Trust Policy	NHS Worcestershire Acute Hospitals NHS Trust

Inpatient Discharge Policy

Department / Service:	Corporate
Originator:	Kathleen Simcock, Divisional Director of Operations, Surgery
Accountable Director:	Paul Brennan, Deputy Chief Executive/Chief Operating Officer
Approved by:	Trust Management Executive
Date of approval:	14th December 2022
First Revision Due: **This is the most current document and should be used until a revised version is in place**	5th February 2026 1 year following date of approval A post-implementation audit at 3 months is recommended to be undertaken to assess extent to which this policy is being reflected in practice.
Target Organisation(s)	Worcestershire Acute Hospitals NHS Trust
Target Departments	All inpatient wards
Target staff categories	Nursing, Medical, Therapy, Pharmacy, Clinical Site Management, Onward Care Team

Policy Overview:

This policy sets out the standards and responsibilities for safe, timely and appropriately planned discharge for people who have undergone an inpatient admission. It has been developed to ensure that the Trust meets National discharge standards and that appropriate arrangements are made for patients. This policy document reflects the Hospital Discharge and Community Support guidance (updated in July 2022), the findings and recommendations of a Healthwatch Report on 'People's Experience of Leaving Hospitals' and feedback from the national Clinical Lead for Urgent and Emergency Care.

As the transition to Integrated Care Systems takes place within our NHS and social care system, a more joined up approach to the provision of intermediate care for people in our hospitals, following discharge has been piloted. Arrangements will be kept under review. The aim of ensuring each person leaves hospital without delay, with the care and support they need to return to the place they call home or, in some cases, move to an alternative setting for a further period of rehabilitation or assessment is at the core of this policy.

Although this policy document applies to Worcestershire Acute Hospitals NHS Trust, it should be considered in the context of wider System working. Colleagues in the Herefordshire and Worcestershire Health & Care Trust, Worcestershire County Council and the Integrated Care Board have contributed to the development of this policy.

The content of this policy reflects the Trust's strategy of 'Putting Patients First' and 4ward behaviours of 'no delays, everyday' and doing 'what we say we will do'. It also incorporates important aspects of the clinical vision for flow which underpins delivery of the best healthcare and outcomes by describing respective responsibilities that enable patients to be discharged safely, effectively and without delay.

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

Contents:

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1. Introduction

This policy sets out the standards and responsibilities for safe, timely and appropriately planned discharge for people who have had an inpatient admission. It has been developed to ensure that National standards for appropriate discharge arrangements are made for patients incorporating the individual's needs and those of their family and carers. It reflects the Hospital Discharge and Community Support Guidance (updated in July 2022), the findings and recommendations of a Healthwatch Report on 'People's Experience of Leaving Hospitals' and feedback from the National Clinical Lead for Urgent and Emergency Care.

As the move to Integrated Care Systems takes place within our NHS and social care system, a more joined up approach to the provision of intermediate care for people in our hospitals has been piloted. Arrangements will be kept under review. The aim of ensuring each person leaves hospital with the care and support they need to return home or, in some cases, move to an alternative setting for a further period of rehabilitation or assessment is at the core of this policy.

Planning for a patient's discharge from hospital is a key aspect of effective care. Although in excess of 80% of discharges are simple, many patients discharged from hospital will have on-going care needs that must be met in the community. Such care comes in many forms, including the use of specialised equipment, daily support from carers to complete the activities of daily living, or regular visits from district nurses to administer medication.

There is a wide variety of care available in the community, but it needs to be planned in advance of the patient's return home, to ensure that there is no gap in the provision of care between discharge from hospital and the initiation of community services.

Poor discharge planning can lead to poor patient outcomes and delayed discharge planning can cause patients to remain in hospital longer than necessary, taking up valuable inpatient beds when they could be more easily and more effectively cared for in the community.

