales Safeguarding Procedures for Children and Adults at risk of Abuse and Neglect (2020). • Cardiff and Vale UHB Information Governance Policy 2024 • The National Framework for Continuing NHS Healthcare (CHC) 2022 • Hospital Discharge Guidance (September 2024) • Reluctant Discharge Guidance (2023) • Social Services and Wellbeing Act Wales (2014) • Mental Health Act (2005)
To be read by	All staff engaged in discharging patients from an adult in-patient setting.
Approved by	Quality Committee

Accountable Executive or Clinical Board Director	Chief Operating Officer
Author(s)	Diane Walker- Head of Integrated Discharge Service (IDS) Frances Woodyatt – Senior Nurse IDS Kate Sharples – Training and Development Manager IDS

Disclaimer

If the review date of this document has passed please ensure that the version you are using is the most up to date either by contacting the document author or the Governance Directorate.

Version Number	Date of Review Approved	Date Published	Summary of Amendments
1			*new document*
2			Review of Document, update to include most recent legislation.
3	16.09.2025	19.09.2025	Review of 2020 policy, updated to include new guidance and discharge pathways.

Abbreviations	
D2RA	Discharge to Recover then Assess
PDD	Predicted Date of Discharge
MDT	Multi-disciplinary Team
LOS	Length of Stay
CHC	Continuing Health care
FNC	Funded Nursing Care
POCD	Pathways of Care Delays
IDS	Integrated Discharge Service
IDH	Integrated Discharge Hub
DSR	Discharge Support Referral
FPOC	First Point of Contact
CRT	Community Resource Team
VCRS	Vale Community Resource Service
CWS	Clinical Workstation
STAMP	System for Tracking and Monitoring Patients
IMCA	Independent Mental Capacity Advocate
IMHA	Independent Mental Health Advocate

1. Purpose

The purpose of this policy is to support the co-ordinated, safe and timely discharge or transfer of care for Cardiff and Vale University Health Board adult in-patients. This policy does not cover patients within the Mental Health Clinical Board.

This updated Discharge Policy embraces our integrated working relationships, to promote a whole system approach and reflects national policies and the principles identified in the Social Services and Well-being Act 2014 (Wales) which was implemented in April 2016.

Delaying hospital discharge is known to increase the risk of harm and lead to deconditioning which could lead to a need for higher levels of support on discharge.

Cardiff and Vale UHB employ the 'Home first' principles as everybody should be supported to recover in their own home or in a community setting at the earliest opportunity and in accordance with their identified individual needs. During a patient's stay in hospital, a proportionate assessment should be undertaken by a variety of professionals (health and social care). For most patients a comprehensive assessment of their care needs should be undertaken during the next stage of their care which should be out of hospital. This assessment must be undertaken in line with the requirements set out in legislation under the Social Services and Wellbeing Act 2014(Wales).

2. Principles

The following principles will support the delivery of effective discharge arrangements.

2.1 Communication between Multidisciplinary Teams

Communication between the patient, ward teams, family/carer and all agencies must be clear and timely. Early discussions to identify any complexities regarding discharge is vital to ensure the facilitation of an early discharge. Any decision regarding discharge will be clearly documented in a way that other agencies can access. This will primarily be in the patient's clinical notes.

Health and Social care partners need to be clear about their responsibility and accountability for the discharge process. When both have a responsibility for the discharge of a particular patient there will be early joint discussions.

We will work together with acute, community, social care, third sector and other partners to make best use of resources.

We will ensure that agreed processes are coordinated effectively so that all stakeholders are clear of appropriate actions and agreed routes of escalation.

2.2 Working to the Values and Behaviours of the Cardiff and Vale University Health Board

Assessment of health, care and support needs are determined by the most appropriate professional at the most appropriate time. Staff will be expected to always work with integrity to secure the best possible outcome for patients, their family/carer, taking full account of their 'protected characteristics' under the Equality Act (2010)

3.Welsh Government Guidelines to support discharge planning

As part of the 6 goals for urgent and emergency care the Welsh government have developed an optimising hospital flow tool kit for all Health board in Wales to use.

