University Hospitals of Leicester NHS
NHS Trust

Discharge and Transfer of Care Policy (Going Home Policy)

For Adults Leaving Hospital

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CONTENTS

REVIEW DATES AND DETAILS OF CHANGES MADE DURING THE REVIEW

March 2021 This review has changed the scope of the policy to Adults only. The main body of the policy is largely unchanged but reflects the changes of the new NHS Hospital Discharge Guidance and removes references to Children and Young People.

KEY WORDS

Discharge (Simple or Complex), Transfer of Care, Self-Discharge, Discharge Specialist Tteam, Integrated Discharge Team and Discharge Hub.

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

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

YES

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

Provide:

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

Discharge summery including:

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

NO

Complex Patients Pathways 1- 3

- Complete Home First form on Nerve centre at least 48 hours before medically optimised date.
- For patients likely to need a discharge MDT with adult social care please refer as soon as possible in the patients journey to the Discharge Hub Ext 5113: / Discharge Specialist team: 07929839672.
- Identify patients as complex on Nerve Centre.
- Front Door wards (i.e. ED, AMU, CDU) can request adult social care via telephone.

Patients transferring to another Acute Trust, community rehabilitation, or step down bed, Nursing or residential home. Please ensure that a transfer letter and verbal handover occurs.

Should there be an absolute need to send the original case notes to any other organisation outside of the UHL, our Community hospital partners' and other healthcare providers within Leicester and Leicestershire district then managerial authority must be sought and a risk assessment completed and notes tracked accordingly. **Refer to Records management policy (B31/2005)**

1 INTRODUCTION AND OVERVIEW

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

1.2 This document sets out the University Hospitals of Leicester (UHL) NHS Trusts Policy and Procedures for the safe and timely discharge and transfer of care of adults admitted to the trust.

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

1.4 The policy provides a framework that enables the delivery of safe, effective and timely discharge or transfer of care for all adult inpatients. The core principles and processes are the same for all inpatient areas but there will be a service specification regarding roles, responsibilities, procedures and pathways that will need to be considered within each Clinical Management Group (CMG).

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

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

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

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

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

c) Right Patient, right place, right care.

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

e) Person-centered and a maximising independence approach

f) Reduced duplication of assessment through trusted assessment principles.

g) Releasing time to care.

2 POLICY SCOPE

2.1 This policy applies to all staff employed within the University Hospitals of Leicester NHS Trust, those staff working in a contracted capacity, and staff contracted with partner agencies or NHS Trusts and working within UHL.

2.2 This policy applies to all adult patients being discharged from inpatient care in UHL, regardless of age or diagnosis. This policy should be read in conjunction with the Trust's Safeguarding Adults policy and The Trust's Capacity and Flow Escalation Policy (refer to Insite for the most up to date version).

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

2.4 The policy applies to all patients registered as inpatients or ambulatory care patients and those attending the hospital for emergency/ urgent assessment and being discharged following a decision not to admit the patient.

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

2.6 This policy has been developed to ensure:

a) All patients experience well organised, safe and timely discharge from hospital with an agreed, smooth transfer to community based health and social services.
b) Each patient is encouraged and supported in self-care activities and helped to achieve the highest possible level of independence.
c) Patients, carers and staff are supported to set realistic expectations of hospital stays.
d) Patient carers and families are prepared, physically and psychologically for transfer home or to an agreed alternative discharge destination.
e) There is effective and timely involvement of patients, carers and family in discharge and transfer planning.
f) There is effective and timely communication of relevant information regarding discharge and transfer plans to patient and their carers.
g) Patients receive an appropriate, skilled and timely assessment.
h) There is continuity of care between hospital and the agreed discharge care environment, with seamless service transition.
i) There are improved patient outcomes by promoting understanding of and concordance with, follow-up arrangements and discharge medication.
j) There is effective and efficient use of the hospitals inpatient bed capacity by reducing unnecessary delays in discharge.
k) Highest standards of communication within the multi-disciplinary team, between primary and secondary care, and with colleagues in health and social care and the independent sector throughout the pathway of care.
l) That discharge planning commences prior to, or immediately on admission to hospital and continues throughout the patient's acute hospital admission.
m) That patients are provided with information/medication/equipment to enable and foster independence for the patient/carer.
n) The provision of appropriate documentation accompanies the patient upon discharge.
o) That unplanned re-admissions do not occur as a result of poor discharge planning.

