Date published: 30 April, 2024
Date last updated: 31 May, 2024

Acute discharge situation report: technical specification

Publication (/publication)

Content

- 1. Introduction
- 2. Context
- 3. Submission process
- 4. Scope
- 5. Care transfer hubs
- 6. Contacts and resources
- Annex A: discharge pathways
- Annex B: discharge pathway codes
- Annex C: reason for discharge delay
- Annex D: criteria to reside
- Annex E: specific acute treatment function codes
- Annex F: acute discharge situation report collection template
- Acute discharge situation report questions

1. Introduction

This guidance supports completion of the Acute discharge situation report (sitrep) (originally the Covid-19 emergency preparedness, resilience and response (EPRR) acute daily discharge situation report* and replaces the previous technical specification that was introduced on 27 May 2022. This guidance will be introduced from June 2024.

* The Covid-19 EPRR acute daily discharge situation report commenced on 8 April 2020, to collect data on the inpatient population of each type 1 acute trust and their discharge status each day, by submitting a template through the Strategic Data Collection Service portal.

2. Context

The data collected is intended to support collaborative working and conversations, both for day-to-day operations and local improvement work. As such, whilst the responsibility for submitting the data lies with trusts, staff should work with colleagues across the system, including from local authorities, to compile and use it.

This is an important data collection, the outputs of which are published monthly. These are regularly reviewed by regional and national teams and government and are available to the public. Your returns are helping to drive the effective implementation of hospital discharge policies. This will lead to better care for patients and service users by increasing understanding of discharge practices, the use of pathways, and demand and capacity availability. Thank you for your ongoing support in helping us to collect accurate and timely information.

3. Submission process

The Acute discharge situation report (sitrep) template needs to be populated by trusts with a type 1 A&E department but excludes the specialist children's trusts Sheffield Children's NHS Foundation Trust and Alder Hey Children's NHS Foundation Trust, and Birmingham Women's and Children's NHS Foundation Trust.

Completed templates should be submitted via the Strategic Data Collection Service portal.

Please note, that to avoid double counting, organisations should not submit data on behalf of any other trust. Trusts should submit their own data directly.

Submissions must be signed off by a duty director, or other senior manager, appointed to this role by the trust's chief executive. It is the responsibility of each trust to ensure its return is accurate and reflects the real position for the relevant time period.

Collection of data for questions 1 to 9 should take place seven days a week. These relate to metric IDs DIS001 to DIS007 in the SDCS template.

Collection of data for questions 10 to 12 should take place once per week, on the same day each week, ideally on a Friday. These relate to metric IDs DIS008 to DIS010 in the SDCS template.

The deadline for submitting your Acute discharge sitrep via the Strategic Data Collection Service portal is 11am each Tuesday. There will be an opportunity to amend submissions in advance of publication, which occurs on the second Thursday each month.

4. Scope

The Acute discharge situation report (sitrep) covers all inpatients with a Length of Stay (LoS) of one night or longer, ie overnight stays, split by those who have been assessed as meeting the criteria to reside (CtR) and those who have been assessed as no longer meeting the criteria to reside (NCtR) (see annex D). A reason for discharge delay (RfDD) is only attributed to patients with a LoS of 7+ days (see annex C).

Patients should be **excluded** where they:

- are under 18 years old
- have a length of stay of 0 days
- have a method of admission other than elective or emergency (codes 31, 32, 82, 83)
- died in hospital or were transferred to another hospital for the same level of care (destination of discharge codes 51, 52, 87, 79 or method of discharge codes 4,5)
- have a treatment function code (TFC) not in the list of “specific acute” treatment function codes (TFCs) (see annex E).

For trusts that deliver both acute and community bedded care, the transfer of a patient from acute care to community care should be treated and reported as a discharge from the acute setting. The subsequent discharge of the person from the community setting will be reported as part of the Community discharge situation report (https://www.england.nhs.uk/publication/covid-19-eprr-acute-and-community-daily-discharge-situation-reports-sitreps/).