Reducing time in hospital - Home

This includes:

SAFER • **S**een – before midday • **A**im- what matters to me • **F**low – right bed right time • **E**arly discharge – discharge before midday • **R**ecovery – when can I go home	**Red 2 Green (R2G)** • For patients who are not yet clinically optimised • A patient who has had a day of value will be green • A day of waiting and no value will be red
Discharge to Recover and Assess (D2RA) • All patient assigned a D2RA pathway within 24 hours of admission • There are 4 pathways: 0 1 2 & 3 • All discharges follow a D2RA approach unless there is a clear rationale not to do so. • With a focus on the 'What matters to you?' conversation when planning discharge, we have the aim of understanding the person in the context of their own life and the things that are important to them. • People will only stay in hospital when there is a clinical need that can only be met in hospital and, at the earliest opportunity, the person should return home or to an appropriate community setting.	**Pathway of Care Delays (POCD)** • Patients who are still in hospital 48 hours after being clinically optimised are a POCD • Pathway of care delays are a performance indicator for the Health Board and Local Authority partners. They are measured and reported monthly using an agreed set of criteria. • The Integrated Discharge Service within Cardiff and Vale University Health board ensure that arrangements are in place for the census to be undertaken monthly and the outcome validated in collaboration with Local Authority (LA) partners.

4. Discharge planning process

4.1 Decision to Admit

No-one should be admitted to acute care, especially those who are frail, unless the only option for treatment is in an inpatient bed.

An assessment must be made when deciding to admit regarding the potential for clinically safe alternatives to admission.

Cardiff and Vale UHB provide Local Authority support within the Emergency Department including short stay assessment areas to support staff with community options as an alternative to admission if safe to do so.

The Emergency Department team can refer to the Safe @ Home (S@H) team if the assessment concludes that the patient can have their care provided by S@H rather than be admitted to hospital.

4.2 Discharge to Recover then Assess (D2RA)

All patients with a decision to admit should be assessed and allocated to one of 4 d2ra pathways within 24 hours of admission. The assessment needs to be done in collaboration with the patient/carer, so they are aware that we are considering discharge at the point of admission.

Allocation of a D2RA pathway will identify early in the patient's admission what levels of support they had prior to admission and a provisional assessment at what support will be needed at the point of discharge to meet their needs (not their wants).

Under the discharge to recover then assess model of hospital discharge, most people are expected to go home (their usual place of residence) following discharge.

There are 4 D2RA pathways	
Pathway 0	Classified as a simple discharge where the patient has no or no new care needs.
Pathway 1	A supported discharge pathway where a patient with new care needs is supported to recover and then be assessed at home.
Pathway 2	A supported pathway of bed-based rehabilitation or reablement for patients who are not safe in between care calls or overnight. Cardiff and Vale UHB do not have pathway 2 beds for patients to be discharged. They will be transferred to a rehab bed and then when discharged they need to be on a pathway 0, 1 or 3 – not 2

Pathway 3	A supported discharge pathway where assessment for a long term care needs is completed in a bed-based environment; for patients who have significant or complex needs and are not safe in between care calls or overnight.

4.3 Clinically Optimised

A patient is deemed clinically optimised when the Multi-disciplinary Team agree that the patients care and / or assessment could be continued at home. The patient no longer needs any care or support that can only be delivered in a hospital setting. Tests/ investigations that are not discharge dependant should be arranged and carried out in the community.

4.4 Board Rounds

All patients should be discussed during a daily board round which is a summary discussion of the patient's journey. It identifies what actions are required to support the patients' progress. It also helps to identify and resolve any delays in the patients' hospital stay to aid efficient discharge, and this in turn enhances the overall patient experience. The Board Round is not an in-depth MDT discussion of each patient. The board round must be led by the ward consultant or ward sister/charge nurse and the outcomes/actions from the board round must be recorded onto CWS and STAMP and reviewed.

4.5 Predicted Date of Discharge

A PDD should be set within 24hr of admission and should be reviewed at the daily board round.

This is the date when it is expected that the patient will be able to leave a hospital setting, it should be clearly communicated with patient, family/carer. This will be documented on the patients 'When can I go home' leaflet. When can I go home?

PDDs in community hospitals should be set within 24hrs and based on a realistic time-frame.

Discharge hub/community partners may on occasion amend this date if they have further intelligence regarding care availability, and this is permissible. This change must be communicated to the patient/carer

4.6 Discharge Support Referral (DSR)

If it has been identified that the patient requires formal support on discharge, then a Discharge Support Referral form needs to be completed. This form is available on Clinical Workstation and electronically sent to the Integrated Discharge Hub (IDH) for Cardiff residents and C1V Hub for Vale residents. This is a **single point of access** process for discharge support.