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 with regard to 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 to Assess' 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, reable, 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

Onward Care Team - A multi-disciplinary team based on the Trust's two main Acute sites providing advice and assessment for patients requiring support with their discharge. The team is made up of Discharge Nurses, Social Workers and Social Work Assistants. The team makes referrals to discharge pathways.

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.

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-wide Responsibilities

At System level effective discharge planning is monitored by the Discharge Requirements and Implementation Group (DRIG). The role and responsibility of DRIG is to monitor expected levels of performance across partner organisations in the discharge process. It is the responsibility of the DRIG to manage and monitor progress with implementation of improvement actions.

4.2. Trust-wide Responsibilities

The Trust Management Executive has overall responsibility for ensuring that agreed discharge standards and processes are consistently achieved. Clinical Divisional, Clinical Directorate and Ward-level responsibilities are outlined in section 5.1.

4.3. Monitoring and Accountability

The Trust has in place via its established performance management processes established mechanisms for monitoring and assessing the extent to which the required discharge standards and agreed improvement actions are being achieved. Such processes include the Adult Inpatient Wards Quality Check and a programme of audit together with the more generic performance management and review processes in place between the Trust Executive and the Clinical Divisions.

At ward level, the Nurse in Charge has day-to-day responsibility for the discharge process. Senior support is provided by the appropriate Matron and Divisional Director of Nursing.

5. Discharge Planning Process

Best practice in hospital discharge involves multi-disciplinary teamwork to actively manage all aspects of the discharge process. It should be planned at the earliest stage with the full involvement of the patient. Patients should be asked if they have or would like to identify a nominated family member/carer who should also be involved in decision making about their care.

All people will have a comprehensive assessment of their care needs by nursing and/or therapists as appropriate to determine the level of care and support they will need during their stay. Any potential issues that may impact or delay their discharge will be identified at the earliest opportunity and a referral made to the Onward Care Team.

5.1 Urgent and Emergency Admissions

For those people admitted on an urgent and emergency basis, discharge planning begins when admission avoidance options have been ruled out and there is a clinical requirement to provide treatment and care on an acute in-patient basis i.e. discharge planning begins on admission. In such cases the risk of admission will have been actively considered and the benefits of admission will outweigh risks.

5.2 Elective Admissions

For those admitted to an acute inpatient bed on an elective basis, discharge planning begins prior to admission, as part of the pre-assessment process. Pre-operative assessment requires completion of an on-line health questionnaire. Information gathered as part of this process and during the physical pre-operative assessment is recorded and included in the patient's medical record. This is available to ward staff. For those that do not have access to on-line services, a hard copy of the questionnaire is made available.

5.3 Estimated Date of Discharge (EDD)

An estimated date of discharge (EDD) will be identified within 24-hours of admission by the MDT. The EDD will be appropriate to the patient's needs and based on clinical judgement. Patients and the nominated family member/carer will be informed of this expected date in order that they can begin to prepare for discharge.

Most admissions will result in straight-forward discharge home, referred to as 'Simple' discharge. Discharges that are highlighted and assessed as requiring support are referred to as 'Complex' discharges and are categorised according to the discharge pathways, 1 to 3.

5.4 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.

The referral process for homelessness or threat of homelessness for patients is to the Homeless Pathway Officer directly by phone or email or via the Onward Care Team. The Homeless Pathway Officer will then assesse the patient and make appropriate referrals for accommodation to be available at discharge.

5.5 Involvement of Carers in the Discharge Planning Process

It is the responsibility of ward teams to involve a nominated carer/s in discharge arrangements. Good communication with identified carers will ensure they are informed of the expected date of discharge and the arrangements that will be made. The Onward Care Team have a particular role to ensure that all on-going carer requirements are fully assessed.
Government guidance (July 2021) states that before discharge a determination must be made about the status and views of any carers who provide care, including that they will be able to do so.

5.6 Discharge pathway timings

Referrals to each of the supported discharge pathways are expected to leave the hospital within a given timescale from referral as follows: Pathway 1 within 24-hours, Pathway 2 within 48-hours and Pathway 3 within 72-hours.