5. Care transfer hubs

A care transfer hub (CTH) is a focal point for coordinating discharges for patients with new or increased needs who require post-discharge health and/or social care and support, that is to say those on discharge pathways 1-3.

In general, a patient likely to have complex discharge needs is referred to a care transfer hub by ward staff, who begin discharge planning from the point of admission and describe relevant information about the patient’s needs. Hub staff then determine the most appropriate discharge pathway, taking a ‘home first’ approach.

Care transfer hubs may operate at trust, place*, or system-level depending on what makes sense locally. Each should comprise a multidisciplinary and multi-agency team of health, social care, housing and voluntary sectors partners, with strong links into care providers.

*Place-based partnerships often (although not always) match the area covered by an upper-tier or unitary local authority. This means that in many areas, place is the level at which most of the work to join up budgets, planning and pathways for health and social care services will need to happen.

6. Contacts and resources

Please direct queries relating to this collection to england.nhsdata@nhs.net (mailto:england.nhsdata@nhs.net).

Webinar recordings and useful documents can be found on the Hospital Discharge and Recovery Programme (https://future.nhs.uk/system/login?nextURL=%2Fconnect%2Eti%2FRLHSNN%2Fview%3FobjectID%3D25521744) located on the FutureNHS collaboration platform (login required).

Annex A: discharge pathways

The Acute discharge situation report (sitrep) collects details of the discharge pathway for patients discharged each day. The following pathways are as outlined in the Hospital discharge and community support guidance (https://www.gov.uk/government/publications/hospital-discharge-and-community-support-guidance/hospital-discharge-and-community-support-guidance#summary-of-changes---january-2024) published 26 January 2024 and their relationship with the discharge pathways collected is outlined in annex B.

Pathway 0

- Simple discharge home/to usual place of residence (or to temporary accommodation) coordinated by the ward without involvement of the care transfer hub:
    - no new or additional health and/or social care and support
    - self-management with signposting to services in the community
    - voluntary sector support
    - re-start of pre-existing home care package at the same level that remained active and on pause during the person's hospital stay
    - returning to original care home placement with care at the same level as prior to the person's hospital stay.

Pathway 1

- Discharge home/to usual place of residence (or to temporary accommodation) with health and/or social care and support coordinated by the care transfer hub, including:
    - home-based intermediate care on a time-limited, short-term basis for rehabilitation, reablement and recovery at home
    - re-start of home care package at the same level as a pre-existing package that lapsed
    - returning to original care home placement with time-limited, short-term intermediate care
    - long-term care and support at home following a period of intermediate care in the community.

Pathway 2

- Discharge co-ordinated through the care transfer hub to a community bedded setting with dedicated health and/or social care and support, including bed-based intermediate care on a time-limited, short-term basis for rehabilitation, reablement and recovery in a community bedded setting (bed in care home, community hospital or other bed-based rehabilitation facility).

Pathway 3

- In rare circumstances, for those with the highest level of complex needs, discharge to a care home placement coordinated via the care transfer hub, including:
    - care home placement for assessment of long-term or ongoing needs and facilitation of patient choice in relation to the permanent placement
    - long-term care and support in a care home following a period of intermediate care in the community.

Annex B: discharge pathway codes

The table below provides details of how the discharge pathway codes collected via the Acute discharge situation report (sitrep) relate to the discharge pathways described in the Hospital discharge and community support guidance (https://www.gov.uk/government/publications/hospital-discharge-and-community-support-guidance/hospital-discharge-and-community-support-guidance#summary-of-changes---january-2024) published 26 January 2024 (see annex A).

Discharge pathway*	**Discharge pathway code**
Pathway 0	Simple discharge home/to usual place of residence (or to temporary accommodation) coordinated by the ward without involvement of the care transfer hub.
No new or additional health and/or social care and support Self-management with signposting to services in the community Voluntary sector support Restart of pre-existing home care package at the same level that remained active and on pause during the person's hospital stay	P0 – discharge to a domestic home, hotel, or other temporary accommodation without the need for new/increased care or support from health and social care.
Returning to original care home placement with care at the same level as prior to the person's hospital stay	P0 – discharge back to an original care home placement when the care home has confirmed they can continue to meet the person's needs with the same level of support.
Pathway 1	Discharge home/to usual place of residence (or to temporary accommodation) with health and/or social care and support coordinated by the care transfer hub.