Clinical Teams do not need to identify the support that is required on discharge, this is the responsibility of IDH/C1V.

Discharge outcomes from DSR will include-

- Information, assistance, advice
- Restart/Increase packages of care
- Discharge with CRT/VCRS (Therapies only or Full Team (therapies and domiciliary care))
- Discharge with D2RA (Cardiff Domiciliary Care support)
- Social Work assessment for complex discharge planning this may include requests for a Discharge 2 Assess (D2A) care home bed. (interim placement to facilitate a complex discharge)
- Housing input from social services
- Discharge Liaison Nurse /CHC review to be arranged.
- First Point of Contact (pink army) Hospital Team

4.7 Transfer to Non-Acute Beds

During the board round, it may be decided that the patient has recovered sufficiently and no longer needs an acute bed but is still requiring support and treatment, e.g. rehabilitation that can only be delivered in hospital. On these occasions the patient will be transferred to a non-acute bed within the UHB. Patients should be assigned the amber flag on CWS/STAMP and assigned a D2RA pathway 2.

Clinical ward staff are responsible for referring appropriate patients via the electronic referral form accessible via the IDS SharePoint page. The referral is transferred to a TEAMs list which is accessed by the ward sister or deputy who has designated responsibility to 'pull' to their vacant rehab bed.

The same process is in place for patients who are clinically optimised but require complex discharge planning. These patients will be identified as D2RA pathway 3 and will have a green flag on clinical workstation.

4.8 Discharge Lounge

All patients need to be transported to discharge lounge before 10am on the day of discharge, in some cases it may be necessary to be transferred to discharge lounge the evening before discharge. Patients and families must be made aware if this occurs.

There are very limited exceptions for transfer to discharge lounge these include (but are not limited to) Fast Track palliative patients and IPC patients – please contact OPAT/Site team directly for individual discussion if unsure.

4.9 Transport

Wherever possible the patient should be transported home by family/carer, using their own transport.

If own transport is not available, the following can be considered:

- Non-Emergency Patient Transport Services (NEPTS)
- Welsh Ambulance Service Trust (WAST)
- Voluntary sector resources

- Taxi (preferably funded by the patient)
- If Out of Area transport is needed, this needs to be booked with a minimum of 48hrs notice.

Decisions regarding appropriate transport will be made by the ambulance booking system.

Transport bookings should be made the day before discharge. Exceptions are made for acute assessment/short stay wards/units, where there is a need for some same day discharges.

The date and confirmation of transport must be recorded in the patient medical notes.

5. Documentation

Good standards of record keeping at every stage of the discharge process is an essential requirement and will ensure that there is continuity in the discharge process reducing miscommunication and delays. Any member of staff must document if they have had any discussion regarding the patient's discharge.

Contemporaneous record keeping (via patient notes/ Clinical Workstation, Welsh Nursing Care record), Local Authority case management systems, whether at an individual, team or organisational level in relation to discharge planning from hospital care must:

- Demonstrate how decisions related to the discharge process were made and why.
- Document the discharge pathway and update when/if it changes.
- Include copies of any documents relating to Lasting Power of Attorney, Deputyship or any advanced decisions.

6. Information sharing with patient, family/carer and Advocacy

As part of the delivery of high-quality person-centred care the patient will be involved throughout with their discharge plan. At times, family members/carers will also need to be involved.

A 'when can I go home?' leaflet must be given and discussed with the patient and or family/carers on admission to ward. This will include a predicted date of discharge (PDD). The leaflet can be accessed here,

The cultural and communication needs of the individual, family/carer must be always considered.

Every effort must be made to communicate in a manner appropriate to the individual, both verbally and in writing to meet specific communication needs (e.g. if they have a sensory loss) and language needs (e.g. if they wish to communicate in Welsh or any other language).

The All-Wales Standards for Accessible Communication for People with Sensory Loss and the Cardiff and Vale UHB Interpretation and Translation Services policy University Health Board Policy on Accessing an Interpreter will be used if appropriate.

Translation & Interpretation Services - Home

Advocacy support should be considered for all individuals who might benefit from such services at any stage of their discharge planning process.