3 DEFINITIONS AND ABBREVIATIONS

3.1 The majority of patients who are discharged from hospital will be classified as a **simple** discharge. A simple discharge is one that:

'Involves minimal disturbance to the patients' activity of daily living; does not hamper a return to their usual residence and where there is no significant change in the support offered to the patient or their carer in the community.' These discharges will be managed at ward level.

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

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

b) Patients with short term health needs

c) Patients requiring ongoing treatment out of an acute setting

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

e) Patients being discharged to a care home.

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

g) Patients with mental ill health/learning disabilities.

h) Victims of neglect or of sexual or domestic violence.

i) Patients who are homeless.

j) Patients that have no recourse to public funding

k) Those who self-discharge against medical advice

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

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

n) Individuals with safeguarding concerns regarding discharge

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

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

q) Family disputes

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

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

t) Out of area patients

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

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

- Patients own home
- Community team
- Acute mental health team
- Primary care
- Nursing/ Residential Home
- Clinical Commissioning Group's
- Another hospital service e.g. acute hospital.
- Social care.

3.5 **LLR Integrated discharge team (IDT)/ discharge hub** is a collaborative service bringing together employees from seven Health and Social Care Organisations namely:

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

The model is primarily focused on a multi-agency team providing a single point of access to the Trusts wards by providing expertise and advice in the safe and effective discharge of patients with complex discharge needs and acting as experts on discharge planning for the wards.

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

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

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

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

4 ROLES – Responsibilities within the Organisation

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

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

4.3 It is the responsibility of the **Consultant** to ensure that:

a) All patients in his/her care have an estimated discharge date (EDD) within 24 hours of admission to hospital and that this is discussed with the patient and family/ carer and is reviewed daily in line with the SAFER patient flow bundle and Red2Green bed days approach and recorded on nerve centre. (see discharge tool kit on Insite for further details)

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

c) Board/ward rounds occur each working day, to identify patients who are ready for discharge. Patients potentially ready for discharge should be reviewed as early in the day as is consistent with clinical priorities (i.e. at the beginning of the board/ward rounds wherever possible, sickest patients first then potential discharges, then new patient and then the ward round of remaining patients).

d) The patient is assigned a 'reason to stay' (reside) code on nerve centre each day.

e) The frequency of individual patient discharge reviews reflects the clinical condition of the patient and the nature of the discharge plans (some patients may require a twice daily review to progress plans).

f) All patients have a Consultant approved care plan that includes physiological and functional clinical criteria for discharge. Consideration being given to whether the patient would be better off in an acute hospital or in an alternative setting to receive on going care and treatment (community hospital for medical step down/ rehabilitation, or Home with Home first support services). To include consideration for outpatient testing/ follow – up (x-rays, scans etc.).

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

h) Plans are put in place to identify patients who may be ready for discharge at weekends and bank holidays when board/ward rounds may not be routine. Consideration should be given to delegated criteria led (nurse led) discharge. For further details please refer to the Trust's adult policy (Trust Ref: B21/2013)

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

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

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

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

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

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

b) Ensuring the Discharge Checklist on nerve centre is complete.

c) Ensuring that the nerve centre board round/ discharge profile is completed and kept up to date with 'simple/ complex discharge and medically optimised for discharge status.

d) Ensuring that all patients have an EDD recorded in their notes, detailed on nerve centre and that this date has been communicated to the patient, relatives/carer, as appropriate.

e) All information relating to the discharge is recorded on the board round/ discharge profile on nerve centre.