Home-based intermediate care on a time-limited, short-term basis for rehabilitation, reablement and recovery at home Restart of home care package at the same level as a pre-existing package that lapsed	P1 – discharge to a domestic home, hotel, or other temporary accommodation, or hospice at home with rehabilitation, reablement and recovery. P1 – discharge to a domestic home, hotel, or other temporary accommodation, or hospice at home with other new/additional support (for example, end of life care).
Returning to original care home placement with time-limited, short-term intermediate care	P1 – discharge back to original care home placement with rehabilitation, reablement and recovery or with an increased level of support.
Long-term care and support at home following a period of intermediate care in the community	N/A this part of the definition only applies to community beds.
Pathway 2	Discharge coordinated via the care transfer hub to a community bedded setting with dedicated health and/or social care and support.
Bed-based intermediate care on a time-limited, short-term basis for rehabilitation, reablement and recovery in a community bedded setting (bed in care home, community hospital or other bed-based rehabilitation facility)	P2 – short-term bed/hospice for rehabilitation, reablement and recovery/end of life care.

Pathway 3	In rare circumstances, for those with the highest level of complex needs, discharge to a care home placement coordinated via the care transfer hub.
Care home placement for assessment of long-term or ongoing needs and facilitation of patient choice in relation to the permanent placement	P3 – discharge to a care home as a new admission. P3 – discharge to a care home/hospice as a new admission for end-of-life care.
Long-term care and support in a care home following a period of intermediate care in the community	N/A this part of the definition only applies to community beds.

* Defined in the Hospital discharge and community support guidance (26 January 2024).

Annex C: reason for discharge delay

It is important that system partners, both locally and nationally, have a good understanding of the reasons behind discharge delays in order to target action on reducing them. A reason for discharge delay (RfDD) should be selected when a patient with a length of stay (LoS) of at least 7 days remains in the acute setting after being assessed by their medical team as having no criteria to reside (NCtR). The day on which a patient is assessed as having NCtR is also their discharge ready date (DRD).

Note: patients awaiting transfer to another acute bedded service or virtual ward are likely to have CtR. These patients should not be included in the NCtR figures or have a RfDD included in submissions of the Acute discharge situation report (sitrep).

Definitions of the reason for discharge delay parent codes

The reason for discharge delays codes are listed under five categories which cover the different stages in discharging a patient. The category definitions provided below should be used alongside NHSE's RfDD accompanying guidance.

"A" codes – hospital process

These codes capture hospital process delays at either the beginning or end of the discharge process. We would normally expect these to be captured at ward level. The majority of delays related to discharges on pathway 0 are likely to fall into this section. It may also capture delays at the beginning or end of the process for patients on pathways 1-3.

All staff responsible for coordinating and reporting on pathway 0 discharge delays should focus on learning the category A and B codes, whereas discharge coordinators in care transfer hubs will need to be familiar with all the codes.

"B" codes – wellbeing concerns

These codes capture delays caused when wellbeing concerns or concerns about readiness for discharge are raised about a patient, either by themselves or a third party and the concerns are not yet resolved.

"C" codes – care transfer hub process

These codes capture delays that happen immediately after the patient has been referred to a care transfer hub (or an equivalent coordinating team for P1-3 discharges under a different team) and where action is required by the hub. They include confirming a patient's immediate care needs and pathway, making onward referrals, or (in limited cases not being dealt with under the 'discharge to assess' policy) waiting for confirmation of funding eligibility.

"D" codes – interface process

These codes capture delays that occur after the care transfer hub has made a referral to the person(s) or organisation(s) who will arrange a patient's post-discharge package. This could include NHS or community partners, the local authority, social care and/or housing colleagues. These delays are during the phase where the care transfer hub is brokering or discussing the patient's discharge; or where a self-funded arrangement or an arrangement by an out of area hub is still being made. Once the care package or provision has been

agreed, or all local provider options have been exhausted, further delays to the commencement of the package should be captured under section E (capacity). The exception to this is D8 where the care is agreed but the provider has requested further actions or information before receiving the patient.