6.1 Carers information

Cardiff and Vale UHB pride itself in supporting carers and identifying unpaid carers.

People may not see themselves as carers, rather seeing caring as an extension of their familial role, good neighbour or friend.

The patient should be asked who they wish to be involved and/or informed in discussions and decisions about their discharge, and appropriate consent received. This may include a person's family members, friends or neighbours.

It is only through meaningful involvement and consultation with unpaid carers that staff will be able to arrive at an accurate and honest appraisal of what the carer is willing and able to provide after discharge

All plans that involve the unpaid carer's provision of care, need to be coproduced between the patient/individual, clinicians and the carer. An unpaid carer must be willing and able to provide care. For further information or support for unpaid carers please refer to the patient experience team (see SharePoint page)

Patient Experience - Home

For carers of people at the end of their life Future Care Plan should be jointly discussed and agreed. Further information can be accessed here.

6.2 Young Carers

Young Carers are children under the age of 18 years old, with caring responsibilities. They will be assessed under the Social Services and Well-being Wales Act.

Assessment is the first stage in helping a child and their family. There must be considerations applied to the needs of the children.

Refusal of an assessment must be overridden, where there is a refusal, this would be inconsistent with a child's well-being and referral to the local safeguarding team. Any safeguarding concerns identified must be raised in line with the All-Wales Safeguarding Procedures for Children and Adults at risk of Abuse and Neglect (2020).

Safeguarding Wales

6.3 **Supporting Carers**

Carers have a right to a Carers Assessment, which considers the needs of a carer, alongside the needs of the person they care for this is **not** discharge dependant and will be carried out in the community once the ward has made a referral for the assessment to be carried out by the Local Authority /Health Board.

Consent should be achieved to make a referral for a carer's assessment.

7. Mental Capacity

The Mental Capacity Act 2005 (MCA) was introduced in 2007, to provide a statutory framework to empower and protect vulnerable people over the age of 16. It enables people to plan for a possible loss of capacity and provides a legal framework for making decisions on behalf of those who are unable to make at least some decisions for themselves. It has two overarching aims:

- To promote autonomy of decision making for all
- To protect vulnerable adults from harm.

The Act was amended in 2009 to provide safeguards for people who need to be cared for or treated under significant restrictions (the Deprivation of Liberty Safeguards). The Act reflects the development of case law relating to mental capacity and the European Convention on Human Rights (ECHR).

Mental Capacity is the ability of an individual to make decisions about specific issues in their life. It is also sometimes referred to as 'competence'. Capacity is not an absolute concept: the level of understanding required will increase with the complexity of the decision and capacity can vary over time. The Cardiff and Vale Mental Capacity Act (MCA) policy sets out what evidence is required when assessing an individual's mental capacity ensuring healthcare staff are protected from liability when acting in a persons' best interests without their consent.

See guidance on MCA SharePoint page Mental Capacity Act Team

8. Lasting Power of Attorney

Adults over the age of 18 years can authorise another adult over the age of 18 years to make decisions on their behalf in the event of a loss of capacity. Lasting Powers of Attorney (LPA) can be made for property and finances and / or for health and welfare matters.

Once the LPA has been registered with the Office of the Public Guardian (OPG) the appointed attorney will have authority to make certain decisions on behalf of the donor, if the donor lacks capacity to make the decision.

The LPA document will specify what powers the attorney holds and any exceptions. If the attorney is asked to make any decisions about life sustaining treatment the LPA document must specify that they have this power, it is not automatically granted.

Professionals must ask to see evidence of any LPA, to check that the power has been registered and that the relevant decision falls within the scope of the power. A copy of the LPA should be taken and maintained in the medical record. The attorney must act in the donor's best interests in line with person's known wishes and feelings and if professionals have

concerns about an attorney's actions, the matter must be referred to the Office of the Public Guardian.

LPAs registered on or after 1st January 2016 in England and Wales can be accessed online with an access code provided by the LPA.

LPAs must formally request access to the person's notes via information governance.

For further guidance please see the UHB's Information Governance Policy

It is important to note that the LPA powers are only enacted if the individual has been deemed to lack capacity to make that specific decision. A person with fluctuating capacity should always been given the opportunity to make decisions for themselves when able to do so, this may include giving the person multiple opportunities to consider such a decision.

