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HINCHINGBROOKE

Discharge Standards Bundle

(Based on the principles of ECIP S.A.F.E.R. Patient Flow Bundle designed for Acute/Emergency Care)

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Discharge Standards Bundle

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Managing Patient Transfers and Reporting Delays

Patient discharge planning needs to be supported by timely (within 24 hours) medical, nursing and therapy review with a reasonably accurate PDD set within 24 hours of admission at the daily ward board round. The 11 standards of this discharge bundle need to be consistently applied to ensure all the hospital multi disciplinary team (MDT) and Integrated Discharge Team (IDS) are working to the PDD as a shared goal.

Once the PDD is agreed, the **ward welcome meeting** takes place within 72 hours of admission to help establish realistic patient and family/ carer expectations and sightedness on the patient's PDD. This is the opportunity to request helpful information for IDS discharge planning, anticipate an access visit where indicated and gather information to make the Assessment Notification helpful and shareable early on in admission. It will also support in identifying any carer needs or concerns and ensuring we ask relatives of patients with dementia to complete a "This is me" personal information document.

The **Discharge Notification** should be completed as early as possible preferably looking 5 days ahead to help the IDS broker care/ services where required, MSSU is the exception to this given the short stay nature of the ward, ideally patients requiring longer stays should transfer to appropriate wards. ***ANs/ DNs should be completed daily after the ward board rounds to enable a smooth flow of referrals daily rather than 'batches' that prove challenging for services to respond to especially with minimum notice.***

The **daily IDS PTL meeting** is the forum to: -

- confirm planned discharges over a rolling 5 days basis
- understand the plan for people coming up to their EDD and potential barriers to discharge and identify any joint actions required to manage achieving the date
- identify 'stranded' patients (DToCs) and gain senior manager escalation where required to system partners and commissioners. An escalation log should be kept and updated daily.

Escalation guidance is part of each IDS hub Discharge Standards Bundle and where there is slow progress in a patient's discharge journey the IDS senior managers should support escalation to the respective area to help further progress. There are 4 levels to escalation the final level being Deputy Chief Operating Officer escalation to Commissioners.

Discharge delays must be discussed at the daily PTL and initial agreement reached on where the delay sits in line with national and local DToC coding. This should be recorded on the PTL and shared with partner organisations for weekly sign off at the Friday validation meeting. This is an opportunity to also highlight on going common delays to Commissioners.

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1. HINCHINGBROOKE – Discharge Bundle
Standard: Daily Board Meetings

Aim: is for the multidisciplinary team to review on a daily basis the actions required to steadily progress each patients discharge element of the patients pathway, with the opportunity to escalate appropriately any block's to this process.

No	Standard
1.	The meetings will occur every weekday except Bank Holidays.
2.	Meetings will start at the agreed time for each area.
3.	The meeting will last for no more than 20 - 30 minutes dependant on unit size.
4.	Detailed discussions of individual patients or action are to take place after the meeting.
5.	The most recent update from the Discharge Team report titled for specific wards 'DTOC Updates' must be printed and available to inform the meeting of complex patient progress with system partners. This report is informing the ward of the most update position for complex patients and the responsibility of outstanding actions, of which may relate to the ward too.
6.	Any additional information that needs sharing must be done so at an agreed time by the group.
7.	The core team for this meeting includes a Nurse-in-charge, therapist, Consultant or Register (being decision-maker), nominated member of the IDS team.
8.	The meeting will be led by the agreed ward representative that day.
9.	All patients will be discussed, EDD reviewed and updated, status confirmed and actions updated and agreed regarding discharge planning.
10.	It remains the responsibility of each MDT member to document any actions planned, undertaken or confirmed in the MDT notes.
11.	Actions requiring escalation must be identified and reported to the Discharge Team.
12.	The nominated IDS attendee must feedback any change to plan; potential barriers to discharge for patients on the PTL at the 3pm huddle
13.	Leadership team conducting as 'Ward Sponsor' is expected to attend a Daily Board Meeting at least twice a week to enable being an appropriate support to the ward clinical leaders

Standard agreed: March 2019
Audit due: TBC
Audit start date: TBC
Responsibility:

North West Anglia NHS Foundation Trust

2. HINCHINGBROOKE – Discharge Bundle

Guidance: Managing Predicted Date Discharge (PDD).

(To be used with Standard for Daily Board Meetings)

Aim: to provide the patient, family/carers and MDT with the 'best evaluation' of the patient's progress to reach a timely discharge date.

No	Guidance
1.	The minimum data set required to be recorded on the ward discharge board to facilitate the patients discharge is, • Patients name • Patients pathway • Patients 'PDD' • Todays 'outstanding actions'.
2.	The Board meeting must be action focused and meaningful to the patients discharge process, it is not another 'handover' of activities meeting.
3.	The purpose in agreeing a PDD is to determine the timescale required for the patient to meet their specific recovery goals.
4.	The patients PDD must be considered as a result of the patients initial admitting therapy/nursing assessments and it is expected this is within a 24hour period from admission. The PDD must be reviewed within 72 hours by the MDT at the Board Meeting, following the initial assessments.
5.	The Board meeting discussion is as follows, • Patients name • The accuracy of the pathway reflecting the patient's condition and needs. • The accuracy of the PDD, questioning if the PDD continues to be appropriate and realistic when considering the patients progression towards readiness to discharge. • To identify the outstanding actions to meet the discharge plan, the actions must be dated with a person responsible assigned the action
6.	Reviewing of the PDD is the assessment to determine if the patient is on track to meet their goals of recovery, thereby a PDD can be changed if the patient needs more time to achieve their goals of recovery.
7.	Changing the PDD – when can it happen? • When the patients progress towards their discharge goals is either quicker or slower than initially expected. • If the patient becomes unwell. • If the patient becomes 'End of Life' and the hospital is the patients 'preferred place to die' the PDD is removed and recorded as 'NA'. (NB. If the patient's admission is for symptom control rather than end of life care then an PDD continues to be required, to ensure the patient is supported to reach their preferred place to die, beyond this hospital admission).
8.	A PDD is not changed to meet the requirements of services to achieve the patients exit from the trust e.g. limited therapy capacity (internal) PoC/Care Home not available (external).
9.	A key element in delivering the patients discharge plan is to be clear when an action continues not to be met, and as a team there is agreement that all obvious avenues have been exhausted. The concern/issue must be escalated at the daily IDS '1015hrs PTL' in order to find resolution and achieve a safe and timely discharge for the patient.
10.	When the patient is fit to be discharged and is delayed by the services required to support the patients discharge the PDD must not be changed but the difference in time from the predicted date to actual discharge is recorded as a delay and described on the white board as the DTOC delay, as identified in the DTOC categories.