“E” codes – capacity

These codes capture delays where the patient’s discharge destination, package or care is determined but the discharge is delayed due to capacity constraints. This could be because the required service doesn’t exist in the local system, it exists but has no capacity to receive/support the patient, or it has been sourced but is not immediately available. This category also includes delays waiting for housing adaptations or for equipment and associated training to be delivered.

The national codes and definitions are set out below:

- A1: hospital process – awaiting therapy review of need for supported discharge.
- A2: hospital process – awaiting medical review of need for supported discharge.
- A3: hospital process – awaiting referral to care transfer hub for supported discharge.
- A4: hospital process – awaiting patient transport services.
- A5: hospital process – awaiting medicines to take home, discharge letter or other discharge documentation.
- A6: hospital process – remaining in hospital due to infection prevention and control restrictions.
- A7: hospital process – awaiting formal decision to discharge (including diagnostic test results).
- B1: wellbeing concerns – patient/family/carer concerns over discharge readiness.
- B2: wellbeing concerns – ongoing safeguarding concern.
- B3: wellbeing concerns – awaiting determination of mental capacity.
- B4: wellbeing concerns – issues with discharge destination readiness.
- C1: care transfer hub process – waiting for confirmation of immediate care needs and pathway.
- C2: care transfer hub process – awaiting necessary referrals by care transfer hub.
- C3: care transfer hub process – awaiting confirmation of funding eligibility.
- D1: interface process – home based rehabilitation, reablement or recovery service arrangements still underway (pathway 1).
- D2: interface process – other home-based social care service arrangements still underway (pathway 1).

- D3: interface process – other home-based community health service arrangements still underway (pathway 1).
- D4: interface process – housing provision arrangement for homelessness still underway (pathway 0 or 1).
- D5: interface process – bed-based rehabilitation, reablement or recovery service arrangements still underway (pathway 2).
- D6: interface process – residential/nursing home care arrangements still underway (pathway 3).
- D7: interface process – end-of-life care, including fast-track continuing healthcare arrangement still underway (pathway 1 or 3).
- D8: interface process – further action requested by agreed provider.
- D9: interface process – homeless with no recourse to public funds.
- D10: interface process – self-funded care package arrangements still underway.
- D11: interface process – patient/family/carer choice discussions on package still underway.
- D12: interface process – out-of-area discharge arrangements requested but not completed.
- E1: capacity – home-based rehabilitation, reablement or recovery services not yet available (pathway 1).
- E2: capacity – other home-based social care service not yet available (pathway 1).
- E3: capacity – other home-based community health services not yet available (pathway 1).
- E4: capacity – housing provision not yet available (pathway 0 or 1).
- E5: capacity – bed-based rehabilitation, reablement or recovery services not yet available (pathway 2).
- E6: capacity – mental health admitted patient care not yet available (pathway 2).
- E7: capacity – residential/nursing home care not yet available (pathway 3).
- E8: capacity – end-of-life care, including fast-track continuing healthcare not yet available (pathway 1 or 3).
- E9: capacity – housing adaptations not yet completed (pathway 1 or 3).
- E10: capacity – equipment and associated training not yet delivered (pathway 1-3).
- E11: capacity – awaiting restart of existing social care arrangements (pathway 0).

For national reporting purposes, patients should only be counted as having **one** reason for delay. This should be the primary reason for delay and in the case of more complex discharges (usually pathways 1-3) should reflect a shared picture across all system partners involved, and partners should be involved where

appropriate in advising on the correct code. This code should reflect the most recent reason for delay, which may change for a patient from week to week of submission.

Local systems will need to determine the best process for capturing accurate information with cross-system recognition depending on their existing ways of working.

In general, we would expect care transfer hubs to be holding up-to-date, mutually agreed information on the progress of each discharge on at least pathways 1-3, and for this to form the basis of recording reasons for delay.