5.7 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.

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 in order to agree whose care needs can be provided in an alternative facility, with a focus on home, safely and with confidence.

6.3 'Criteria-led Discharge'

The maintenance of good decision making in acute settings and expeditious discharge will be informed by 'Criteria led discharge'. This requires dated and signed documentation in the medical notes of the criteria which define the patient as suitable for discharge. It also includes ensuring that the Electronic Discharge Summary (EDS) and To Take Out (TTOs) medication will be ready. 'Criteria led discharge' enables nursing staff to discharge a patient as soon as the criteria are met without needing to request a further medical review.

6.4 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. Once a patient is discharged, electronic systems should be updated by ward staff to ensure an accurate record is maintained at all times.

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

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 underlying 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 Onward Care Team. The information gathered by the ward ensures that full consideration is given to the full range of supported discharge pathways that are available, taking into account the wishes of patients and their family/nominated carer/s.

6.6 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 in a way that is clear and understandable.

Maintaining continuity with regard to 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.

The table below shows the requirements for EDS and TTOs for each type of discharge.

	Simple (Home)	Pathway 0 (Home)	Pathway 1 (Reablement/ Neighbourhood Team)	Pathway 2 (Community Hospital)	Pathway 3 (Bed-based Care)	Transfer to acute provider
EDS	Required	Required	Required	Required	Required	Required
TTO	Required	Required	Required	Required	Required	Not Required

For Pathway 2 discharges to Community Hospitals, Pharmacy check the TTO to determine which drugs need to be dispensed and taken with the patient and which the Community Hospital has in its own on-site supply.

In addition, for discharges to Community Hospitals in Worcestershire, the medical casenotes are sent with the patient and returned back to the discharging ward. For discharges to Community Hospitals outside Worcestershire, relevant sections of the notes are photocopied and sent with the patient.

The patient will be advised regarding all follow-up clinic appointments and details given to the patient/family member or nominated carer/s. Valuables belonging to the patient will be retrieved and handed back to the patient on discharge ensuring appropriate documentation is completed for all transactions.

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.

6.7 Non-Emergency Patient Transport Services – (NEPTS)

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.

6.8 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 in order 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 bedded and seated areas and meals and refreshments are provided as well as the administration of required medicines.

6.9 Golden Discharges

Early discharge is part of the SAF**E**R patient flow bundle, the 'E' in SAFER. The bundle is a combined set of simple rules for adult inpatient wards to improve patient flow and prevent unnecessary waiting for patients. Early discharge is important with an aim to have 33% of all patients discharged from the base wards before midday. The identification of so-called 'golden' discharges, to be discharged before 10.00 am is an important part of overall achievement and delivery of early discharge and good flow. Wards are encouraged to identify 'golden' discharges on the preceding day so that they can be transferred to the Discharge Lounge early the following morning.

The cut-off time for discharge from in-patient beds should be no later than 8.00 pm wherever possible. In the event of a discharge taking place after 8.00 pm, the discharging team should assure themselves that the discharge is safe and that appropriate measures have been taken.

6.10 Covid testing and communication

The Trust's 'Infection Prevention and Control' service is responsible for providing and updating advice to ward staff on swabbing, testing and reporting results.

7. Onward Care Team (OCT) Responsibilities

The Onward Care Team (OCT) has a fundamental role in the pro-active management of patients requiring support following discharge from an acute in-patient bed. The operating model for the Onward Care Team supports the HomeFirst/'Discharge to Assess' requirements for supported and complex discharges.

Their role is to work as part of the ward MDT, identifying patients who require support on discharge and ensuring that early planning and arrangements are made to meet these requirements in partnership with the patient and nominated family member/carer.