Standard agreed: March 2019
Audit due: TBC
Audit start date: TBC
Responsibility:

North West Anglia NHS Foundation Trust

3. HINCHINGBROOKE – Discharge Bundle

Guidance: Does the patient require a referral for discharge support?

(To be used with the Standard for Communicate Adult Social Care Assessment is required))

Aim: is to provide a screening process to determine if the patient requires a referral for support on discharge, supported by the MDT decision regarding the discharge pathway the patient is suggested to be referred to.

No	Guidance – Social Care/Reablement/ICT
1	Use these questions to assist in determining if a patient is likely to require assistance at home on discharge, which would then require an Assessment Notification (known at Hinchingbrooke Hospital as an RDS)/Discharge Notification (known at Hinchingbrooke Hospital as a CDS) to be completed at the appropriate times.
2	If one of the following questions are answered as indicated it would be appropriate to consider a referral for support on discharge: • Has the patient had discharge support before? YES (If yes – is there evidence of not meeting their needs?) • Has the patient suffered a recent possible major change in function, eg stroke? YES • Does the patient lack capacity? YES • Has the patient had multiple admissions to hospital with associated decline in function? YES
3	If support for discharge is indicated, as above, it is then necessary to gain the patients consent in order to make the referral, thereby asking the patient if they require support on discharge.
4.	The discharge referral is made via completion of an AN, expected to be completed by 72hrs of the patients inpatient admission. • Ensure when completing the AN that it reflects the Welcome Meeting dialogue and completed as fully as possible to ensure adequate triage by the Integrated Discharge Team • The ward nurse; therapist or Discharge Assistant is expected to complete the AN to ensure it meets timescales of referral to the IDS
5.	The patient's DN is expected to be completed as soon as there is a medical/therapy plan in place with a reasonably stable PDD identified by the MDT at the wards daily Board Meeting. • The ward nurse; therapist or Discharge Assistant is expected to complete the AN to ensure meets timescales of referral to the IDS • The **minimal** acceptable timescale for a DN referral is 24hrs prior to the patients PDD; preferably this should be at least 72 hours • If there are any changes to the patient's condition or PDD the DN must be updated in order to inform the relevant IDS supporting the patients discharge, to secure the best possible outcome for the patient.
6.	The expectation is for the decision about the patient's most appropriate pathway for discharge to be made at the daily Board Meeting by the MDT. • The patients DN is completed reflecting this decision and forwarded to Discharge Team mailbox for triage and forwarding to the relevant system partner for action.

No	Guidance – Health
1.	Use these questions to assist in determining if a patient is likely to require assistance at home on discharge, which would then require a Care Needs Test (CNT) to be completed by a Discharge Pathway Specialist Nurse from CPFT and Social Worker as a joint assessment.
2.	The criteria for a patient to be a **'consideration'** for CNT is as follows: • Does the patient have any health needs? • Does the patient have any registered nursing needs? • Does the patient have a terminal diagnosis that may require a Fast-Track assessment?
3.	An answer of **'NO'** to all the questions asked in point 2 is concluding: 'A consideration for CHC has taken place by the MDT but CNT is not deemed appropriate at this time.'

	This conclusion with rationale must be recorded formally in the patient's documentation and on the Assessment Notification, if required.
4.	An answer of **'Yes'** to any one of the questions asked in point 2 is indicating the patient may be eligible for Continuing Health Care support and requires the completion of a Care Needs Test.
5.	The completion of the Care Needs Test is expected 48 hours of the request being made. The outcome of the assessment will determine if the patient requires • 'Health' support which will be forwarded to Continuing Health Care for further verification which will be managed by the DPSN from CPFT • 'Social' support which will be taken forward by the Social Worker.
6.	The Discharge Team will monitor the progress of the decision taken through the PTL at 1015hrs meeting. The wards will be informed of the Care Needs Test outcome and then further progress by the forwarded action tracker via email from the Discharge and Capacity Coordinator, following the daily PTL meeting.

Standard agreed: March 2019
Audit due: TBC
Audit start date: TBC
Responsibility:

North West Anglia NHS Foundation Trust

4. HINCHINGBROOKE – Discharge Bundle

Standard: Welcome Meeting (Completion of an Assessment Notification)

Aim: is every patient and appropriate family/carers will take part in the Welcome Meeting dialogue to establish expectations and commitment to the process of discharge planning to achieve a timely discharge.

No	Standard
1	All patients admitted to the ward must have a welcome meeting with one or more members of the MDT team. The 'Welcome Meeting' dialogue is included in the body of the Assessment Notification (RDS) for those patients who agree to consider additional support from social care or community services.
2	This meeting is expected to be undertaken within the first 48 hours, but must be within the first 72 hours of the patient's admission.
3	Welcome meetings should be face to face but may be undertaken by telephone should the relevant carers/relatives not be able to attend the ward.
4	The expectation is that the Welcome meeting lasts up to 30 minutes.
5	Timings of the Welcome meeting should be agreed between the staff and the family/carer
6	Informed consent to be gained from patient where possible or documented if meeting held in patients best interest.
7	The prompt sheet should be used to guide the format of the meeting and the standardised documentation completed and signed by the staff member
8	Patient Discharge Information Leaflet 'Leaving Hospital' will be given at the meeting and discussed as appropriate.
9	'Forget-Me-Not' scheme information must be available should this be appropriate.
10	Estimated Discharge Date (EDD) must be established prior to the meeting. This should be discussed at the meeting, the possible reasons why it would change dependent on clinical need and where it will be documented in the patient's bed area.

