Trust Policy

Worcestershire Acute Hospitals NHS Trust

Inpatient Discharge Policy

Department / Service:	Corporate
Originator:	Jo Whitehouse
Accountable Director:	Chief Operating Officer
Approved by:	Improving safety Action Group
Date of approval:	9th April 2026
First Revision Due: This is the most current document and should be used until a revised version is in place	9th April 2029
Target Organisation(s)	Worcestershire Acute Hospitals NHS Trust
Target Departments	All inpatient wards
Target staff categories	Nursing, Medical, Therapy, Pharmacy, Clinical Site Management, Integrated Discharge Team

Policy Overview:

Key amendments to this document

Date	Amendment	Approved by:
December 2022	New document approved	TME
5th Aug	Document extended for 6 months, new owner and discharge process being redesigned	Jo Whitehouse
16th January	Document extended for 6 months to allow time for review and update	Jo Whitehouse
April 2026	DRD, EDD and reporting information included Description of Urgent Care Team	Jo Whitehouse

The content of this policy supports the Trust's overarching commitment to high-quality, safe, and person-centred care and aligns with system-wide priorities to improve patient flow and timely discharge. It clearly defines roles and responsibilities across multidisciplinary teams and partner organisations to ensure people are discharged home first wherever clinically appropriate, safely and effectively, and without avoidable delay. The policy also ensures that appropriate care, support, and follow-up arrangements are in place to meet individual needs and reduce the risk of readmission.

The purpose of this Policy is:

- To highlight the importance of discharge planning from the time of admission (or before)
- To facilitate a safe and timely patient discharge
- To improve the patient's continuity of care and transition back to the community or care home setting

- To reduce the potential risks associated with patient discharge
- To standardise and manage the discharge process for in-patients at the acute hospital
- To ensure all staff understand their roles and responsibilities

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1. Introduction

This policy sets out the standards and responsibilities for the safe, timely, and person-centred discharge of people following an inpatient admission. It has been developed to ensure compliance with national hospital discharge standards, supporting people to be discharged as soon as they are clinically optimised for transfer, with arrangements focused on maximising independence and outcomes.

This policy supports the Home First approach, whereby discharge planning prioritises a return home wherever clinically appropriate. In line with Discharge to Assess (D2A) principles, decisions about longer-term care and support needs are, wherever possible, made after discharge, in the community or a non-acute setting, rather than in hospital. System discharge arrangements and intermediate care pathways will be kept under regular review to ensure they remain responsive to patient need and system demand.

Effective discharge planning is a core component of high-quality inpatient care and should begin at the earliest opportunity. While many discharges are straightforward, a significant number of patients require ongoing health and/or care support following discharge. This may include therapy input, provision of equipment, short-term reablement, domiciliary care, or ongoing community health services.

Discharge arrangements must be coordinated and planned early to ensure continuity of care and avoid gaps between acute and community services. Failure to discharge people in a timely and coordinated way can result in poorer outcomes and experience for patients, increased risk of readmission, and avoidable occupancy of acute hospital beds when care could be more appropriately delivered in a community setting.

 Most patients are expected to return to their usual place of residence if clinically appropriate. If ongoing care or rehabilitation is required, that should be delivered after discharge and in the most appropriate setting, with assessments undertaken at the right time and place.

Other than in exceptional circumstances, patients should not be discharged directly to a permanent care home placement without first exploring recovery at home or another lower-dependency setting.

2. Scope of this document

This policy applies to all staff involved in the discharge of all inpatients in the Worcestershire Acute Hospitals NHS Trust. It should however be considered in the context of wider system working, particularly regarding the provision of intermediate care.

3. Definitions

Discharge – When an episode of care within an inpatient setting is complete.

Discharge Planning – A coordinated, multi-professional and multi-agency process which facilitates the safe and timely discharge of an inpatient from the care provided in an in-patient bed. Simple discharges often do not require a multi-agency process.

Criteria led Discharge – Facilitates a reduction in delays to discharge and empowers ward teams to discharge in a timely manner, whilst keeping governance and accountability with the consultant in charge.

Delayed Discharges – A delayed discharge of care occurs when a patient is ready to leave and remains occupying an in-patient bed.

Discharge Pathways

Pathway 0 – Simple discharge home; no new or additional support is required to get the person home or such support constitutes only:

- Informal input from support agencies
- A continuation of an existing health or social care package that remained active while the person was in hospital

Pathway 1 – Able to return home with new, additional or a re-started package of support from health and/or social care. This includes people requiring intensive support of 24-hour care at home.