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

g) Ensuring that where possible all discharges take place before 11am.

h) Jointly work with the Senior Decision Maker to ensure review of patients at daily Board Rounds and later in the day follow up of actions in line with Red2Green principles and a reason to stay (reside) code has been applied.

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

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

k) Any delays to patient progress (diagnostics, tertiary opinion, referrals) to be reviewed and escalated as per Clinical management group (CMG) escalation pathway i.e. through Matron or General Manager.

l) Ensure Home First documents are completed on Nerve Centre in a timely manner using the Home First principles.

4.6 **The Registered Nurse** is responsible for ensuring:

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

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

c) In the absence of the Senior Nurse /Nurse in Charge jointly work with the Senior Decision Maker to ensure review of patients at daily Board Rounds and later in the day follow up of actions.

d) All information relating to the patients discharge is recorded on the patients discharge care plan and on nerve centre.

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

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

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

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

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

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

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

l) The receiving hospital, care home or social care facility (or community nurse team, if the patient is returning home) is notified of any known infection and the current infection control practices in place e.g. antibiotic therapy, dressing regime, barrier nursing. An inter healthcare patient infection prevention transfer form will be completed.

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

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

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

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

q) All necessary information for discharge/transfer of care and management is gathered, recorded and communicated appropriately.

4.7 **The Discharge Support Assistant/Assistant Practitioner for Discharge** works in support of the MDT team undertaking delegated tasks to facilitate safe and timely discharge of patients.

4.8 **All members of the multidisciplinary team** (MDT) have the responsibility to ensure patients their families and carers are consulted and regularly updated about discharge planning from admission (or preadmission when patients are attending pre-assessment clinics prior to admission); throughout inpatient stay and up until 30 days post discharge; sign posting patients/carers where necessary.

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

4.10 **The Allied Health Professionals** (OT, Physio, and other allied groups) provide holistic functional patient assessment and consider equipment, adaptations and/or goals for rehabilitation, for patients who are expected to improve their functional ability. They will liaise with patients, their carers, families and multidisciplinary teams within UHL and externally to enable the needs of the patient to be met. They form part of the IDT and work using the principles of trusted assessment, Home first and Discharge to assess. Assessments for long term needs will take place outside of the acute hospital setting.

4.11 **Pharmacy staff** are responsible for timely preparation of discharge medication and ensuring medicines are returned to the appropriate ward or discharge lounge when it is open.

4.12 **CMG Discharge Specialist Teams** provide expert clinical leadership in relation to patient flow and discharge specific to the CMG linking with the Hospital wide Discharge Specialist team and wider Integrated Discharge team to ensure safe and timely discharge / transfer of care and best practice is advocated.

4.13 **The Discharge Specialist Team / Emergency Floor Discharge Practitioners** provide expert clinical leadership in relation to complex and delayed discharges in conjunction with the ward sister and multidisciplinary teams by:

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

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

c) Developing strong links with all CMG's within UHL, community health services, including community hospitals and other partner agencies to identify and progress delayed discharges.

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

e) Completion of fast track assessments and coordinating discharge for patients who are End of life.

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

g) Collation of daily complex medically optimised for discharge census for delayed transfers of care on each hospital site to enable tracking of patients.

h) Complete risk assessments and order equipment for patients with nursing needs following discharge and ensuring timely handover to appropriate care provider in the community

4.14 **The Head / Deputy Head of Nursing Patient Flow and Discharge** have responsibility for bringing about sustained improvement in discharge planning by working with multidisciplinary teams within UHL and partner agencies by:

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

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

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

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

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

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

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

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

4.15 **The Patient Duty, Flow and Capacity Bed Team** manage the daily flow of patients into and out of the Trust and promote/initiate the use of appropriate services and schemes to enable safe and early transition to home. They will maintain and communicate accurate information on bed status and liaise with clinical staff to support an overview and understanding of pressures within the service to inform operational and clinical decision making processes. They will work with clinical colleagues to enable morning transition of patients to home whenever possible so that sufficient beds are available to enable patient's timely access to the most appropriate care setting and level of care.