Standard agreed: March 2019
Audit due: TBC
Audit start date: TBC
Responsibility:

ASSESSMENT FOR DISCHARGE SUPPORT

Social Service Referral Requires 72 Hours' Notice
Assessment Notification Given Under Paragraph 2 (1) (b) of schedule 3 of the Care Act
SHARE with patient - Patient Discharge Information Leaflet 'Leaving Hospital'

'WELCOME' information is gained from both patient and appropriate family/carer
HIGHLIGHT/DELETE WHERE APPROPRIATE:

PATIENT CONSENTS TO REFERAL	MAIN CARER AWARE	PATIENT BEST INTEREST

PATIENT DETAILS

NHS NO:		PMI:		DOB:	
FIRST NAME:		SURNAME:			
ADDRESS:					
POSTCODE:	TEL:	POSTCODE:	TEL:		
MARITIAL STATUS: WIDOWED	RELIGION: CHURCH OF ENGLAND	ETHNICITY: BRITISH			
INTERPRETER REQ:		LANGUAGE SPOKEN:			
FIRST CONTACT:		CONTACT TEL:			
CONTACT RELATIONSHIP:		LASTING POWER OF ATTORNEY Is there a registered POA? If yes need to view original docs (POA can be in place if patient has capacity)			
IS PATIENT A CARER Is Attendance Allowance in place, if not signpost to Benefits agency		ADDITIONAL INFO: Which Agency is used? Frequency of visits? Any indications an increase of visits is required?			

ADMISSION DETAILS:

DATE OF ADMISSION:		WARD:		TEL:	
REASON FOR ADMISSION:					
CONSULTANT:					

SUMMARY OF RELEVANT PAST MEDICAL HISTORY:

- Where patient fell / how many falls in last year?

NAME OF REFERRER		JOB TITLE:	
DATE		TIME	

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NAME		**SURNAME**		**DOB**		**PMI**	
END OF LIFE CARE			**PREFERED PLACE OF CARE**				
WASHING AND DRESSING:							
MOBILITY AND TRANSFER STATUS							
MOBILITY AIDS			**TRANSFER AIDS**				
COMMUNICATION / VISUAL (INCLUDE ANY DIFFICULTIES):							
WATERLOW		**SAFEGUARDING**		**DEMENTIA**			
WANDERING		**REQUIRED 1:1**		**UNDER MH?**			
CONTINENCE/URINARY/FAECAL:							
CATHETER		**LONG TERM / DATE CHANGE /REMOVAL**					
NUTRITION SCORE		**FEEDING/DRINKING**					
MEDICATION (REFER TO CURRENT DRUG CHART):							
ABLE TO SELF MEDICATE			**BLISTER PACK**				
EQUIPMENT NEEDED: • What equipment is being used at home? • Is the equipment from hospital or privately purchased? • Is any equipment unused or broken at home?							
EQUIPMENT ORDER DATE			**EQUIPMENT DELIVERY DATE**				
THERAPY SUMMARY (INCLUDING GOALS AND CURRENT INTERVENTION):							
PREVIOUS SUPPORT / SERVICE AND SOCIAL HISTORY: (Including informal care/personal care/meal prep/cleaning) Any concerns prior to admission • Can carer still cope? Is Carer Assessment required? • Do neighbours provide informal care? Can this continue? • Is early signposting to Care Network / GP carer support groups required • Household issues – eg boiler broken, new carpet required, house in poor environmental repair • Sensitive discussion about what really brought patient into hospital. • Have other services been involved? Eg proactive care, responsive services							
ACCESS TO PROPERTY: Who has the house keys?			**KEY SAFE CODE NEEDED:**				
REASON FOR SUPPORT REQUEST (Restart/short term/interim/inpatient rehab) • Plan of rehabilitation – sensitive discussion re. Functional rehabilitation not needing to be therapist led – eg. Walking to dining room etc. • Realistic expectation discussion (especially if acute have not been accurate in transfer details.) • Can patient realistically return home? Have alternative plans already been discussed elsewhere?							
CHC CHECKLIST							
PATIENT PDD Reasons for setting PDD explained			**PATIENT IS MFFD AND COULD BE DISCHARGED PRIOR TO PDD**				
NAME OF REFERRER			**JOB TITLE**				

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5. HINCHINGBROOKE – Discharge Bundle

Standard: Is this a value added day or not to the patients progress? (Red/Green Days)

(To be used with standard for Daily Board Meeting/ Managing Escalation of Patient Flow Issues)

Aim: is to use this quick visual aid to demonstrate the 'stranded' patients in the system, requiring additional intervention/escalation to unblock the problems holding the patients progress back.

"Red events stop Green events from proceeding"

No	Standard
1.	Definition of a **GREEN** event is: 'When the patient has received an intervention that supports their journey through to discharges equating to a positive experience for the patient.'
2.	Examples of green events are: • Formal review by the clinical team, with clinical management plan being devised. • Therapy assessment or intervention • A diagnostic intervention that supports the progress of the patient through their episode of care • Continuation of planned treatment. Planned discharge events, (eg POC, placement, delivery and installation of equipment, family activity) dovetail to meet the patients predicted PDD or earlier, as appropriate.
3.	Definition of a **RED** event is: 'When a patient does not receive an intervention to support their pathway of care through to discharge'.
4	Examples of red events are: • A planned diagnostic is not undertaken as requested or there is a wait for the diagnostic. • Planned therapy intervention does not occur, e.g. lack of staff, OPA. • Medical management plan is not reflecting the present needs of the patient • Waiting input from a clinical speciality. • Awaiting review or input from a supporting team. • Awaiting the availability of POC/Placement • Awaiting the progress and conclusion of assessment for Adult Social Services/CHC • Awaiting the delivery and installation of equipment • Awaiting family decision/action. *Please note this list is not exhaustive.*
5.	At the daily Board Meeting the MDT consider if the patients anticipated planned actions and interventions, are expected to be adding value to the patient's progression to meet their PDD, on that given day.
6.	The outcome of point 5 consideration will determine if the patient is a 'red' or 'green' day and will be indicated on the ward Board as such, by magnetic dot or drawing a dot.
7.	The patient who is considered in a red event will require escalation, as appropriate for the division.

