

A manager's guide to criteria-led discharge

October 2019



Introduction

As NHS staff, we strive to provide the most efficient and high-quality care possible for our patients. The discharge process is key to this, aiming to get patients home as soon as is safe and appropriate for them, and opening up beds for those who need them next. Criteria-led discharge (CLD) is an effective solution which reduces length of stay and empowers staff and patients.

This guide to CLD supports managers to implement, sustain and spread CLD, as well as providing context and evidence around the process.

It draws on the work of our CLD collaborative which saw participating trusts going through the process of implementing CLD, celebrating their successes and watching them find effective solutions to barriers.

What is criteria-led discharge?

CLD is a process that empowers a competent member of the multidisciplinary team (MDT) (eg junior doctor, registered nurse, therapist) to discharge a patient when they meet pre-agreed clinical criteria for discharge (CCD). This removes the need for the patient to wait for the lead clinician (eg consultant) to approve discharge.

The lead clinician identifies the CCD; these criteria may be standardised for particular procedures or conditions, but they must also always be adapted and individualised to meet the needs of each patient. The CCD are discussed with the patient and MDT, and used to identify the expected date of discharge (EDD), all of which is clearly recorded in the patient's notes. If there are no complications or concerns, a competent member of the MDT discharges the patient when the CCD are met.

Patients should be actively involved in discussions throughout the whole process, with a clear understanding of their own CCD and EDD.

You may have heard this process called nurse or therapist led discharge. The key to CLD is focusing on the patient, not the professional conducting the discharge.

Criteria-led discharge and the NHS Long Term Plan

Chapter 1 of the [NHS Long Term Plan](#) “sets out how the NHS will move to a new service model in which patients get more options, better support, and properly joined-up care at the right time in the optimal care setting”.

The plan talks of the need to ease pressure on emergency departments by increasing ‘same day emergency care’, in which acute admissions are discharged on day of attendance. It also acknowledges the need for “further action to cut delayed hospital discharges [to] help free up pressure on hospital beds”.

CLD can be used in acute, mental health, community and specialist settings for both emergency and elective admissions. Effective implementation and use will have a direct positive impact on the above aims and can reduce length of stay, presenting the opportunity to improve flow and reduce emergency and elective wait times.