4.16 The LLR Discharge Cell and the UHL Safe and Timely Discharge group support the working of this policy and the safe and timely discharge work steam.

5. POLICY IMPLEMENTATION AND ASSOCIATED DOCUMENTS –WHAT TO DO AND HOW TO DO IT

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

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

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

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

5.1.3 All patients must be given an Estimated Date of Discharge (EDD) within 24 hours of admission which will be recorded in the case notes and nerve centre and on the 'Supporting you to leave hospital' booklet and be assigned a daily reason to stay (reside) code. This date will be discussed and agreed with patients their relatives or carers and any changes to this date will be discussed with the relevant stakeholders.

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

5.1.5 All patients will have a UHL Discharge planning care plan commenced on admission. The Discharge planning care plan is the single document recording all MDT referrals relating to the patient journey from admission to discharge/transfer of care and is part of the Nursing assessment documentation.

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

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

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

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

5.1.10 On the day of discharge the discharging nurse must confirm that the patient is fit to leave hospital and check that all arrangements are in place with the patient, family/carer.

5.1.11 A copy of the discharge letter (TTO) should be ready 24 hours before discharge/transfer wherever possible.

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

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

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

5.1.13 The discharging registered nurse is responsible for ensuring the patient and/ or carer understands their medication regime on discharge by discussing the following:

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

If appropriate medications counselling by a pharmacist should be considered.

Please refer to the TTO Checking - Home Discharge Medications UHL Pharmacy Guideline (B19/2015) for further information.

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

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

5.1.16 Those patients planned for patient discharge will be ready to leave the ward area before/by 11am (this includes all patients where on-going care is expected to be completed on the discharge lounge, where this is available).

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

5.1.18 All adult patients should be transferred to a Discharge Lounge or an area to wait away from their bed prior to discharge to assist with early flow and capacity throughout the hospital if they do not have one of the exclusion criteria. See insite for details.

5.2 Out of hours discharge.

5.2.1 Staff should not routinely discharge patients after 9pm, unless the patient or family request and are happy for discharge after this time.

5.2.2 In the event of patients leaving the hospital after 9pm every effort should be made by the ward nurse discharging the patient to contact the family, carers, unless the patient requests otherwise.

5.2.3 Referrals for social care (city & county) e.g. emergency placement for Emergency department (ED), out of hours including weekend and BH: ring 0116 2551606

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

5.3 Where Applicable.

5.3.1 The nurse discharging the patient should confirm that the patient and/or carer understands the information provided and, where English is not the patient's first language, staff should request assistance from an interpreter. Interpreters and written translations including Braille can be booked via their online booking portal on INsite.

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

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

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

5.3.5 If dressings are required:

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

b) If the patient is not well enough to attend the surgery, then a referral should be made for the district nurse to visit the patient within their home environment.

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

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

5.3.8 Contact the Discharge Specialist team for assistance with contact numbers for patients who are out of county please ring: 07929839672 or The LLR Discharge Hub on ext: 5113.

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

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

5.3.11 Where patients are identified as being at high risk of readmission (PARR 30 tool score >40), staff responsible for discharge planning should check that the patient and carer/family are fully informed about their condition and understand their care plan, including administration of medicines, management of pain & constipation; side effects of medicines and contact numbers for them to contact if they are concerned or worried. They should be highlight as a 'readmission risk' in the transfer/discharge letter to the GP.

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

a) The physiotherapist will assess for mobility aids e.g. walking frame/ stick, rotunda and order as appropriate and arrange further physiotherapy assessment/support in the community if required.

b) The Occupational therapist will assess for aids to assist transfers e.g. hoist, bed lever, commode and order as appropriate and arrange further occupational therapy assessments/support in the community if required.

c) The Discharge Speciailist team will assess for nursing aids e.g. Pressure relieving, hospital bed and accessories, bed rails and arrange further assessments in the community if required.