Standard agreed: March 2019
Audit due: TBC
Audit start date: TBC
Responsibility:

6. HINCHINGBROOKE – Discharge Bundle

Specification for the Leadership Team attending the ward as a 'Ward Sponsor' role

(To be used with Standard for Daily Board Meetings).

Aim: To promote engagement regarding patient flow processes between ward clinical staff and Leadership Team, being matrons, service managers etc.

The Leadership Team will take an active involvement in understanding the patient flow blockages on the ward and share the responsibility with the Ward Manager in finding solutions.
The Leadership Team will share the responsibility with the Ward Manager to escalate patient flow blockages hindering patient discharge to the appropriate person/level.

Behaviour:

- Be an exemplar of the principles set out in the standards document:
  - Supportive challenge
  - Spirit of open inquiry
  - Support the team to be intolerant of delay (but not each other!)
  - Champion the needs and best interests of patients
  - Be reliable and predictable
  - Don't look for blame or scapegoats, look for facts

Role of the Ward Sponsor.

- Build a relationship with the named ward's Ward Manager, by taking a responsibility in knowing the challenges the Ward Manager is facing in delivering timely discharge.
- Attend the ward daily and the ward Board Meeting at least twice a week supported by contact with the Ward Manager throughout the week.
- The Ward Sponsor supports the process of escalation of unresolved patient flow issues/delays, expected at the daily Discharge Team meeting at 1015hrs and relevant Bed Meetings in the Ops Centre.

Support matrix:

Ward	Sponsor
Bay	*Insert name*
Plum	
MSSU	
Cherry	
Birch	
Walnut	
Apple	
Pear	

Standard agreed: March 2019
Audit due: TBC
Audit start date: TBC
Responsibility:

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7. HINCHINGBROOKE – Discharge Bundle

Standard: Process where Discharge Team manage daily Patient Flow

Aim: describe the flow of information in establishing the actual and potential bed state and flow issues throughout the day.

No	Standard – Discharge Assistants (DA)
1.	**0800-0930hrs** the DA assess each wards position of patient flow and readiness of the days discharges. This is done by: • Collecting a ward handover sheet • Checking if yesterdays expected discharges actually happened, particularly if ECAMIS is suspected not to have been updated • Checking admission of any new patients on to the ward • Review the wards white board information for PDD's and if AN/DN's are required • Engage with the Nurse-in-Charge (NIC) of the ward The outcome being to inform the NIC of outstanding patient flow actions such as AN & DN for completion, recorded therapy dialogue required etc to complete system paperwork.
2.	New Patient Admissions Report (of over 65yrs) The DA will receive this report into the Discharge Team Mailbox every weekday, • The aim being to target these patients to determine discharge care requirements within 72hrs of admission (see Standard 4: Welcome Meetings). • Identify the patients who have come from a residential or care home and inform, via email, the hospitals Trusted Assessor. DA will check each new patients address via ECAMIS to determine if appropriate for the Trusted Assessor.
3.	**0930-1000hrs** the DA huddle with discharge team lead to feedback their respective wards patient flow position (as above) and any outstanding issues or concerns.
4.	Discharge team lead uses the gained ward patient flow intelligence to support the preparation of the 'Patient Tracker List' (PTL) for the system partners meeting at 1015hrs.
5.	**1000-1500hrs** the DA prioritise the outstanding actions gleaned earlier in the day and outstanding actions from the PTL meeting, as follows: • Prioritise DN's related to PDD's/MFFD position and complete as early as possible • Meet new patients and complete Welcome Meeting/AN as appropriate
6.	Patient Flow Coordinators as link to the Neighbourhood Teams • St Neots & Huntingdon: Le-Ena Margree contact 07854 982108 / 01480 223458 • St Ives: Elaine Lewis contact 07817 615887 / 01480 328016 • March: Sue Spenser contact 07854 705194 / 01945 498757 DA to contact the relevant Patient Flow Coordinator for all newly admitted patients to aid the dialogue to determine the patients requirements on discharge (see Standard 4: Welcome Meetings).
7.	**1500hrs** CoP Huddle the DA support the feedback of actions taken to update the patient flow progress

No	**Standard – Integrated Discharge System: Patient Tracker List (PTL) meeting @ 1015hrs (**see Terms of Reference**)**
1	To oversee the discharge action progress for patients on pathways 1-3. Identifying barriers to timely discharge in line with patients PDD. Providing the opportunity to solution out of hospital support for patients with multi factor/ agency needs.
2	The group is responsible for: Assuring patients are on the correct discharge pathway, minimising handoffs between agencies and assessments. • Minimising length of stay and discharge after the PDD. • Each organisation will attend the meeting prepared with an update that has definitive timescales for discharge progress. • Managing escalation of discharge delays beyond their control in line with the agreed

	escalation levels and timescale tolerance.
3.	In order to gain clarity on the most up to date position of those patients waiting for CPFT pathway 2 (Interim Health Beds, Rehab beds) the PTL chair ensures CPFT Community Hub is contacted and updates PTL accordingly: • CPFT Community Hub 01223 219530
4.	Post meeting the lead Discharge Nurse completes the action tracker to be distributed to each ward by the Discharge and Capacity Coordinator
5.	The PTL action tracker is printed off by each ward to inform the daily ward board meeting and actions for the ward to progress discharges
6.	Escalations in line with the escalation grid are recorded on the master PTL by the Discharge and Capacity Coordinator