We would expect that care transfer hubs would engage with most code allocations. Exceptions are likely to include the A and B codes and E11.

Definitions of the reason for discharge delay codes

This section provides further details of what is and is not covered under each of the reason for discharge delay (RfDD) codes, so that reporting against each of them is clear and consistent.

The following delay codes should be selected if:

“A” codes – hospital process

These codes capture hospital process delays at either the beginning or end of the discharge process. We would normally expect these to be captured at ward level. The majority of delays related to discharges on pathway 0 are likely to fall into this section. It may also capture delays at the beginning or end of the process for patients on pathways 1-3.

All staff responsible for coordinating and reporting on pathway 0 discharge delays should focus on learning the category A and B codes, whereas discharge coordinators in care transfer hubs will need to be familiar with all the codes.

A1: hospital process – awaiting therapy review of need for supported discharge

Therapy staff have not yet carried out the necessary initial reviews to identify whether a patient may require discharge supported by new intermediate or community healthcare or social care (pathway 1-3) discharge.

A2: hospital process – awaiting medical review of need for supported discharge

Medical staff have not yet carried out the necessary initial reviews to identify whether a patient may require discharge supported by new intermediate or community healthcare or social care (pathway 1-3) discharge.

A3: hospital process – awaiting referral to care transfer hub for supported discharge

Reviews by ward staff (including therapy or medical staff) suggest that the patient is likely to require a supported discharge, but the patient has not yet been referred to a care transfer hub (or equivalent local function).

A4: hospital process – awaiting patient transport services

Transport to the patient's discharge destination which is being provided by an NHS commissioned transport provider has been requested but has not yet been arranged or is not available. For delays related to family arranged transport record under B4.

A5: hospital process – awaiting medicines to take home, discharge letter or other discharge documentation

The patient is awaiting medicines to take out (TTO) and the delay could be with the clinical staff prescribing the medicine, or the pharmacy dispensing it. Also includes delays where the hospital has not yet completed the discharge letter or other relevant documentation**.**

A6: hospital process – remaining in hospital due to infection prevention and control restrictions

The patient has no criteria to reside (NCtR) but remains in hospital because of concerns (either on the part of the acute hospital or a receiving organisation) over the spread of an infectious condition with which they have been diagnosed.

A7: hospital process – awaiting formal decision to discharge (including diagnostic test results)

In exceptional circumstances, the patient has been assessed as no longer meeting the criteria to reside (NCtR), but a clinician (could be medical, therapy or other decision maker) needs to give further input or has requested additional tests before they leave the acute setting.

“B” codes – wellbeing concerns

These codes capture delays caused when wellbeing concerns or concerns about readiness for discharge are raised about a patient, either by themselves or a third party and the concerns are not yet resolved.

B1: wellbeing concerns – patient/family/carer concerns over discharge readiness

The patient, their family, or a carer has raised concerns about readiness for discharge and these have not yet been resolved. (This is distinct from concerns about this pathway, package or placement itself, which is captured under D11).

B2: wellbeing concerns – ongoing safeguarding concern

There is a safeguarding concern that has not yet been assessed or is not resolved. This code includes delays due to Court of Protection.

B3: wellbeing concerns – awaiting assessment of mental capacity

The patient requires an assessment and determination of their mental capacity before their discharge can progress. This may include the patient’s capacity to consent.

B4: wellbeing concerns – issues with discharge destination readiness

The patient’s home or place of residence on discharge is not yet ready, for instance because food or heating need to be arranged (excluding delays relating to NHS or local authority funded housing adaptations or equipment – see E10 and E11), further cleaning is required, the property cannot be accessed (for example keys are not available) or a receiving organisation of family/carers (on any pathway) is refusing to accept the patient at the time required despite a package having been arranged (for example because they regard it as too late in the day).

“C” codes – care transfer hub process

These codes capture delays that happen immediately after the patient has been referred to a care transfer hub (or an equivalent coordinating team for P1-3 discharges under a different team) and where action is required by the hub. They include confirming a patient's immediate care needs and pathway, making onward referrals, or (in limited cases not being dealt with under the 'discharge to assess' policy) waiting for confirmation of funding eligibility.