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

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

5.3.13 Where there is an urgent need to discharge a patient prior to the TTO medicines being physically available to ensure placements are not lost due to the delay in discharge. These are limited to discharge to a:

- Residential Home
- Care Home or
- Community Hospital

There are patient exclusion criteria based on certain medicines. Please refer to the Policy for the Discharge of Patients to Residential Homes, Care Homes or Community Hospitals prior to TTO Medicines being available via Insite.

5.4 Complex Discharges

5.4.1 Once a patient has been identified as having complex needs on Nerve Centre they will be triaged by the Discharge Specialist Team they should be referred via a Homefirst Form on nerve centre.

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

5.4.3 Where it is suspected that patients lack capacity regarding decisions relating to discharge an assesemnet should be undertaken using the ‘Mental capacity and Best Intertests assessment’ on nervecentre.

5.4.4 Where patients lack capacity regarding decisions relating to discharge the views of family members must be sought and considered. It is the relevant decision makers responsibility to determine the future management of the patient’s healthcare needs, in the ‘best interests’ of the patient, unless there is someone who has authority under a valid and applicable Lasting power of attorney or have been authorised to make decisions as a deputy appointed by the court of protection. (Mental Capacity Act 2005). For further details please refer to the Trust’s Mental Capacity Act Policy (Trust Ref: B23/2007) and the Trust’s Advance Decisions and Lasting Power of Attorney Policy (Trust Ref: B20/2004)

5.4.5 Where patients lack capacity regarding decisions relating to discharge and there are no family or friends the MDT must consider making a referral to an independent mental capacity advocate (IMCA) by completing an IMCA POhWER

referral form available on INsite. (Mental Capacity Act 2005). For further details please refer to the Trust's Mental Capacity Act Policy (Trust Ref: B23/2007)

5.5 Assessment of on-going care needs/care packages

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

5.5.2 Patients will be referred to physiotherapy and occupational therapy, if they have not returned to their pre-hospital functional status to determine whether they have potential for their functional ability to improve. To consider suitability for rehabilitation at home via 'Home First Community services' or social care reablement; OR inpatient rehabilitation/ step down in a community hospital if the patient has night time needs.

5.5.3 The MDT are advised to seek early help and advice from the IDT with patients who have complex care needs or any issues that could potentially result in a delayed discharge (refer to the specialist discharge team on ext. 5113).

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

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

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

Out of county referrals can be made by contacting the Specialist Discharge team

5.5.7 Patients with exceptional high levels of care that would also require the care in the community, the specialist discharge team will liaise with Midlands and Lancashire on behalf of the Clinical Commissioning Groups to arrange the relevant care and further assessment in the community utilising the Discharge to Assess pathways.

5.5.8 If the patient requires enteral feeding following discharge the Leicester Intestinal Failure Team (LIFT) team will need to be contacted to provide support and training to the patient, family, carer or care providers. See Insite for details.

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

a) at home with 'Home First' services OR

b) If the patient is stable and does not have night time needs a referral form is completed by the MDT identifying specific treatment and goals for improvement and faxed to SPA on 0116 2958772. The referral should be recorded in the discharge planning care plan.

c) Within a community hospital. If the patient is stable a home first referral form is completed by the MDT on nerve centre, identifying treatment and goals for improvement.

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

5.5.11 If the patient requires pressure relieving equipment the nurse will need to make a referral to the Specialist discharge team, who will review the patient and order the equipment if required. A referral will be made to the district nursing service to monitor the patient following discharge.

5.5.12 A bed rail risk assessment will be completed by the specialist discharge team for patients requiring bed rails, as identified by ward staff. The referral will be completed via telephone to the service responsible for monitoring post discharge. E.g. Community nurse/ social services/ placement.