No	**Standard – Patient Tracker List (PTL) Huddle @ 1500hrs**
1	To oversee the discharge action progress for patients on pathways 1-3. Identifying barriers to timely discharge in line with patients PDD. Providing the opportunity to solution out of hospital support for patients with multi factor/ agency needs.
2	The huddle is responsible for: • Ensuring progress updates or issues are conveyed in person by all IDS partners ensuring clarity of discharge progress • Barriers to discharge progress to be managed by the lead discharge nurse and escalated to the Deputy COO as is required

Standard agreed: March 2019
Audit due: TBC
Audit start date: TBC
Responsibility:

North West Anglia NHS Foundation Trust

Terms of Reference
Integrated Discharge Service (IDS): Patient Tracker List Meeting

Purpose	To oversee care planning and provide accountability regarding the management of Complex patients (those patients with a AN/DN in place and Delayed Transfer of Care (DTOC) patients.
Function	To ensure the effective and smooth running of the discharge process for DTOC's and complex discharges at PCH and HH - each organisation has a responsibility for less 5% occupied bed days attributable to DTOCs
Level of Authority	The group is accountable for: • Promoting collaborative integrated working • Removing obstacles to the IDS model's successful delivery, adoption and use • Decision making for DTOCs within each organisation with influence for exploration of alternative support services
Level of Financial Authority	None
Reports to	Organisation Leads, CCG transformation Lead
Status	This Terms of Reference is effective from12/11/2018 and continues until the end of December 2018, pending a formal review of the process.
Frequency and Duration	HH meetings will be held daily at 10.15 for a maximum of 30 minutes in the Discharge Team office, HH.
Minimum Required Attendance	Representation from four of the organisations
Chair	NWAFT IDS Lead
Deputy Chair	NWAFT Discharge Nurse
Minute-taker and Archive responsibility	NWAFT to ensure daily list / log sent prior to each meeting. Each organisation responsible for updating own actions and identifying/escalating complex patients with unclear pathways, blocks to discharge etc.
Risk Responsibility	Associated with NWAFT High Risk – to reduce number of DTOC's, assessment commences at earliest opportunity

Procedural Responsibility	N/A
Standing Agenda Items	Discussion of barriers affecting discharge planning / timely discharge of patients. Agreed remedial action Cross boundary working (where appropriate)
Quorum	Representative from NWAFT and three other organisations
Standards	The membership of the advisory group will commit to: • Role modelling the IDS behaviours • Validated patient level data circulated to all participants at least 30 minutes in advance • Sharing all communications and information across all group members • Making timely decisions and taking action so as to continuously improve the service • Attending all meetings and if necessary nominate a representative/deputy
Membership	Member of following organisations (with influence to change practice): NWAFT – HH representative CPFT Cambridgeshire City Council (Social Services) C&P CCG Transformation Team representative

Standard agreed: March 2019
Audit due: TBC
Audit start date: TBC
Responsibility:

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8. HINCHINGBROOKE – Discharge Bundle

Guidance: Managing Escalation of Patient Flow Issues.

Aim: The principle of escalation in the IDS Meeting is regarding any patient who is waiting for any action which is going to take over 48hrs to meet or is without resolution, thereby impinging on the patient meeting a timely discharge

Delay	**ISSUE**	**1st Level of Escalation**	**2nd Level of Escalation**	**3rd Level of Escalation**	**4th Level of Escalation**
Escalation timescale	**If no progress in resolving the issue raise IDS Escalation at meeting no later than day 2**	**If the plan not progressing at day 3 escalate to 2nd level**	**If the plan not progressing at day 4 escalate to 3rd level**	**If the plan not progressing at day 5 escalate to 4th level**	**If the plan still not progressing at day 6 highest level of escalation initiated**
External **CPFT**	Availability of Pathway 1 - ICT Pathway 2 - Health Interim Beds - Rehab beds	Raised via IDS Escalation meeting dealt with by IDS chair to: Vanessa Bunn ICT & D/C Planning TL 01480 416003 07970 707190 vanessa.bunn@cpft.nhs.uk vanessa.bunn@nhs.net Community Hub 01223 219530	Raised by Julie Stokes, D/C Planning Nurse to: Nicky Brady Ops Manager Intermediate Care (N) 07967 773257 nicola.brady@cpft.nhs.uk nbrady@nhs.net Katie Wilson Operational Clinical Manager Community Hub 07967 773536 katie.wilson@cpft.nhs.uk katiewilson2@nhs.net	Raised by Mary Donaldson, Discharge Planning Manager to: Diana Baird Deputy Manager Unplanned Care 07790 572434 01223 219400 diana.baird@cpft.nhs.uk alternatively Mark Cooke Countywide Manager Unplanned Care 07773 073990 mark.cooke@cpft.nhs.uk	Raised by Nicky Leighton-Davis, Deputy COO to: John Martin ADO 07970 679165 John.martin@cpft.nhs.uk