7.1 Onward Care Team Ward Cluster Working

The OCT provides discharge nurse, social worker and social work assistant input to wards based in clusters. Their role is to provide constructive challenge to the discharge process, promotion of the HomeFirst/'Discharge to Assess' requirement and that timely referral is made by the wards, through the 'Safe to Transfer' form to enable the appropriate discharge pathway to be sourced.

Leadership of the OCT, facilitates engagement with the broader Integrated Care System to promote and support implementation of 'discharge to assess' processes and culture. Their role is fundamental to ensuring that discharge arrangements operate effectively across the system and a high proportion of people ready for discharge achieve a same-day discharge to the most suitable destination for their needs.

7.2 Discharge Cell

The Discharge Cell is a daily process for reviewing all patients on the Worcestershire Patient Tracker awaiting supported discharge. It is intended to identify outstanding actions and expedite safe and timely discharge. A coloured coded summary is produced each day and widely circulated. The summary shows actions for ward staff in red, actions for the Onward Care Team and the Continuing Healthcare team in yellow with discharges with an agreed date in green.

8. Clinical Site Management Team (CSM)

The team provides a clinically-led and operationally resilient on-site presence throughout a 24-hour period, 365 days a year on both of the Trust's acute hospital sites. The 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 rota, Monday to Friday of a nominated senior manager who leads on flow through their bed base. These individuals work closely throughout the day with Matrons and the Clinical Site Management team to managed flow through the available bed base. Nominated leads play a key role in ensuring safe and timely discharge of patients. This includes progressing identified 'golden discharges' and securing timely discharge of others.

Clinical Divisional leads attend Divisional safety and staffing huddles at timed points throughout the day. They also represent their Division at the Clinical Site meetings. Progressing EDS/TTOs and NEPTS to support discharge and the escalation of delays to discharge are key activities.

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

Hospital Discharge and Community Support: Policy and Operating Model	July 2021
Healthwatch Report – People's Experience of Leaving Worcestershire Hospital's During Covid-19	August 2021
Hospital Discharge and Community Support Guidance	July 2022

15. Supporting Background

    a. Equality Requirements

    b. Financial Risk Assessment

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 and Flow - WAHT
Assistant Chief Operating Officer – H&WHCT
Assistant Director of Adult Social Care - WCC
System Discharge Requirements Implementation Group
Healthwatch Worcestershire

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

Committee
System Discharge Requirements Implementation Group

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

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

Date	Amendment	By:

Appendix 1

Supporting Document 1 – Equality Impact Assessment form

NHS Worcestershire Acute Hospitals NHS Trust

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
	Kathleen Simcock	Interim Head of Service, Integrated Intermediate Care. Director of Operations, Surgery.	kathleen.simcock1@nhs.net
Date assessment completed	16.2.2022.		

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 described the process of planning for the discharge of in-patients, outlining responsibilities, expectations and standards reflecting the Hospital Discharge and Community Support: Policy and Operating Model (July 2022).		
Who will be affected by the	x❑ Service User	x❑	Staff

development & implementation of this activity?	x❑ Patient x❑ Carers x❑ Visitors	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 have you reviewed to help inform this assessment? (Please name sources, eg demographic information for patients / services / staff groups affected, complaints etc	National policy. Update of working practices, incorporating new 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 positive impact	Potential neutral impact	Potential negative 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 &	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
Maternity				As above
Race including Traveling Communities	x			As above
Religion & Belief	x			As above
Sex	x			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	K Simcock
Date signed	16.2.2022.
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

Appendix 3

- Hospital discharge information for patients entering hospital (Leaflet A) – to be shared and explained to all persons on admission to hospital
- (Leaflet B) to be shared and explained to all persons prior to discharge. This is split into:
- Your hospital discharge – going home (Leaflet B1) – for persons who are being discharged home
- Your hospital discharge to another place of care (Leaflet B2) – for persons moving or returning to further non-acute bedded care
- Looking after friends or family when they leave hospital (Leaflet B3) is for family or friends who will be providing care to people on discharge