9. Deprivation of Liberty

Section 6 of the Mental Capacity Act permits restriction of movement that does not amount to a deprivation of liberty. Restrictions amounting to a deprivation of liberty requires a formal legal authorisation process under either, the Mental Health Act, MCA Deprivation of liberty safeguards or a court order.

This only applies to people over 18 who are in a hospital or living in a registered care home. If the inpatient is 16 -17 years old or resident in any other setting but you believe that they are being deprived of their liberty seek legal advice.

A restriction of movement (restraint) will become a deprivation of liberty when the restraint results in the person being under 'continuous supervision and control and not free to leave'.

See guidance on DoLS SharePoint page: Deprivation of Liberty Safeguards (DoLS) - Home (sharepoint.com)

10. Self-funding and full cost contribution for care home placements

Self-funding describes a private arrangement i.e. a situation where a person and or their family/representative arranges their own care and support without the involvement of social care services or consideration of eligibility (no assessment or care plan is required; LA is not the placing authority does not source the care does not hold the contract and are not required to review etc). Prior to agreeing the placement care homes and families should ensure that self-funders have adequate funds to support them for the entirety of their stay.

Full cost contribution describes arrangement via statutory services i.e. a situation where following an assessment and identification of eligible need and subsequent financial assessment the Local Authority supports a person to secure care home services and the person due to their level of finances / assets is then charged for the full cost of the care home placement (LA is the placing authority and remain responsible for overseeing contract and reviewing care arrangements)

Finances form part of regular review and once money/assets drop below the threshold the contribution level is reassessed.

Patients who are self-funding are always able to request an assessment at any point, and if eligible, to have their care managed by the LA under full cost recovery, but they may not be able remain in a high cost placement if they have chosen one that is significantly above the usual rate paid by the LA/UHB if they do not have sufficient funds to pay the additional cost known as a “top up” fee, or additional cost contribution. LA duty to meet needs is only triggered once the assessment of eligible need is concluded. The LA will not backdate payments for people who made a choice to self-fund or if their money has dropped below thresholds.

11 Choice of Accommodation following hospital stay

Where a person is clinically optimised and ready to be discharged, they cannot remain in hospital if the care home that they have expressed a wish to move to does not have an immediate vacancy or meet their current care needs. In these instances, the IDS team or the Social worker will support the patient to move to a care home on an interim basis while waiting for their choice of accommodation.

The arrangements and legal requirements around choice of care home accommodation, involving the person and their carer, must be applied where a person is being discharged from hospital to a care home on a permanent or temporary basis (more than eight weeks but usually fewer than 52 weeks as set out in legislation).

Choice does not apply where a care home stay is for a short term (fewer than eight weeks).

12. Continuing NHS Healthcare (CHC)

Continuing Health Care is decided on a patient’s needs basis and not preference/ availability. The Guidance can be found here: National framework for Continuing NHS Healthcare National framework for Continuing NHS Healthcare | GOV.WALES

13. The Fast Track Process

It will be necessary to safeguard an individual’s well-being by “Fast Tracking” them for immediate provision of CHC. An example of this may be the individuals who are rapidly deteriorating or entering the end of their life. In such circumstances, people can be supported in their preferred place of care without waiting for a full CHC eligibility process to be completed.

For patients identified as being in the last days or weeks of their life, Community Nursing teams and specialist community Palliative Care teams, will work with the Integrated Discharge Teams, to co-ordinate and facilitate a rapid discharge to home, care home or hospice (based upon ‘preferred place of death’) via the CHC fast-track end of life process.

For patients who meet the criteria, the ward nursing team, supported by the DLN will complete the referral and appropriate paperwork. The Fast Track process will be co-ordinated by Palliative Care Team.

For patients who do not meet Fast Track criteria but are identified as entering into the end stage of their prognosis and a Pathway 3, a DSR should be completed for support on discharge.

All staff involved in the Fast Track process must read the National Framework for Continuing Healthcare guidance carefully and have a clear understanding of the requirements for this process including the need for the Fast Track Care Plan.

14. Reluctant Discharge

A reluctant discharge is when a person who has been assessed as no longer needing care or treatment in hospitals refuses to engage in the discharge process or actively refuses to leave hospital.