External **Local Authority - Huntingdon**	POC Placement Interim beds Reablement delays	Raised via IDS Escalation meeting dealt with by IDS chair to: Grace Clark Team Manager LA 01480 416087 07770 934679 graceE.clark@cambridgeshire.gov.uk grace.clarke5@nhs.net	Raised by Julie Stokes D/C Planning Nurse to: Jane Fowler Service Manager for Discharge Planning Teams LA 01480 372411 / 07468 766370 jane.fowler@cambridgeshire.gov.uk Reablement Lucy Davies Service Manager Reablement Service- North Prevention and Early Intervention Services 07768 822939 Lucy.davies@cambridgeshire.gov.uk	Raised by Mary Donaldson Discharge Planning Manager to: Carol Bargewell Head of Service CCC/PCC Transfers of Care 01223 706145 / 07917 091105 carol.bargewell@cambridgeshire.gov.uk Reablement Vicky Main Head of Prevention & Early Intervention 07557 800663 vicky.main@cambridgeshire.gov.uk	Raised by Nicky Leighton-Davis, Deputy COO to: Debbie McQuade AD ASC PCC/CCC Debbie.mcquade@cambridgeshire.gov.uk
External **C&P CCG**	POC/Placement/Interim beds	Raised via IDS Escalation meeting dealt with by IDS chair to: Duty Nurse Case Management Team 01223 725429	Raised by Julie Stokes D/C Planning Nurse to: Team Lead Case Management 01223 725429	Raised by Mary Donaldson Discharge Planning Manager to: Senior Management Team (Xolie Ncube /Lyndsay Codd/ Cathy Barresi) 01223 725429	Raised by Raised by Nicky Leighton-Davis, Deputy COO to: Mandy Staples Head of Clinical Services CHC 07773 951287 Mental Health (CHC) Linda Chibuzor Ass Dir of Complex Cases 01223 725429/725335
External	Availability of Equipment essential for discharge CPFT Nurses – beds & mattresses	Raised via IDS Escalation meeting dealt with by IDS chair to: Vanessa Bunn ICT & D/C Planning TL 01480 416003 07970 707190 vanessa.bunn@cpft.nhs.uk vanessa.bunn@nhs.net	Raised by Julie Stokes D/C Planning Nurse to: Nicky Brady Ops Manager Intermediate Care (N) 07967 773257 nicola.brady@cpft.nhs.uk	Raised by Mary Donaldson Discharge Planning Manager to: Diana Baird Deputy Manager Unplanned Care 07790572434/01223219400 diana.baird@cpft.nhs.uk	Raised by Raised by Nicky Leighton-Davis, Deputy COO to: John Martin ADO 07970 679165 John.martin@cpft.nhs.uk

	NWAF Therapists – other eq.	Team Leader of the given area Rebecca Murphy (Medicine) Cara Burgess (Stroke/Neuro) Andrea Linnell (Ortho)	Julie Flint Inpatient Therapy Team Manager 07876 588912 Julieflint@nhs.net	Susan Bentley Head of Therapies 01733 673672 Susan.bentley3@nhs.net	
External CPFT	Access to Psychiatrists Psychiatrists available 9-5 M-F	Raised via IDS Escalation meeting dealt with by IDS chair to: Psychiatric Liaison (Hinchingbrooke) Angus.brown@cpft.nhs.uk Susan.green@cpft.nhs.uk Mohammad.malkera@cpft.nhs.uk	Raised by Julie Stokes D/C Planning Nurse to: Peter Williamson Team Manager Peter.williamson@cpft.nhs.uk	Raised by Mary Donaldson Discharge Planning Manager to: Gwen Hughes Service Manager LPS Gwen.hughes@cpft.nhs.uk	Raised by Raised by Nicky Leighton-Davis, Deputy COO to: Colette Turner ADO 07976 434980 Colette.turner@cpft.nhs.uk
External	Bedfordshire ICT / Health Interim / Rehab services	Raised via IDS Escalation meeting dealt with by IDS chair to: One Call 03456 024064	Raised by Julie Stokes D/C Planning Nurse to Debbie Martin ?? Tel ? Debbie.martin@nhs.net	??	??
External	Bedfordshire Social Care	Raised via IDS Escalation meeting dealt with by IDS chair to Bedford Discharge Team 01234 792305	??	??	??
External	Bedfordshire CHC	Raised via IDS Escalation meeting dealt with by IDS chair to CHC team 01525 864430 / 624300	??	??	??
Internal Bed meetings 0845hrs 1300hrs 1530hrs	Services from within Hinchingbrooke Hospital ie. OPA/lack of medical report etc. NB dealt with on the given day	Raised via IDS Escalation meeting dealt with by IDS chair to: Site Manager Bleep 1140	Raised by Julie Stokes D/C Planning Nurse to: Senior Manager on Call (SMOC) via switchboard 01480 416416	Raised by Mary Donaldson Discharge Planning Manager to Nicky Leighton-Davis, Deputy COO working hrs M-F/ Director on Call (DOC) after 5pm via switchboard 01480 416416	

External	Admission of a patient on 'Functional' pathway – STRANDED patient.	Raised via IDS Escalation meeting by ward rep/WM dealt with by IDS Chair escalating to level 3	NA	Raised by Mary Donaldson Discharge Planning Manager to appropriate agency responsible for the 'STRANDED' patient position.	Raised by Raised by Nicky Leighton-Davis, Deputy COO to appropriate agency responsible for the 'STRANDED' patient position