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

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

5.5.15 Staff may need to liaise with the Manual Handling team for advice regarding the needs of Bariatric patients

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

5.6 Patients who are homeless

5.6.1 Homeless patients frequently have complex health, social and mental health issues. The multidisciplinary team should seek early advice from the Discharge Specialist team.

5.6.2 Patients visiting from abroad should be referred to the persons from abroad team (ext. 5734/8908) to determine eligibility for health care services.

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

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

5.6.4 The multidisciplinary team needs to refer the patient to housing support officer for a housing assessment or referral for a hostel. If patient is optimised for discharge the patient can be also be directed to: Housing Options Team at Leicester City Council at Customer Service Centre 91 Granby street Tel: 0116 4541008 opening times Monday Tuesday and Thursday 8.30am – 5pm Wednesday

9.30am – 6pm and Friday 8.30am – 4.30pm or Dawn Centre if out of hours Tel: 0116 2212770. For advice

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

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

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

5.7.1 The multidisciplinary team need to contact the Discharge Specialist team as early as possible in the patient journey for support.

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

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

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

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

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

5.8 Patients with mental health/ behavioural issues

5.8.1 The MDT need to contact the Discharge Specialist team as early as possible for support, advice or assistance with discharge planning.

5.8.2 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 as an

emergency by switchboard; non urgent referrals by can be arranged by contacting 0116 2255911

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

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

5.9 Patients with a learning disability

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

5.9.2 Refer to learning disability acute liaison nurse, for support with discharge planning, if the patient has ongoing care needs or issues relating to discharge.

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

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

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

5.10.2 Ensure the patient and the family are aware that death is imminent.

5.10.3 Establish if patient prefers to die at home.

5.10.4 Ensure DNACPR & End of life medication is prescribed with drug authorisation letter for district nurse.

5.10.5 For same day discharge make an urgent referral before midday to the Discharge Specialist team via a home first form for rapid discharge with Hospice at home. Discharge Specialist team to contact family to discuss discharge planning- ensure downstairs existence and there are no access issues into property.

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

5.10.7 Discharge Specialist team to determine whether equipment is required for discharge e.g. hospital bed, slide sheets, pressure relieving mattress, and notify Hospice at home who will organise urgent delivery on the same day of discharge.

5.10.8 Three days supply of End of life drugs to be prescribed by medical staff, and community nurse drug authorisation form to be completed. (Available on ICE)

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

5.10.10 Refer to home oxygen service if palliative oxygen is required and mark as urgent.

5.10.11 Ensure the patient is pain free and comfortable before discharge.

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

5.10.13 Notify GP and Hospice at home (01509 410395 or 0300 300 1000 out of hours and weekends) of actual time of discharge.

5.10.14 Ensure patient has copy of GP letter; DNACPR form; transfer letter; nursing documentation; drug authorisation form and relevant medicines/ water for injection & syringe driver. Inform discharge team when syringe driver has been sent with patient, so that they can arrange for it to be returned.

5.11 Self-Discharge against medical advice

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

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

5.11.3 The doctor and nurse should make an assessment of capacity in relation to the patients' ability to make a decision to self-discharge and this should be recorded on the 'Discharge against medical advice form' and filled in the medical notes. (available from the print room/download from Insite).

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

5.11.5 If the patient does not have capacity the doctor will need to make a best interest's decision whether the patient needs to be detained in hospital and consider whether an urgent DoLS application is required. For further details refer to the Trust's Deprivation of Liberty Safeguards Policy (Trust Ref: B15/2009).

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

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

5.12 Delayed Transfers of Care

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

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

5.12.3 The Trust informatics team and Discharge Specialist team coordinate the daily discharge sitrep report will ensuring that delays are accurately assigned on the Strategic Data Collection Service

5.13 Patients who Refuse Discharge

5.13.1 On occasions a person fit for discharge, may refuse to leave hospital. In these circumstances the person refusing should be evaluated by the doctor to establish medical/psych/social basis for that patient's refusal. If no resolution from the MDT involve the Discharge Specialist team to enact the 'Patient Choice' procedure.