Patients are accommodated in a hospital bed as a licensee. The Health Board as the owner of the hospital grants a patient a license to be on its premises. This license exists for such time until the Health Board deems it appropriate for the license to be revoked, i.e. when the patient is clinically optimised. A person does not have an enforceable legal right to occupy a hospital bed indefinitely and the Health Board is under no legal duty to accommodate them when other safe alternatives for discharge have been identified.

Please contact the IDS team as soon as you are aware you have a patient who may fall under this category for advice and guidance.

Supporting documentation: Reluctant discharge process – Reducing time in hospital - Home

15. No Suitable Abode / Homelessness

Discharge from hospital can exacerbate vulnerability and frailty for those who are homeless, at risk of homelessness or those for whom a hospital admission increases the likelihood of them becoming homeless (due to current accommodation no longer being suitable for example).

People at risk of homelessness use more acute hospital services and emergency care than the general population. When admitted to a hospital, the length of stay is usually much longer because of multiple unmet needs. However clinically optimised patients regardless of accommodation needs do not have the right to remain in a hospital bed and appropriate and timely support should be offered and those with unsuitable housing must return home if it is reasonably practicable to do so.

Supporting documents: Unsuitable Housing/Homelessness Process Homeless Support (CAVHIS)

16. Discharge Against Clinical Advice (DACA)

For individuals discharging against professional advice the Cardiff and Vale University Health Boards Discharge against Clinical Advice Policy should be followed.

In summary the professional involved must take every reasonable step to ensure that any ongoing health care needs are met and the following actions considered to mitigate the risk of an unsafe discharge:

- Establish the reason for this intention
- Attempt to resolve any issues
- Advise the patient of the consequences of leaving

- Encourage the patient to see a doctor
- Assess the risks to the person and/or others and take any necessary action;
- Document a full account of the events and the relevant discharge plan, together with the patient's responses
- Encourage the patient to sign a "discharge against clinical advice form"
- Liaise with management/site team OOH
- Inform the patient's GP, Community Nurse and other relevant community services by telephone.
- If the patient is unable to arrange suitable transport, the ward should arrange transport as required.
- Following discharge, the ward should make a welfare check telephone call, to ensure the patient has arrived home safely.
- Complete the Datix incident reporting system.

Where there are reasons to doubt a patient's capacity to make a decision about discharge against medical advice a formal assessment of capacity must be considered in accordance with the Mental Capacity Act.

Discharge against clinical advice may be viewed as an "unwise decision" but this does not necessarily mean that the patient lacks capacity to make it. As well as a concern about the decisions being made, there must be some evidence of impaired or disturbed functioning of the mind or brain (e.g. stroke, dementia, mental illness, delirium, intoxication, etc.) before a functional assessment of the patient's capacity can be undertaken.

If the patient is found to lack capacity to make a decision about their discharge, the decision will need to be made following the best interest's process. If it is concluded that the patient is unable to give valid consent to remaining in hospital an application for authorisation under the Deprivation of Liberty Safeguards must be made.

17. Discharge Concerns

If a concern is raised by a patient and/or family/carer or advocate in any stage of the discharge planning process, ward staff initially need to ensure that all practical steps are taken to communicate to patients and families to address any concerns raised.

If these are not able to be resolved at ward level please seek senior support, if still unable to resolve this should be dealt with using the appropriate guidance which includes 'Putting Things Right' – Raising a concern about the NHS (2011) and the relevant local authority process. If concern remains unresolved refer the complainant to the Concerns Team.

If there is a concern regarding an unsafe discharge an incident form via Datix Cymru should be submitted.

18. Safeguarding

Some individuals may require additional support when planning their ongoing care arrangements and may include; individuals with a learning disability, people who are homeless, those who have a physical or sensory disability, people who have a mental illness, including dementia, and elderly patients with frailty.

There should also be due consideration of those adults and children who have existing safeguarding plans in place. Any safeguarding concerns identified must be raised in line with the All Wales Safeguarding Procedures for Children and Adults at risk of Abuse and Neglect (2020). Safeguarding Wales

Where there are concerns that an individual may be an 'Adult at Risk' the assessing professional must follow local safeguarding procedures.

Where safeguarding investigations are already underway, professionals involved in the patient's care must ensure that the Safeguarding lead officer is kept informed of any discharge plans. The multi-disciplinary team should work with safeguarding colleagues to ensure that a robust plan is in place to manage the risk of further abuse or neglect on discharge.