Every effort should be made to follow Home First principles, allowing people to recover, rehabilitate or die in their own home.

Pathway 2 – Recovery, rehabilitation, assessment, care-planning or short-term intensive support in a 24-hour bed-base setting, except under exceptional circumstances, before returning home.

Pathway 3 – For people who require bed-based 24-hour care: includes people discharged to a care home for the first time plus existing care home residents returning to their care setting. Those discharged to a care home for the first time will have such complex needs that they are likely to require 24-hour bedded care on an on-going basis following an assessment of their long-term care needs.

Discharge Summary - A clinical report prepared by doctor or other health professional at the conclusion of an inpatient stay or series of treatments. It outlines the person's diagnosis, treatment and on-going clinical management. Referred to as an Electronic Discharge Summary (EDS).

Fast-track - In the event of a person's condition deteriorating rapidly or entering a terminal phase, the Fast Track Continuing Healthcare (CHC) pathway can be used. Fast Track CHC allows a clinician with appropriate knowledge of the patient to immediately assess for an appropriate care and support package to be put in place.

Multi-Disciplinary Team (MDT) - A team or group consisting of representatives from several different professional backgrounds who have a range of expertise and who meet regularly to communicate, collaborate and consolidate knowledge from which plans are made, actions determined and future decisions influenced. The MDT usually includes doctors, nurses, occupational therapists, physiotherapists and social workers.

Nominated Carer/Family Member - Person/s nominated by the patient to be the main point of contact for their inpatient stay and with whom discharge arrangements should be discussed

Integrated Discharge Team (IDT) - A multi-disciplinary team based on the Trust's two main Acute sites providing advice and assessment for patients requiring support with their discharge. This team is made up of Registered Nurses, Administrative Staff and progress chasers. Additionally, discharge is supported by the Urgent Care Team – a team of Social Care Practitioners who support processes via MDT working and ensuring Care Act considerations are made at the right point in a patient journey. In addition any safeguarding referrals from WMAS are directed through this team who will liaise with ward staff.

Simple discharges - A simple discharge is one that can be executed at ward level with the multidisciplinary team (MDT); funding issues, change of residence or increased health and social care needs make the discharge complex.

SAFER patient flow bundle - A combined set of simple rules for adult inpatient wards to improve flow. S=Senior Review, A=All patients, F=Flow, E=Early discharge, R=Review.

Discharge Ready Date (DRD) The Discharge Ready Date is the first date a patient meets No Criteria to Reside meaning they no longer require acute hospital care and are clinically safe to leave, pending any necessary discharge arrangements (e.g. social care, transport, community support).

Estimated Discharge date (EDD) The Estimated Discharge Date is the predicted date a patient is expected to leave hospital**,** based on their current clinical condition, treatment plan, and anticipated recovery.

To Take Out (TTOs) – An electronic form completed for all patients being discharged from hospital. It acts as a prescription to order the drugs that a patient needs to take home with them. As far as possible the TTO should be completed the day prior to the patient being discharged, to minimise or avoid delay in getting the required drugs from Pharmacy. Any subsequent revision to required discharge medication can then be incorporated more swiftly.

WAHT - Worcestershire Acute Hospitals Trust.

H&WHCT - Herefordshire and Worcestershire Health and Care Trust.

WCC - Worcestershire County Council.

4. Responsibility and Duties

The following provides a summary of the roles, responsibilities and accountabilities for discharge processes.

4.1 System Responsibilities

Discharge is delivered within a system model. Partner responsibilities include (not exhaustive):

- **ICB / System partners**: Commissioning and oversight of pathway capacity, escalation routes, performance reporting requirements.
- **Herefordshire & Worcestershire Health and Care NHS Trust / community providers**: Delivery of community nursing, therapy, intermediate care, community hospital capacity, D2A support.
- **Worcestershire County Council**: Social care assessment, care package sourcing, Care Act responsibilities, safeguarding interface.
- **Transfer of Care Hub (where operational):** Coordination of pathway referrals, capacity matching, and system escalation.

4.2 Trust-wide Responsibilities

The Trust Management Executive retains accountability for ensuring discharge standards are achieved and discharge processes are resourced and implemented.