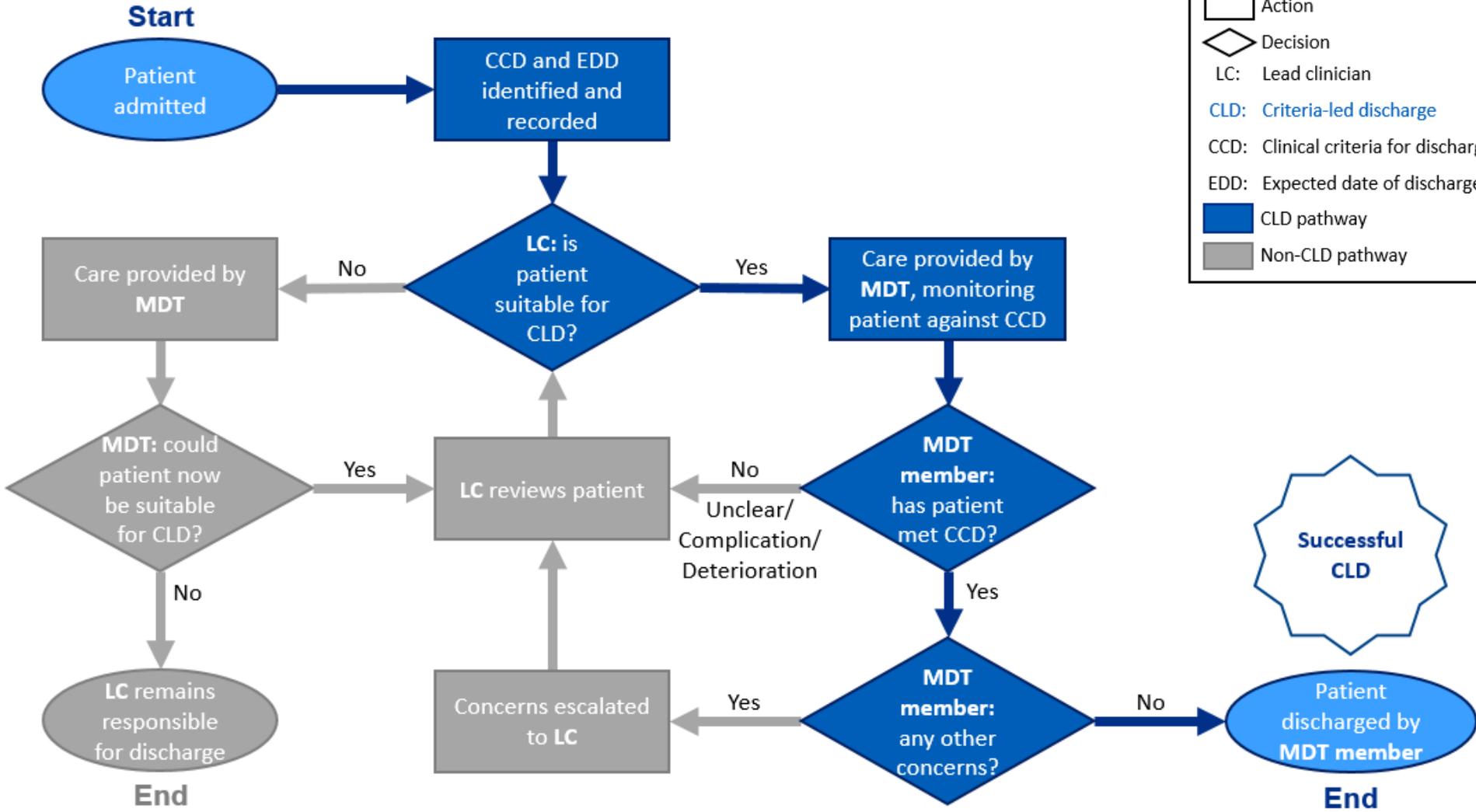
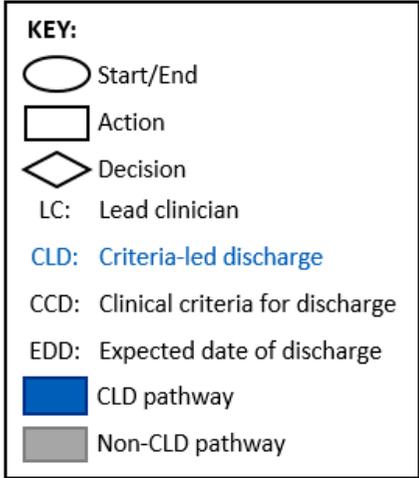
The benefits

The [evidence](#) demonstrates that CLD results in:

- reduced length of stay in surgical, paediatric and medical settings
- reduced practice variability for children admitted with bronchiolitis
- reduced discharge delays for elective otolaryngology patients by 41%
- increased pre-9am discharges for elective surgery patients by 28%
- no increase in complications, readmissions or contact with primary care
- no reduction in patient satisfaction
- increase in staff satisfaction.

Pilot areas for CLD have also experienced increased weekend discharges, resulting in a more even spread of discharges throughout the week.

The CLD process



- The 'MDT member' included in the CLD flow chart could be a junior doctor, nurse, therapist or other health professional, as long as they are competent and confident in patient assessment and the CLD process.
- The patient's CCD and EDD should be set as early as possible: immediately for electives and as soon as is practical for emergency admissions.
- It may be appropriate for members of the MDT to identify and propose possible CLD candidates for the lead clinician to review on the ward round.
- Complications and concerns regarding CLD patients should always be escalated to the lead clinician who will then reassess the patient's suitability for CLD.
- Patients not initially identified for CLD should be observed to monitor whether changes to their condition make them suitable later.
- The lead clinician always retains responsibility for patients. This responsibility does not transfer to the MDT member conducting the patients' discharge. There must be a clear process for escalating concerns and handing back to the lead clinician.