C1: care transfer hub process – waiting for confirmation of immediate care needs and pathway

The patient has been referred to a care transfer hub to decide what (if any) care they will need in the immediate period after leaving hospital, but the care transfer hub has not yet made a final decision on the pathway and/or appropriate immediate care package.

Note: under good practice guidance (the intermediate care framework and the community rehabilitation and reablement model), patients with rehabilitation, reablement and recovery needs should be given an opportunity to receive intermediate care outside of an acute setting whilst long-term care assessments, decision-making and arrangements take place if required.

C2: care transfer hub – awaiting necessary referrals by care transfer hub

The patient has been referred to a care transfer hub and a multidisciplinary decision has been taken on the pathway and appropriate package of care, but onward referrals have not yet been made to all the other organisations or teams required to arrange the post-discharge package (including for the care itself, any additional assessments, housing provision, housing adaptations, equipment or an out-of-area care transfer hub).

C3: care transfer hub process – awaiting confirmation of funding eligibility

In exceptional circumstances, a decision on funding eligibility must be made before the patient leaves hospital and this decision has not yet been made. Under the discharge to assess policy, decisions on funding eligibility should be made after discharge but may need to happen before discharge in some circumstances, for example where the individual has no recourse to public funds.

"D" codes – interface process

These codes capture delays that occur after the care transfer hub has made a referral to the person(s) or organisation(s) who will arrange a patient's post-discharge package. This could include NHS or community partners, the local authority, social care and/or housing colleagues. These delays are during the phase where the care transfer hub is brokering or discussing the patient's discharge; or where a self-funded arrangement or an arrangement by an out of area hub is still being made. Once the care package or provision has been agreed, or all local provider options have been exhausted, further delays to the commencement of the package should be captured under section E (capacity). The exception to this is D8 where the care is agreed but the provider has requested further actions or information before receiving the patient.

D1: interface process – home based rehabilitation, reablement or recovery services arrangement still underway (pathway 1)

For patients discharged home (or to their usual place of residence or temporary accommodation) with intermediate care on a time-limited, short-term basis for rehabilitation, reablement and/or recovery. Includes patients discharged to their original care home placement with time-limited, short-term intermediate care. Or other home-based rehabilitation, reablement or recovery service arrangements.

The team (which may be the care transfer hub or an external brokerage/sourcing/commissioning team) has made a referral and are in the process of getting the necessary arrangements in place, but these are not yet complete (excluding where the delay is caused by a shortage of capacity – see E1).

D2: interface process – other home-based social care arrangements still underway (pathway 1)

For patients requiring home-based social care which may be a new requirement or the re-start of a pre-existing package.

The team (which may be the care transfer hub or an external brokerage/sourcing/commissioning team) has made a referral and are in the process of getting the necessary arrangements in place, but these are not yet complete (excluding where the delay is caused by a shortage of capacity – see E2).

D3: interface process – other home-based community health service arrangements still underway (pathway 1)

For patients requiring community health services to support pathway 1 discharge (for example, district nursing). The team (which may be the care transfer hub or an external brokerage/sourcing/commissioning team) has made a referral and are in the process of getting the necessary arrangements in place, but these are not yet complete (excluding where the delay is caused by a shortage of capacity – see E3).

D4: interface process – housing provision arrangements for homelessness still underway (pathway 0 or 1)

New housing accommodation (ie not a bedded health or social care setting) needs to be arranged for a pathway 0 or pathway 1 discharge, for example for patients who are homeless on admission and also includes patients whose homes become unsuitable during their hospital admission (excluding cases where the delay is caused by a shortage of capacity – see E4).

D5: interface process – bed-based rehabilitation, reablement or recovery service arrangements still underway (pathway 2)

Time-limited, short-term (typically no longer than 6 weeks) community bedded setting with health and/or social care and support for rehabilitation, reablement and/or recovery needs to be arranged. A referral has been made by the care transfer hub, but the relevant brokerage, sourcing or commissioning team has not yet completed the process to make the necessary arrangements (excluding cases where the delay is caused by a shortage of capacity – see E5).