Patient Flow leadership within the Trust:

- Associate Director of Patient Flow – strategic oversight
- Flow Manager – operational capacity oversight
- Flow Matron – clinical operational oversight
- System Flow Lead – system interface and cross-organisational alignment
- Integrated Discharge Team Lead – day-to-day IDT leadership and delivery

All wards and MDTs are responsible for discharge planning from admission, daily R2R review, and timely completion of required documentation.

Criteria-led discharge (CLD)

Where appropriate, specialties should implement CLD for defined patient groups, including:

- Written criteria agreed by consultant team
- Clear escalation triggers
- Documentation in the clinical record and handover

This reduces avoidable waits while maintaining consultant accountability.

5. Discharge planning process

The Discharge Ready Date (DRD) is the earliest date on which a patient is clinically optimised for transfer from acute hospital care and can be discharged without the need for ongoing acute inpatient treatment, provided that any required discharge arrangements are in place.

5.1 Risk of Homelessness or Homeless

Under the Homelessness Reduction Act 2017, hospitals have a duty to refer individuals to a local authority housing team that are at risk of homelessness or are homeless. This means a person's housing situation must be considered as part of the discharge planning process.

Patients Who are Homeless or Living in Temporary Accommodation Identifying a person's housing status on admission is essential for successful discharge to take place. People who are homeless or living in temporary or insecure accommodation must be referred to the Integrated Discharge Team at the earliest opportunity

5.2 Involvement of Carers in the Discharge Planning Process

It is the responsibility of ward multidisciplinary teams to identify and involve any nominated carer(s) in discharge planning at the earliest appropriate opportunity. Clear, timely communication with carers is essential to ensure they are informed of the anticipated discharge readiness date, proposed discharge arrangements, and any ongoing support requirements.

The Integrated Discharge Team has a key role in coordinating and supporting the assessment of any ongoing carer needs, working in partnership with health and local authority colleagues to ensure that appropriate support is in place following discharge, in line with Home First and Discharge to Assess principles.

In accordance with the *Hospital Discharge and Community Support Guidance* (most recently updated 2023), issued by NHS England, a clear determination must be made prior to discharge regarding the involvement, views, and willingness of any unpaid carers. This includes confirmation that carers are able and willing to continue providing care, and that they have been offered appropriate information, advice, and support. Where required, carers must be referred for a Carer's Assessment in line with the Care Act 2014.

5.3 Pathway Discharge Units (PDU) at Worcestershire Royal Hospital (WRH) and Alexandra Hospital (ALX)

Pathway Discharge Units are in operation on two wards in the Trust, one at the WRH (since July 2022) and one at the ALX (since November 2022). The PDUs accommodate patients who are assessed as medically fit for discharge and who are awaiting capacity in Pathways 1 and 2. Patients with a confirmed Pathway 3 destination may also be transferred to the PDU. Patients referred and accepted have received completed Physiotherapy and

Occupational Therapy assessment, EDS and TTOs have been completed together with a Safe to Transfer Form (STTF).

The PDUs do not have sufficient capacity to accommodate all patients awaiting pathway discharge. A waiting list is maintained of suitable patients. The PDUs are designed to support a fully integrated system wide approach to complex discharge and enable rapid physical transfer.

6. Ward Level Responsibilities

6.1 Communicating Arrangements for Discharge

It is the responsibility of ward staff to ensure that discharge planning commences at the earliest possible point, directly following admission to an inpatient bed. It involves gathering and recording information from the patient about the support they receive from family, friends, informal and formal carers, and their home environment. It also involves providing information to the patient and with their agreement, involvement of family members/nominated carer/s about preparing for discharge and what to expect on discharge from hospital.

Discharge arrangements should be person-centred recognising the individual's needs and wishes. The single point of contact for those involved in discharge arrangements is the ward.

Provision of written information to the patient will include the Annex B leaflet of the Hospital and Community Support Policy for those admitted on an emergency and urgent basis. Provision of this written information will be recorded in the patient's care record.

6.2 Ward and Board Rounds

A clinically led review of all patients at a morning board round underpins the required pro-active approach to discharge planning. Questions of 'Why not home, why not today?' will be asked and addressed for each patient to agree whose care needs can be provided in an alternative facility, with a focus on home, safely and with confidence.