Where it is not possible to discharge a patient to their home whilst investigations are being carried out, this does not mean that they have to remain in an acute setting, if their health needs do not require it. The multi-disciplinary team should consider alternatives such as a transfer to a non-acute site, stepdown accommodation or a temporary placement until the safeguarding process is resolved.

19. Mental Health (This Policy does not apply to specialist in-patient mental health units).

Individuals who are detained under the relevant sections of the Mental Health Act 1983 and its amendments can only be discharged in accordance with the statutory requirements.

The requirements of Section 117 of the Mental Health Act and good discharge planning need to be discussed with the patients Mental Health Practitioner.

Where it is considered appropriate, an IMCA / or IMHA must be appointed. It is essential that the individual wishes are expressed through an advocate, this will lead to greater participation and understanding of the discharge plan.

For people with new mental health concerns, psychiatric liaison teams should be contacted in the first instance to review and assess as appropriate.

For people with a pre-existing mental health concern who are known to mental health services, their care coordinator or relevant mental health clinician should be involved in their discharge planning to ensure their mental health needs are considered as part of the discharge process.

20. Out of Area Discharges

The Integrated Discharge Hub/ C1V does not process referrals to other Local Authority areas.

Ward staff will be required to contact the responsible Local Authority directly if support on discharge is required.

If there is a doubt around the responsible Local Authority, please contact Integrated Discharge Service for advice and support.

21. Infection Control

The management and treatment of individuals with a known or suspected infection is described in detail in the Health Board Infection Control and Prevention Policy. It is important to ensure that the relevant agencies (community nurses / ambulance service / care home, Domiciliary Care providers) involved in the individual's discharge are in informed of the individual's infection status, prior to their discharge so that appropriate arrangements and risk assessments can be put in place.

22 Roles and Responsibilities

22.1 Cardiff and Vale University Health Board

The health board will ensure that the discharge process in place links with national guidance and standards. It will continue to review and refine the discharge processes and assure that local practices and enabling processes are fit for purpose and resources effectively deployed.

It will ensure operational, professional and clinical management and oversight to effectively collaborate and manage the discharge process.

The Chief Operating Officer will take the executive responsibility on behalf of the Health Board for the strategic vision, development and implementation of the Discharge Policy.

Clinical Board Triumvirates will support the Chief Operating Officer, to ensure that the policy is put into operational management across the organisation.

22.2 Local Authority Adult Social Services.

Local Authority Adult Social Services will undertake an assessment of need for individuals who may appear to be in need of care and support in line with Social Services Wellbeing Act (2014).

They will ensure that the National Hospital Discharge Guidance (2023) for Social Care Charging and Financial Assessment Arrangements are followed and appropriately communicated to patients, families and unpaid carers.

All interim placements will be closely reviewed in line with legislation in place under the Social Services and Well-being (Wales) Act 2014. An interim placement must not lead to a lower priority for a permanent placement than those in NHS beds, which may be perceived to be under greater pressure

22.3 Joint responsibilities of health and social services teams

Health and social services teams will ensure that discharge standards are adhered to at all levels and that delivery of discharge pathways observes national guidance and standards.

They will ensure that the national Hospital Discharge Guidance (2023) for Social Care Charging and Financial Assessment Arrangements are followed and appropriately communicated to patients, families and unpaid carers.

They will flexibly deploy staff across hospital and community settings to support patients on relevant discharge pathways where such input is identified and as required.

They will provide capacity to undertake an appropriate needs assessment should it appear that any involved carers have a need for support.

22.4 Ward MDT

The ward MDT will conduct a clinically led review of all patients at least once a day (for example a board round, see above).

The ward board rounds/huddles should have appropriate representation from the multi-disciplinary team to review patient progress towards being clinically optimised and the possible support needed to facilitate their discharge

This can include, but not be limited to:

- Consultant
- Resident doctors
- Nursing
- Therapist – physiotherapy/Occupational Therapy/Speech and language / Dieticians
- Pharmacists
- Social workers
- Operational Managers
- FPOC (First Point of Contact – Cardiff only)
- Integrated Discharge Service

22.5 Integrated Discharge Hub / C1V (Local Authority services)

The Integrated Discharge Hub/C1V will triage all DSR referrals for care and support / community services and discuss with wards if further clarity is needed once referral has been received.