Note: under good practice guidance (the Intermediate care framework (https://www.england.nhs.uk/wp-content/uploads/2023/09/PRN00761-intermediate-care-framework-rehabilitation-reablement-recovery-following-hospital-discharge.pdf) and the Community rehabilitation and reablement model (https://www.england.nhs.uk/wp-content/uploads/2023/09/PRN00761ii-a-new-community-rehabilitation-and-reablement-model.pdf)), patient with rehabilitation, reablement and recovery needs should be given an opportunity to receive intermediate care outside of an acute setting whilst long-term care assessments, decision-making and arrangements take place if required.

D6: interface process – residential/nursing home care arrangements still underway (pathway 3)

A new residential or nursing home placement, or one where the patient's needs have increased, needs to be arranged and a referral has been made by the care transfer hub, but the relevant brokerage, sourcing or commissioning team has not

yet made the necessary arrangements (excluding cases where the delay is caused by a shortage of capacity – see E6).

D7: interface process – end-of-life care, including fast-track continuing healthcare arrangement still underway (pathway 1 or 3)

The patient requires end-of-life care (including fast-track continuing healthcare), and a referral has been made by the care transfer hub, but the relevant brokerage, sourcing or commissioning teams have not yet made the necessary arrangements. This includes care provided in patient's own home, hospice, or community setting (excluding cases where the delay is caused by a shortage of immediate capacity – see E7).

D8: interface process – further action requested by agreed provider

A package or placement (of any kind) has been arranged with a receiving provider, but they have requested further processes to be completed or information to be provided prior to acceptance of patient (for example, request for a behaviour chart or to visit the patient). This code also includes delays where the provider has capacity but are selective over when they receive the patient (for example, they don't accept discharges over the weekend). For delays relating to the agreed provider's capacity to receive the patient – see 'E- capacity' codes.

D9: interface process – homeless with no recourse to public funds

A patient has no recourse to public funds and has been assessed as not having needs under the Care Act, and therefore cannot be provided with housing or social care by the local authority (excluding cases where an assessment is still underway – see C3).

D10: interface process – self-funded care package arrangements still underway

The patient or their family or carer are arranging a self-funded care plan, but the arrangements have not yet been completed.

D11: interface process – patient/family/carer choice discussions on package still underway

The patient or their family/carer have unresolved concerns about the proposed package of care, or wish to explore alternative care provision options, requiring patient choice guidance to be followed.

D12: interface process – out-of-area discharge arrangements requested but not completed

The patient may require a pathway 1, 2 or 3 discharge (or a pathway 0 discharge with housing or equipment needs) and their likely discharge destination is beyond the routine geographic coverage of the care transfer hub managing discharges from the acute hospital in which they are currently resident. The care transfer hub which covers the area into which the patient will be discharged has been contacted but the arrangements for discharge have not yet been made.

“E” codes – capacity

These codes capture delays where the patient’s discharge destination, package or care is determined but the discharge is delayed due to capacity constraints. This could be because the required service doesn’t exist in the local system, it exists but has no capacity to receive/support the patient, or it has been sourced but is not immediately available. This category also includes delays waiting for housing adaptations or for equipment and associated training to be delivered.

E1: capacity – home-based rehabilitation, reablement or recovery services not yet available (pathway 1)

Home-based rehabilitation, reablement or recovery services are not yet in place due to lack of capacity because either all options have been exhausted and the required care doesn’t exist in the local system; suitable care providers exist but have no capacity; or the capacity has been sourced but is not immediately available (for example, the provider doesn’t have beds or staff to receive the patient).

E2: capacity – other home-based social care service not yet available (pathway 1)

Other home-based social care requirements are not yet in place due to lack of capacity because either all options have been exhausted and the required care doesn’t exist in the local system; suitable care providers exist but have no capacity; or the capacity has been sourced but is not immediately available, that is to say the provider doesn’t have beds or staff to receive the patient).