6.3 Timely Recording and Update of Electronic Systems

There is a responsibility on ward staff to ensure that as part of daily board/ward rounds, timely and accurate information is collected and recorded on the Whiteboard and Worcestershire Patient Tracker. This is to include an EDD and DRD individualised to the patient. Once a patient is discharged, electronic systems should be updated by ward staff to ensure an accurate record is always maintained. It is imperative that all data across all systems is updated as timely and in a live environment to ensure that all reporting and data taken from it is as accurate as possible. Reporting is taken from information from both PAS and the Whiteboard and monitors areas such as how many patients are currently in the hospital, how long those patients have been there, why they are there, which patients are in

escalation/corridor spaces and the number of patients admitted and discharged in a day both retrospectively and live.

6.4 Worcestershire QES Patient Tracker and Safe to Transfer Form (STTF)

The Patient Tracker enables a consistent way of gathering, sharing, and storing information between system partners, providing a clear understanding of where in the discharge/transfer process patients are.

It is the responsibility of the ward team to complete the first part of the 'Safe to Transfer' form for each patient requiring support with their discharge. The only exception to this, are patients who are Fast Track eligible. The form is required to be completed with essential information to support a safe and timely discharge. The purpose is to provide a description of the needs of the patient and not a pathway prescription.

Once the first part of the form has been completed, this is available electronically to the Integrated Discharge Team. The information gathered by the ward ensures that full consideration is given to the full range of supported discharge pathways that are available, considering the wishes of patients and their family/nominated carer/s.

6.5 Electronic Discharge Summary (EDS) and To Take Out Medicines (TTOs)

It is the responsibility of ward teams to maintain timely and high-quality transfer of information to Primary Care and all other relevant health and care professionals on all people discharged. Completion of an Electronic Discharge Summary is critical to delivering this responsibility and ensures the smooth transfer of care, following an acute in-patient stay.

Likewise, the early completion of the prescription for medication required for discharge is equally important. This enables medicines to be dispensed and given to the patient before they leave the hospital. The purpose of medication and how to administer and manage it should be explained to the patient and nominated family member/carer clearly and understandable. Maintaining continuity regarding on-going care providers should be assured. The expectation is that a telephone call will be made by the ward to the care provider sufficiently in advance of discharge to allow providers to put the necessary arrangements in place.

Completion of the EDS and TTOs must not be a barrier to timely discharge. Delays have wide-reaching negative implications for individual patients waiting to go home, support services that have been arranged to provide assessment and care when they get home and for those patients awaiting admission.

6.6 Patient Transport Service (EMED)

Discussion with patients about their requirements for transport home should be held at an early stage. For those patients who require transport from hospital, it is the responsibility of ward staff to book appropriate transport where family/nominated carer/s/voluntary sector provision or taxi is not appropriate or available.

Transport should routinely be booked on the day prior to discharge to enable the transport provider to provide a time slot to the ward.

6.7 Discharge Lounge

Discharges should be identified for early transfer to the Discharge Lounge, and every effort should be made to ensure they take place before 12 noon to safeguard patients against the associated risks of late/out of hours discharges and support patient flow.

The Discharge Lounges on each acute site provide safe and comfortable discharge spaces for people to be transferred to from all ward areas. Timely transfer to this facility enables a person to wait comfortably for the final steps in the discharge process, particularly transport. A standard form for information transfer from wards to the Discharge Lounge is completed by Discharge Lounge staff at handover.

Accommodation consists of trolleys and seated areas; meals and refreshments are provided as well as the administration of required medicines.

6.8 Golden Discharges

A planned discharge of a patient who is clinically optimised for transfer, completed before 10:00 am, with all discharge documentation, medication (TTOs), transport and onward care arrangements finalised in advance to enable safe and timely departure from the inpatient ward.

A golden discharge is not just "patient left early." It must be:

- Clinically optimised
- EDS completed
- TTOs ready
- Transport arranged
- Equipment/care package confirmed (if required)
- Discharge lounge transfer coordinated where appropriate

Delayed discharge escalation
Hospital-acquired functional decline refers to a deterioration in a patient's physical or cognitive ability to perform activities of daily living that develops during a hospital admission and was not present on admission. Older and frail patients are particularly vulnerable. Prolonged hospitalisation and delays in discharge increase the risk of such decline through

immobility, deconditioning, delirium, reduced nutrition and loss of independence within the acute care environment. Once patients are medically optimised, timely discharge should therefore be prioritised to minimise the risk of hospital-acquired functional decline and to support recovery in the most appropriate setting.