They will provide advice and support to the ward teams on the appropriate D2RA Pathways.

They will act as a key problem-solving contact between hospital and community teams.

22.6 Integrated Discharge Service (IDS)

The Integrated Discharge Service, comprises of:

- Discharge Liaison Nurses
- Social workers
- Discharge Co-ordinators
- Discharge Support Officers
- Social work assistants
- Housing Solutions Officers
- First Point of Contact Officers
- Integrated Discharge Hub

The IDS will work with clinical teams to support discharge planning processes for people with ongoing health and social care needs.

The IDS Team will:

- Act as a resource to all members of the multi-disciplinary team, to provide expert discharge planning advice.
- Provide teaching and training, both formal and informal, at ward and departmental level to improve discharge planning.
- Provide expert advice and support for complex discharge pathways (all D2RA pathway 3 and in other pathways on referral)
- Act as the coordinator for complex pathway 3 patients who require a DST.
- Act in a supportive role to the nursing staff for DSTs and Nursing Needs Assessments.
- Ensure all patients identified as being in the last days or weeks of their life are rapidly transferred (via a fast-track pathway) to the care of an appropriate team who will be responsible for co-ordinating and facilitating rapid discharge to home (which may be a care home), community hospital or community Palliative Care Service.
- Liaise with community nursing and specialist palliative care teams to ensure arrangements are in place to provide advice, training and support to family/carers and care and support providers for End-of-Life Care.
- Ensure that guidance on Continuing NHS Healthcare is followed in line in the Continuing Healthcare Assessments and the National Framework.

22.7 Third Sector

The third sector has a valuable contribution to make in facilitating discharge, providing support to people as they recover from an illness or stay in hospital and to prevent readmission. The UHB and local authorities have several Service Level Agreements with third sector providers (further information can be found on DEWIS CYMRU) dewis.wales

These providers can specifically support hospital discharge.

A wide range of voluntary organisations and community groups provide services and activities which maintain people's independence, connect them to their communities to reduce isolation and loneliness and promote opportunities to improve health and wellbeing.

23. Discharge Training

It is essential that all those involved in the discharge planning process understand their roles and responsibilities regarding the discharge process and their role in reducing time spent in hospital and eradicating avoidable harm.

All staff with responsibility for hospital discharge are required to ensure they have received sufficient training and information to comply with this policy. Training is provided by the IDS team.

Supporting documents/information: Up to date training materials and training dates can be found on Cardiff and Vale Integrated Discharge Service Share point page - Integrated Discharge Service - Home.

24. Legislative and NHS Requirements

24.1 Freedom of Information Act

Policies and procedures are subject to disclosure under the Freedom of Information Act 2000. The Act allows anyone, anywhere to ask for information held by the Health Board and although some sensitive information will be exempt, policies and procedures will be released to the public on request.

24.2 Equality Impact Assessment

(EIA) The Equality Act 2010 requires the undertaking of Equality Impact Assessments (EIAs). All UHB policies will require an EIA. EIAs form a process which finds out whether a policy will affect people differently on the basis of their "protected characteristics" – age, disability, gender reassignment, marriage or civil partnership, pregnancy or maternity, race, religion, sex or sexual orientation as it will affect their human rights. It also takes account of Welsh Language issues. It is designed to ensure that consideration is taken of the needs of all individuals who work for or access the services of the UHB.
Included in Appendix.

25 Performance Measures

Compliance with this Discharge Policy and Procedure will be monitored as part of Cardiff and Vale UHB's operational performance management process to include:

- Number of pathway of care delays with a focus on reduction
- Number of bed days lost with a focus on reduction
- Reduction in number of complaints associated with the discharge process
- Number of readmissions due to poor discharge planning
- Number of incidents reported on Datix Cymru associated with discharge planning
- Number of safeguarding referrals associated with discharge planning

26. Review of Policy

The Policy will be reviewed every three years and will include:

- Regular audit of compliance
- Monitoring of complaints and reported incidents and areas of consistent difficulties
- Feedback from key stakeholders including patients/carers/advocates

27. Audit Arrangements

A review of the Discharge policy and understanding of the policy with key professionals working within the scope of the policy will be undertaken as necessary.
Training objectives will be adapted following key recommendations alongside changes in national frameworks and policies regarding discharge processes.