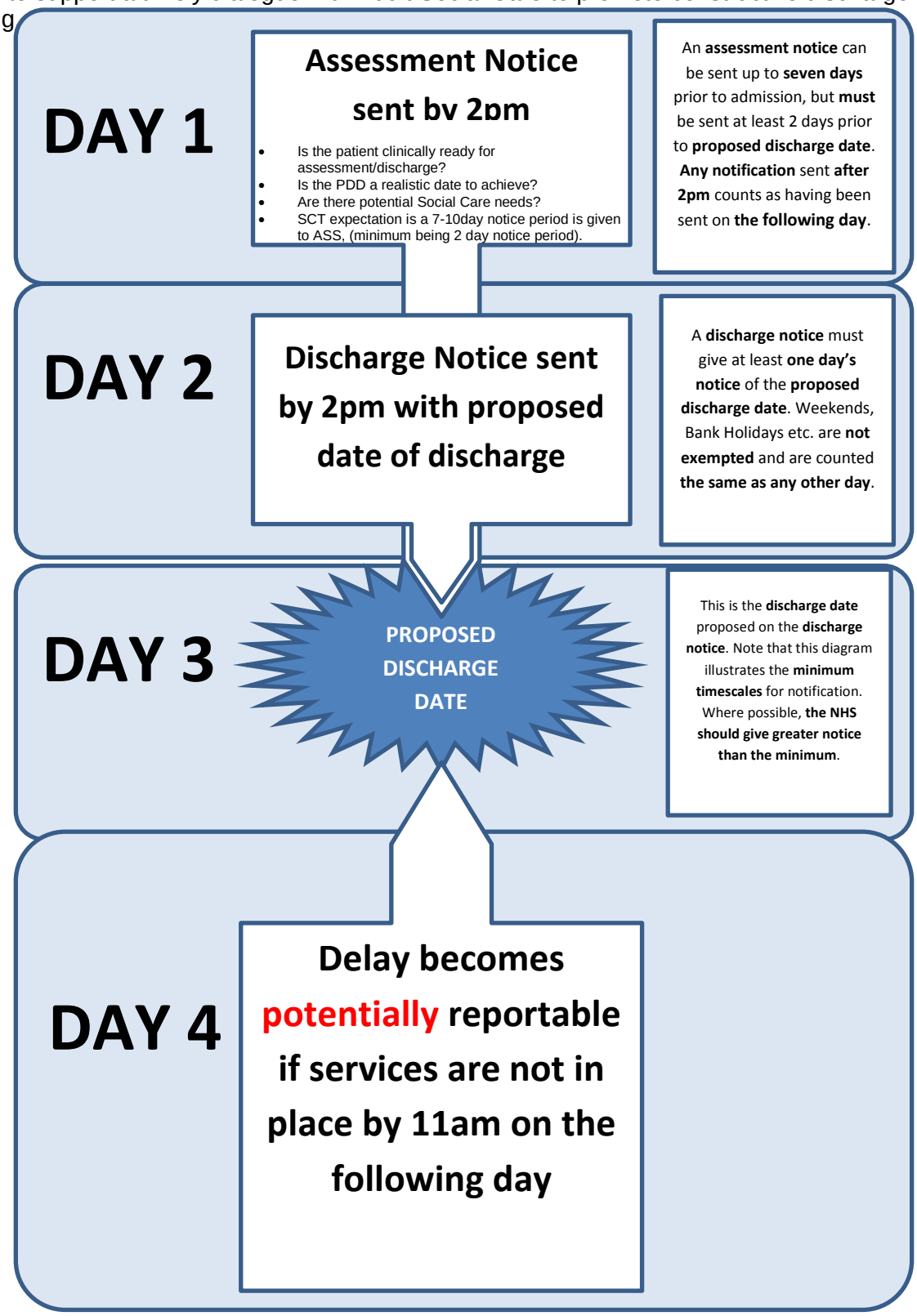
North West Anglia NHS Foundation Trust

9. HINCHINGBROOKE – Discharge Bundle

Standard: Communicate Adult Social Care Assessment (ASC) is required

(To be used with Standard for Daily Board Meeting)

Aim: is to support a timely dialogue with Adult Social Care to promote constructive discharge planning



Standard agreed: March 2019
Audit due: TBC
Audit start date: TBC
Responsibility:

North West Anglia NHS Foundation Trust

10. HINCHINGBROOKE – Discharge Bundle

Standard: MDT Meetings

(To be used with Professional Standards for MDT Roles in Enabling Timely Discharge (SAFER)

Aim: is to support timely and appropriate dialogue and discharge planning to meet the patients 'Predicted Date of Discharge'

No	Standard
1	All discharge planning should be in line with best practice "Ready to go" (DH 2010).
2	All disciplines should regularly participate in the MDT. The core group must include the ward nurse, OT's, Physiotherapists, Social Worker.
3	MDT meetings will happen once a week at an agreed set time, they must last no more that 60-90 minutes dependant on the units' size.
4	Each member of the team must be given time to speak and their input respected.
5	Staff must arrive and be prepared for the meeting to start at the agreed start time.
6	Each meeting will be chaired by a member of the core group agreed at the beginning of the meeting.
7	Staff must be prepared for the meeting and have good knowledge of the patients on their disciplines caseload. This includes progress against goals.
8	Staff must arrive and be prepared for the meeting to start at the agreed start time.
9	The meeting will discuss all patients. The chair will ask each member of the team to discuss progress making reference to the MDT guide.
10	Predicted discharge date must be reviewed and updated if appropriate.
11	Progress discussed and actions agreed must be documented during the meeting using the agreed process
12	The chair is responsible for agency actions that require escalation, who they will be escalated to and who is the most appropriate person to escalate. A record of this decision and the escalation must be made in the discharge planner.
13	Following the MDT meeting each area must ensure that patients receive feedback using the agreed process.
14	Agreement will be sort between health professionals and the Social Worker which patients are delayed discharges. The point in time delayed discharges are identified from is Thursday midnight each week on the agreed DTOC code representing the specific reason for the delay; this will be a conversation between the Discharge Team and system partners on Friday's PTL at 1015hrs, each week.

Standard agreed: March 2019
Audit due*:* TBC
Audit start date: TBC
Responsibility:

11. HINCHINGBROOKE - Discharge Bundle

Professional Standards for MDT Roles in Enabling Timely Discharge (SAFER)

(To be used with standard for MDT meetings)

Aim: to provide clarity to each members role in the process of the patients discharge planning

What are professional standards?	Professional standards are a set of standards agreed across professional groups that identify timely, optimum care for patients and for which each professional group will be held to account by both peers and by use of agreed key performance indicators. The use of professional standards is to ensure that patient flow is maintained; the SAFER bundle is working in practice and subsequently enabling a positive patient experience
Who are professional standards for?	Professional standards are for all professional groups actively involved in the management of patient pathways within community hospitals including: • Nursing staff • Physiotherapists • Occupational Therapists • Medical staff • Social services Other professionals may be involved in a patient's pathway. Standards will be developed over time for all professionals. Prior to any formal standards, there is an expectation that response times and outcomes from assessment / referral will be patient centred and will optimise the patient pathway and experience
How do we measure adherence to Professional Standards?	These standards should be read in conjunction with the agreed Standard Operating Procedures for the Discharge Bundle and the clinical pathways established for each clinical cohort Adherence will be monitored via the daily ward Board Rounds using Red/Green day methodology; MDT meetings and DTOC reporting. An escalation log will be kept to monitor barriers to discharge outside the ward team's control. All MDT records will be held centrally as a reference point at all times on the patient's progress and for reference during Board Rounds/ MDT meetings.