- Delays should be identified daily and escalated via site/flow processes.
- Use SAFER-aligned ward routines (senior review, all patients reviewed, focus on flow, early discharge, and continuous review of stranded patients).
- Long length of stay reviews of all patients over 14 days completed weekly
- Twice weekly review of pathway 2 patients for assurance of appropriate pathway

Criteria to Reside
Criteria to Reside are a nationally recognised set of clinical and functional indicators used to determine whether a patient requires an acute hospital bed. They form part of the national discharge baseline and relate to clinical, physiological, therapeutic and functional needs. A patient meets a Criterion to Reside if there is a clinical or care need that necessitates an acute hospital bed.
No Criteria to Reside (NCTR)
A patient has No Criteria to Reside when they no longer meet any of the Criteria to Reside. No Criteria to Reside status does not automatically equate to discharge but indicates that there is no longer a clinical need for an acute hospital bed. Patients with NCTR should have discharge planning and support to the appropriate place of recovery initiated without delay (e.g., home with support, Discharge to Assess or other community pathway).

7. Mental capacity and best interests
Where there is concern about capacity to make discharge decisions:
- follow Mental Capacity Act principles (assess capacity decision-specifically; best interests; least restrictive option),
- involve family/advocacy as appropriate,
- document clearly (capacity assessment, best interest rationale, risks). *(National legislation – ensure aligned with Trust MCA policy.)*

Safeguarding adults
- Safeguarding concerns must be acted on and documented.
- Discharge should not proceed into an unsafe situation without appropriate safeguarding plan.

7.1 Integrated Discharge Team cluster working

The Integrated Discharge Team (IDT) provides proactive operational and clinical coordination for patients requiring supported or complex discharge. The IDT works alongside ward MDTs to ensure early identification of discharge barriers, timely pathway referral, and escalation of system constraints in line with Home First and Discharge to Assess principles.

7.2 IDT Operational Model and Leadership

The IDT is operationally managed within the Trust's patient flow structure. The IDT interfaces daily with the Transfer of Care Hub and system partners to match patient need to pathway capacity and expedite discharge.

- Maintain accurate real-time status on relevant electronic systems (e.g., tracker/huddle tool)

7.3 Interface with Transfer of Care Hub

The IDT provides a single operational interface to the hub for:

- Pathway referrals and tracking
- Capacity matching and problem solving
- Escalation of delays where system capacity prevents timely discharge

8. Clinical Site Management Team responsibilities

The team provides a clinically led and operationally resilient on-site presence throughout a 24-hour period, 365 days a year on both Trust's acute hospital sites. The Clinical Site Management (CSM) team is primarily responsible for leading and managing the efficient flow of patients throughout the hospital. This activity is critical to the delivery of safe and effective treatment and care.

The team's responsibilities regarding discharge are to oversee the gathering and reporting of all discharges from the wards to inform the Trust's overall bed-state. They have a role to expedite discharge, by supporting wards to move appropriate patients to the Discharge Lounge.

The team has a critical interface role with the Onward Care Team, maximising use of pathway capacity and alleviating wherever possible constraints that the wards may face e.g. transport availability.

9. Clinical Divisional and Directorate Responsibilities

All Clinical Divisions operate a daily operational rota, Monday to Friday, of a nominated senior operational lead with responsibility for patient flow across the divisional bed base. These leads work in close partnership with Matrons, Ward Teams, and the Clinical Site Management Team. Throughout the day, these teams will maintain oversight of capacity, demand, and patient movement, and to optimise flow across available beds.

Nominated operational leads play a key role in supporting the safe and timely discharge of patients. This includes driving progress against priority discharges (including planned early-in-day discharges), supporting the resolution of barriers to discharge for patients who are clinically optimised for transfer, and escalating risks or delays in line with agreed operational processes.

Clinical Divisional leads attend Divisional safety, flow, and staffing huddles at scheduled points throughout the day and represent their Division at Trust-wide operational and site meetings. Core responsibilities include oversight and progression of discharge documentation and medicines, coordination of patient transport, and proactive escalation of actual or anticipated delays to discharge to ensure timely system response.