6 EDUCATION AND TRAINING REQUIREMENTS

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

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

6.3 Ward Sisters, Matrons, Heads and Deputy Heads of Nursing, CMG Heads of Operations, Consultants and Clinical Directors will ensure that all staff have access to training and education to maintain up to date knowledge of local and national policies relating to discharge planning.

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

7 PROCESS FOR MONITORING COMPLIANCE

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

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

b) Completion of discharge / transfer of care letter/TTO.

c) Readmission rates within the first 7 days of discharge.

d) Daily Discharge Sitrep reporting to the Strategic Data Collection Service (SDCS).

e) Datix incidents relating to discharge

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

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

These are set out in the Policy Monitoring table below.

8 EQUALITY IMPACT ASSESSMENT

8.1 The Trust recognises the diversity of the local community it serves. Our aim therefore is to provide a safe environment free from discrimination and treat all individuals fairly with dignity and appropriately according to their needs.

8.2 As part of its development, this policy and its impact on equality have been reviewed and no detriment was identified.

9 SUPPORTING REFERENCES, EVIDENCE BASE AND RELATED POLICIES

9.1 This document has been developed in conjunction with hospital staff, local LLR Health and social care partners.

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

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

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

c) NHS Improvement 'A brief guide to developing Criteria led discharge' (2017)

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

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

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

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

h) NHS Commitment to carers (NHS England 2014)

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

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

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

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

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

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

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

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

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

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

s) Achieving timely "simple" discharge from hospital - Department of Health, 2004,

t) Supporting people with long term conditions - Department of Health, 2005.

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

10 PROCESS FOR VERSION CONTROL, DOCUMENT ARCHIVING AND REVIEW

10.1 This document will be reviewed and updated every three years, or sooner in response to any identified patient care issues or risks.

10.2 The updated version of the Policy will then be uploaded and available through INsite Documents and the Trust's externally-accessible Freedom of Information publication scheme. It will be archived through the Trust's PAGL system.

APPENDIX 1.

POLICY MONITORING TABLE

The top row of the table provides information and descriptors and is to be removed in the final version of the document

What key element(s) need(s) monitoring as per local approved policy or guidance?	**Who will lead on this aspect of monitoring?** **Name the lead and what is the role of other professional groups**	**What tool will be used to monitor/check/** **observe/asses/** **inspect** **Authenticate that everything is working according to this key element from the approved policy?**	**How often is the need to monitor each element?** **How often is the need complete a report?** **How often is the need to share the report?**	**How will each report be interrogated to identify the required actions and how thoroughly should this be documented in e.g. meeting minutes.**
Element to be monitored	**Lead**	**Tool**	**Frequency**	**Reporting arrangements Who or what committee will the completed report go to.**
Evidence of a discharge care plan; including EDD, patient/ carer awareness.	HON Patient Flow and Discharge	Report pulled from Nerve centre/ documentation audit	Annually	Safe and Timely Discharge Group
Completion of discharge / transfer of care letter/TTO/HomeFirst Form	HON Patient Flow and Discharge	Report pulled from nerve centre/ICE	Annually	Safe and Timely Discharge Group
Daily Discharge Sitrep reporting to the Strategic Data Collection Service (SDCS).	HON Patient Flow and Discharge	Report pulled from Nerve centre	Quarterly	LLR Discharge Cell
Datix incidents relating to discharge	HON Patient Flow and Discharge	Report relating to incidents by CMG/ward for the trust	Monthly with quarterly report.	Safe and Timely Discharge Group
Complaint trends and themes where discharge is the key theme.	HON Patient Flow and Discharge	Report relating to complaints by CMG/ ward for the Trust	Monthly with quarterly report	Safe and Timely Discharge Group
Patient satisfaction in relation to the specific national patient experience questions in relation to discharge.	HON Patient Flow and Discharge	Report pulled from national patient satisfaction survey.	Quarterly	Safe and Timely Discharge Group