Professional Standards

Nursing

- Acute trust nursing staff will ensure that all relevant documentation and medication is sent with the patient when discharged.
- All patients will be fully assessed within 24 hours of admission where mental state and consciousness levels allow
- All patients will have the following assessments completed within 24 hours:
  - Falls Assessment
  - MUST score
  - Pressure Care Score
- A meeting with the family will take place within 72 hours of admission to discuss the planned patient pathway and discharge.
- All nursing plans and outcomes will be completed daily
- The Action Tracker, being the outcome from the daily PTL meeting and emailed from the Discharge and Capacity Coordinator, must be printed off and actions followed up as well as informing the MDT at the wards Board Meeting.
- Nursing staff will co-ordinate to ensure that all patients have a provisional date of discharge (PDD) within 24 hours of admission and an actual date of discharge within

3 days. This date will be communicated to the patient and their family where appropriate within 24 hours of a date being agreed
- All referrals to other services will be completed as per instructions and sent within 24 hours of decision to refer
- All contributions to Care Needs Test will be made within 48 hours of decision to refer
- All ward rounds and MDT's will be attended by a qualified member of nursing staff
- Discharge checklists will be completed at least 8 hours prior to discharge
- All transport and TTOs will be ordered at least 24 hours before discharge date and a.m. transport requested

Physiotherapist
- Appropriate new patients will have an initial assessment completed within one working day of admission as indicated at the wards Board Meeting.
- Appropriate patients will have a full assessment and completed treatment plan as indicated at the wards Board meeting.
- All contributions to discharge referrals and Care Needs Test assessments will be made within 24 hours of decision to refer
- All MDT's and daily board rounds/ huddles will be attended by a qualified member of physiotherapy staff
- All patients goal setting and treatment plans will be reviewed at least weekly

Occupational Therapist
- Appropriate new patients will have an initial assessment completed within one working day of admission as indicated at the wards Board Meeting.
- Appropriate patients will have a full assessment and completed treatment plan as indicated at the wards Board meeting.
- All contributions to discharge referrals and Care Needs Test assessments will be made within 24 hours of decision to refer
- All MDT's and daily board rounds/ huddles will be attended by a qualified member of Occupation Therapist staff
- All patients goal setting and treatment plans will be reviewed at least weekly
- Any equipment needed for a patients discharge will be ordered at least four days prior to discharge

Medical Staff
- All new patients will be medically clerked within one working day of admission.
- All patients will have a full treatment plan within one day of admission/ transfer
- Consultants and senior nursing staff should negotiate appropriate scheduling of ward rounds.
- Daily senior review should be conducted before 11am in the morning to facilitate timely completion of tasks during the working day.
- The Ward Rounds in Medicine *Principles for best practice* recommendations issued jointly by the RCP/RCN (Oct 2012) should be adopted with full MDT support
- Preparation for the ward round should include a pre-round briefing.
- The ward-round team should have prioritised access to IT facilities, patient notes and desk space, and also have a designated area to discuss patient care away from the bedside
- All contributions to discharge referrals and Care Needs Test assessments will be made within 48 hours of decision to refer
- All MDT's will be attended by a member of medical staff
- All TTO's will be written up two days prior to discharge date
- All discharge letters will be completed 24 hours prior to discharge
- All requests for new drug charts and/or new medications will be completed within 4 hours

Social Worker
- All referrals will be reviewed within 48 working hours of referral being received
- All patients, including self-funders will be provided with appropriate support and information as soon as the patients treatment plan indicates a need for placement
- Patients requiring/requesting an assessment will be completed within a timescales of 48 hours.

- All MDT's will be attended by a member of social work team
- All Care Needs Test assessments will be reviewed within 24 working hours of receipt
- All daily board rounds/ huddles will be attended by member of social services staff

Standard agreed: March 2019
Audit due: TBC
Audit start date: TBC
Responsibility:

North West Anglia NHS Foundation Trust

12. HINCHINGBROOKE – Discharge Bundle

Standard: Reporting DTOC ('stranded'/delayed) patient.

Aim: is to provide a systematic review of 'stranded' patients described as a DTOC reason with an aim to address trends from across health and social services together.

No	Standard
1	Definition of a person who is a 'delay' or 'DTOC' or 'stranded' patient means the patient has met their PDD and no longer is in need of the clinical teams' intervention but the services/arrangements required for the patient to be discharged are not in place.
2	The process of acknowledgement when a patient is likely to become 'stranded' is through the daily clinical routines of delivering the Daily Board Meeting (DBM), discussing the patients PDD and weekly MDT.
3	If the patient becomes a delay the patient will be monitored by the Discharge Team with system partners via daily PTL meeting.
4	The Discharge Team will ensure Thursday midday the DTOC report is produced and sent to the respective system partners being Adult Social Care (ASC) and CPFT Managers. This report is discussed on Friday morning at 1000hrs validation, reflecting Thursday midnight delays. NB. Those patients who meet their PDD on Thursday and are -1 day after their PDD on Friday are not validated as a delay on Friday as were not a delay at midnight on Thursday. A patient who is at '0' days is not a delay and must not be DTOC coded as a delay. Any patient not over their PDD MUST NOT be coded with a DTOC code as they are not a delay.
5	The DTOC validation process is conducted together as a system, seeking agreement of the respective delay code.
6	Following the validation process the Discharge and Capacity Coordinator shares with report with the system. This recording is to be completed on Friday, the latest by the close of the following Monday, but this will require each following days DTOC information to be changed as well from Friday to Monday at the latest.
7	Performance: Report the total DTOC for the week in a weekly dashboard by ward and division. Performance: Report a snapshot of the total DTOC position the last Thursday of the month at midnight to the Department of Health, is a statuary requirement.

Standard agreed: March 2019
Audit due*:* TBC
Audit start date: TBC
Responsibility:

North West Anglia NHS Foundation Trust

Work in progress

Developing a referral process for ICT Pathway 1 and 2 a step towards 'home first' discharges

Referral form for
Intermediate Care Pat