10. Concerns, Comments and Complaints

Patients and/or relatives/nominated carers should be supported to use the Trust's Patient Advice & Liaison Service (PALS) if there are concerns or issues that cannot be addressed by ward staff. PALS can be contacted by telephone: 0300 123 1732 *(Office hours: Monday - Thursday 8.30am - 4.30pm, Friday 8.30am - 4.00pm)* or by email at: wah-tr.PALS@nhs.net

In the event that PALS are unable to assist, or if there is a need to pursue a concern or complaint formally, the Complaints team can be contacted by telephone: 0300 1231732 *(Office hours: Monday - Thursday 8.30am - 4.30pm, Friday 8.30am - 4.00pm)* or by email at: wah-tr.Complaints@nhs.net

This information is provided on the Trust's website and displayed in printed form in outpatient/inpatient units. Members of staff can input a compliment on Datix.

11. Implementation

This policy document received approval from the System's Discharge Requirements Implementation Group on 14th October 2022 and the Trust's Management Executive (*pending approval from TME*). Implementation will follow thereafter.

11.1 Dissemination

This document will be disseminated through the Clinical Divisional structure and professional medical, nursing and therapy structures. It will also be accessible on the Trust's intranet. As part of this policy's compilation and approval process, partner organisations have contributed to its revision and development.

11.2 Training and awareness

It is the responsibility of Clinical Divisions and relevant corporate departments to ensure that the contents of this policy are understood by those delivering discharge arrangements.

12. Monitoring and Compliance

Compliance with this policy and its effectiveness will be monitored through existing performance review mechanisms. These are primarily the arrangements in place for performance review and management of the Clinical Divisions responsible for all wards and clinical departments in the Trust. They include clinical governance (quality and safety) assurance processes. In addition, feedback received via complaints, comments,

suggestions and compliments will be an important mechanism for identifying remedial action that needs to be taken.

A further important mechanism for review, given the System-wide involvement and responsibilities for discharge processes and planning is the provision of updates on implementation and operation to the Discharge Requirements Implementation Group.

13. Policy Review

This policy will be formally reviewed after the first year of implementation and at two yearly intervals thereafter. The Deputy Chief Operating Officer will be responsible for initiating and coordinating review.

14. References

- **DHSC (GOV.UK): Hospital discharge and community support guidance** (updated **26 Jan 2024**).
- **NHS England – NHS Standard Contract (2025/26 service conditions)**: discharge summary within **24 hours**.
- **SAFER Patient Flow** guidance (bundle approach supporting early senior review and flow)

15. Supporting Background

15.1   Equality Requirements

15.2   Financial Risk Assessment

15.3 Contribution List

This key document has been circulated to the following individuals for consultation;

Designation
Deputy Chief Nurses – WAHT
Deputy Chief Operating Officer - WAHT
Director of Capacity - WAHT
Associate Director of Countywide Community Services– H&WHCT
Assistant Director of Adult Social Care - WCC
Director of AHP
Healthwatch Worcestershire

This key document has been circulated to the chair(s) of the following committees/groups for comments;

Committee
Improving Safety Action Group

15.3   Approval Process

This document is presented to the Trust Management Executive for final approval.

15.4   Version Control

This section should contain a list of key amendments made to this document each time it is reviewed

Date	Amendment	By:
09/04/2026	DRD, EDD and reporting information included	Deputy Chief Information and Performance Officer
19/03/2026	Description of Urgent Care Team	Home First Lead

Appendix 1

Supporting Document 1 – Equality Impact Assessment form

Herefordshire & Worcestershire STP - Equality Impact Assessment (EIA) Form
Please read EIA guidelines when completing this form

Section 1 - Name of Organisation (please tick)

Herefordshire & Worcestershire STP		Herefordshire Council		Herefordshire CCG	
Worcestershire Acute Hospitals NHS Trust	x	Worcestershire County Council		Worcestershire CCGs	
Worcestershire Health and Care NHS Trust		Wye Valley NHS Trust		Other (please state)	

Name of Lead for Activity	**Kathleen Simcock**

Details of individuals completing this assessment	**Name**	**Job title**	**e-mail contact**
	Jo Whitehouse	**Associate Director of Patient Flow**	**Joanne.whitehosue2@nhs.net**
Date assessment completed	**16.3.2026**		