Settings and pathways

CLD is not restricted to use in certain settings; it is appropriate and effective in acute, mental health, community and specialist areas, for emergency and elective patients, and in both medicine and surgery.

The following are examples of pathways that have successfully implemented CLD:

- community liaison mental health
- elective spinal surgery
- elective trauma & orthopaedics
- frailty
- general medicine
- gynaecology
- midwifery
- oncology
- re-enablement
- renal
- respiratory
- short-stay surgery
- vascular

Implementing criteria-led discharge

Criteria-led discharge and the SAFER patient flow bundle

Many trusts use the [SAFER Patient Flow Bundle](#) to reduce delays for patients in adult inpatient wards. It blends five elements of best practice and can be tailored to local circumstances, supporting engagement and continuous improvement.

The five elements of the SAFER patient flow bundle are:

S – Senior review. All patients will have a senior review before midday by a clinician able to make management and discharge decisions.

A – All patients will have an expected discharge date and clinical criteria for discharge. This is set assuming ideal recovery and assuming no unnecessary waiting.

F – Flow of patients will commence at the earliest opportunity from assessment units to inpatient wards. Wards that routinely receive patients from assessment units will ensure the first patient arrives on the ward by 10 am.

E – Early discharge. 33% of patients will be discharged from base inpatient wards before midday.

R – Review. A systematic MDT review of patients with extended lengths of stay (>7 days – ‘stranded patients’) with a clear ‘home first’ mindset.

The A of SAFER requires all patients to have CDD and an EDD. Defining and clearly recording these in the patient’s notes enables a competent member of the MDT to conduct the patient’s discharge using CLD once CCD have been met.

It is planned to include CLD in the A of the next iteration of SAFER.

The facilitators

Consider the following in conjunction with our [10 steps to CLD](#) (online):

- **Organisational readiness:** The [NHS Sustainability Model](#) will identify areas to address to safeguard sustainability. This should be completed before, during and after the change process.
- **Policy/standard operating procedure:** A clear policy is crucial as it allows executives, managers, lead clinicians and staff conducting discharges to feel confident that the process is robust with clear lines of accountability. [Here is our guidance on writing a CLD policy.](#)
- **Staff engagement:** Involve staff who'll be conducting CLD from the very beginning of the project. Ownership of a task drives staff engagement up, and their knowledge will be invaluable in designing a process fit for their clinical area.
- **Patient involvement:** Ask patients what's important to them when designing the process and encourage lead clinicians to do the same when setting criteria for discharge. This will make patients' wishes known and increase two-way understanding. See page 9 of the [CLD policy guidance](#) for more information.
- **Key influencers:** Executive support can help to launch a project, remove barriers and spread and sustain change. Engage an executive sponsor and keep them informed of your progress. It's crucial to get lead clinicians on board, so make it clear what's in it for them and address any concerns.
- **Staff training:** Consider holding training sessions for staff who will be conducting CLD. This will increase confidence and help to reassure lead clinicians of staff competence, minimising the risk of delay or push-back. See page 9 of the [CLD policy guidance](#) document for more information.
- **Communication during implementation:** Keep all stakeholders informed of progress throughout the implementation process and be open to feedback throughout. This will give you the opportunity to assuage concerns as they arise and reduce pushback.
- **Communication as part of CLD:** CLD thrives in a truly multidisciplinary environment. Use regular MDT meetings to keep all relevant staff informed of patients' wishes, CCD and EDD. Also ensure that staff conducting CLD know and are comfortable with the procedure for escalating concerns about a patient's suitability for discharge.