Section 2

Activity being assessed (e.g. policy/procedure, document, service redesign, policy, strategy etc.)	**Title: In-patient Discharge Policy**
What is the aim, purpose and/or intended outcomes of this Activity?	To describe the process of planning for the discharge of in-patients, outlining responsibilities, expectations and standards within the system
Who will be affected by the development & implementation of this activity?	x❑ Service User x❑ Patient x❑ Carers x❑ Visitors x❑ Staff x❑ Communities ❑ Other _____ ❑
Is this:	x❑ Review of an existing activity ❑ New activity ❑ Planning to withdraw or reduce a service, activity or presence?
What information and evidence	National policy. Update of working practices, incorporating new

have you reviewed to help inform this assessment? (Please name sources, e.g. demographic information for patients / services / staff groups affected, complaints etc	developments regarding discharge arrangements. Findings from a Healthwatch survey and report on 'People's Experience of Leaving Hospital'.
Summary of engagement or consultation undertaken (e.g. who and how have you engaged with, or why do you believe this is not required)	See list of contributors (above).
Summary of relevant findings	Requirement for full adoption of national policy, greater consistency of practical approach and delivery and improvement in involvement and communication with people being discharged from hospital.

Section 3

Please consider the potential impact of this activity (during development & implementation) on each of the equality groups outlined below. **Please tick one or more impact box below for each Equality Group and explain your rationale**. Please note it is possible for the potential impact to be both positive and negative within the same equality group and this should be recorded. Remember to consider the impact on e.g. staff, public, patients, carers etc. in these equality groups.

Equality Group	Potential <u>positive</u> impact	Potential <u>neutral</u> impact	Potential <u>negative</u> impact	Please explain your reasons for any potential positive, neutral or negative impact identified
Age	x			Policy fully reflects the need to plan well for discharge, taking into full consideration individual and home circumstances, a re-emphasis on 'discharge to assess' and reablement, good communication and a focus on improving outcomes.
Disability	x			Early and comprehensive communication with individuals affected, fully reflecting the views of individuals and those that may support them.
Gender Reassignment	x			As above. Focus is on the need for person-centred discharge planning with clear and comprehensive communication regarding the discharge process and offering choice.
Marriage & Civil Partnerships	x			As above
Pregnancy & Maternity	x			As above
Race including Traveling Communities	x			As above
Religion & Belief	x			As above
Sex	x			

Equality Group	Potential <u>positive</u> impact	Potential <u>neutral</u> impact	Potential <u>negative</u> impact	Please explain your reasons for any potential positive, neutral or negative impact identified
				As above
Sexual Orientation	x			As above
Other Vulnerable and Disadvantaged Groups (e.g. carers; care leavers; homeless; Social/Economic deprivation, travelling communities etc.)	x			As above
Health Inequalities (any preventable, unfair & unjust differences in health status between groups, populations or individuals that arise from the unequal distribution of social, environmental & economic conditions within societies)	x			As above

Section 4

What actions will you take to mitigate any potential negative impacts?	Risk identified	Actions required to reduce / eliminate negative impact	Who will lead on the action?	Timeframe
		.		
How will you monitor these actions?	Compliance with this policy will be monitored and reviewed as described under section 7.			
When will you review this EIA? (e.g. in a service redesign, this EIA should be revisited regularly throughout the design & implementation)	To be reviewed at intervals consistent with the arrangements for policy review.			

Section 5 - Please read and agree to the following Equality Statement

1. Equality Statement

1.1. All public bodies have a statutory duty under the Equality Act 2010 to set out arrangements to assess and consult on how their policies and functions impact on the 9 protected characteristics: Age; Disability; Gender Reassignment; Marriage & Civil Partnership; Pregnancy & Maternity; Race; Religion & Belief; Sex; Sexual Orientation

1.2. Our Organisations will challenge discrimination, promote equality, respect human rights, and aims to design and implement services, policies and measures that meet the diverse needs of our service, and population, ensuring that none are placed at a disadvantage over others.
1.3. All staff are expected to deliver services and provide services and care in a manner which respects the individuality of service users, patients, carer's etc, and as such treat them and members of the workforce respectfully, paying due regard to the 9 protected characteristics.

Signature of person completing EIA	J Whitehouse
Date signed	16.3.2026
Comments:	
Signature of person the Leader Person for this activity	
Date signed	
Comments:	

Appendix 2

Supporting Document 2 – Financial Impact Assessment

To be completed by the key document author and attached to key document when submitted to the appropriate committee for consideration and approval.

	Title of document:	**Yes/No**
1.	Does the implementation of this document require any additional Capital resources	No
2.	Does the implementation of this document require additional revenue	No
3.	Does the implementation of this document require additional manpower	No
4.	Does the implementation of this document release any manpower costs through a change in practice	No
5.	Are there additional staff training costs associated with implementing this document which cannot be delivered through current training programmes or allocated training times for staff	No
	Other comments:	None