Criteria-led discharge in practice: the sticker

Below is an example of a CLD 'sticker' to be included in a patient's notes. Although the format and design of the sticker can vary, it is important to include the items circled in this example from Leeds Teaching Hospitals:

Clearly identify the lead clinician responsible for the patient



Clinical Criteria for Discharge (CCD)

Patient's name: Hospital No:

Consultant:

Date CCD agreed:/...../..... Time::..... hrs

CCD completed by Dr (print name) Signature:

The patient will be clinically ready for discharge if the following criteria are met. If there has been no change to their condition, they can safely be discharged with no further medical review required:

1.
2.
3.

Follow up plan and any other comments:

If criteria are not met or results are outside agreed parameters, further medical review must be sought.

eDAN completed by (Print): Date:/...../..... Time::..... hrs	CCD met: Date:/...../..... Time::..... hrs Discharged by (assessing nurse name and signature):
--	--

Oncology CSU

Ensure staff understand when to seek further medical review

Document time of and MDT member conducting discharge for completeness and follow-up purposes

Using quality improvement to implement and sustain CLD

These quality improvement tools give structure to your change process:

- **SMART aim:** ensuring your aim is SMART (specific, measurable, achievable, relevant and time-bound) means you'll be able to monitor your progress more accurately and make adjustments when needed.
 - Which ward(s) are you going to implement CLD on and by when?
 - Are you aiming for a certain percentage increase in pre-10am discharges or discharges over the weekend?
- **Communications plan:**
 - How will you engage with staff and patients throughout implementation?
 - How are you going to spread word of the impact of CLD to other clinical areas and colleagues?
- **Baseline data:** before implementing CLD collect baseline data on key metrics, such as length of stay and time of discharge, to enable you to see whether your change has been an improvement later on.
- **Plan for sustainability:** complete the [NHS Sustainability Model](#) before, during and at the end of your change project to address potential barriers before they arise and safeguard sustainability. It will be helpful to ask a variety of people to fill this out, such as MDT members and your executive sponsor, to gain greater insight.
- **Process map:** take time to understand the current process to identify where it will need to change to facilitate CLD. The [flowchart](#) can act as a guide for your new process but you may want to adapt it for the clinical area in question. Use the [ACT Academy's guide](#).
- **Model for improvement:** can you answer the three questions from the [model for improvement](#)?
 - What are you trying to accomplish?
 - How will you know that a change is an improvement?
 - What changes can you make that will result in improvement?

- **Plan, do, study, act:** use PDSA cycles to try out tests of change. During a change process, there is a temptation to take action before properly studying the effects of an intervention and planning the next test. PDSA cycles ensure these steps aren't missed. Use the [ACT Academy's guide](#).
 - Examples of PDSA cycles when implementing CLD might be discussing CCD at board rounds, recording these criteria on the CLD sticker in the patient's notes, or the lead clinician initially shadowing MDT members discharging patients.
- **Measurement for improvement:** input your data into a statistical process control (SPC) chart to track your progress over time and clearly identify improvement. [This SPC tool](#) makes it easy. Use the [Making data count](#) guides to improve your understanding of SPC charts, their benefits and how to interpret them.

Useful resources

- [NHS Long Term Plan](#)
- [A systematic review on criteria-led discharge](#)
- [SAFER patient flow bundle](#)
- [NHS Sustainability Model](#)
- [Guidance for writing a criteria-led discharge policy](#)
- [Conventional process mapping](#)
- [Plan, do, study, act \(PDSA\) cycles and the model for improvement](#)
- [Statistical process control tool](#)
- [Making data count](#)

You can also go to NHS Improvement's [criteria-led discharge resources](#) page, where you can find more literature, guidance and case studies.

NHS Improvement

0300 123 2257
enquiries@improvement.nhs.uk
improvement.nhs.uk

 **@NHSEngland**

NHS England

This publication can be made available in a number of other formats on request.

NHS Improvement publication code: IT 14/19. Publishing approval reference: 000727.