E3: capacity – other home-based community health services not yet available (pathway 1)

Other home-based community healthcare services are not yet in place due to lack of capacity because either all options have been exhausted and the required care doesn't exist in the local system; suitable care providers exist but have no capacity; or the capacity has been sourced but is not immediately available (for example, the provider doesn't have beds or staff to receive the patient).

E4: capacity – housing provision not yet available (pathway 0 or 1)

New accommodation is required for a pathway 0 or pathway 1 discharge, including for patients who are homeless on admission and patients whose homes become unsuitable during their hospital admission, but are not yet in place. Either because capacity is not yet available because either all options have been exhausted and the required accommodation doesn't exist in the local system; suitable accommodation exists but has no capacity; or the capacity has been sourced but is not immediately available.

E5: capacity – bed-based rehabilitation, reablement or recovery services not yet available

Bed-based rehabilitation, reablement or recovery services are not yet in place due to lack of capacity because either all options have been exhausted and the required care doesn't exist in the local system; suitable care providers exist but have no capacity; or the capacity has been sourced but is not immediately available (for example, the provider doesn't have beds or staff to receive the patient).

E6: capacity – mental health admitted patient care not yet available (pathway 2)

The patient no longer requires treatment in the acute setting but can only be discharged as an admitted patient in a mental health care setting. This is not yet in place because it is taking time to identify a suitable placement, assessments are causing delays, or because of a lack of capacity, because either all options have been exhausted and the required care doesn't exist; suitable care providers exist but have no capacity; or the capacity has been sourced but is not immediately available (for example, the provider doesn't have beds or staff to receive the patient).

E7: capacity – residential/nursing home care not yet available (pathway 3)

A new residential or nursing home placement, or one where the patient's needs have increased, is not yet in place due to lack of capacity because either all options have been exhausted and the required care doesn't exist in the local system; suitable care providers exist but have no capacity; or the capacity has been sourced but is not immediately available (for example, the provider doesn't have beds or staff to receive the patient).

E8: Capacity – end of life care, including fast-track continuing healthcare not yet available (pathway 1 or 3)

An end of life home based package or bedded placement is not yet in place due to lack of capacity because either all options have been exhausted and the required care doesn't exist in the local system; suitable care providers exist but have no capacity; or the capacity has been sourced but is not immediately available (for example, the provider doesn't have beds or staff to receive the patient).

E9: capacity – housing adaptations not yet completed (pathway 1 or 3)

Housing adaptations are required before the patient can be discharged to their residential location. This has been requested by the care transfer hub but not completed. Housing adaptions could include installation of rails, or a stair lift.

E10: capacity – equipment and associated training not yet delivered (pathway 1-3)

The patient requires equipment in order to allow them to be discharged. This has been requested by the care transfer hub but not yet provided, or further training for formal or informal carers is required before it can be safely used.

E11: capacity – awaiting restart of existing social care arrangements (pathway 0)

The patient has a previously agreed social care home-based package or residential or nursing home placement which has been paused whilst admitted into the hospital but cannot be restarted due to lack of capacity.

Annex D: criteria to reside

Having No Criteria to Reside (NCtR), is defined as when a patient meets none of the following Criteria to Reside (CtR) (unless a clinically warranted and justified exception exists) as set out in Hospital discharge and community support guidance (https://www.gov.uk/government/publications/hospital-discharge-and-community-support-guidance/hospital-discharge-and-community-support-guidance#summary-of-changes---january-2024) published 26 January 2024, bulleted below:

- requiring ITU or HDU care?
- requiring oxygen therapy/NIV?
- requiring intravenous fluids?
- NEWS2 greater than 3? (clinical judgement required in patients with AF and/or chronic respiratory disease)
- diminished level of consciousness where recovery realistic?
- acute functional impairment in excess of home/community care provision?
- last hours of life?
- requiring intravenous medication > b.d. (including analgesia)?
- undergone lower limb surgery within 48 hours?
- undergone thorax-abdominal or pelvic surgery with 72 hours?
- within 24 hours of an invasive procedure? (with attendant risk of acute life-threatening deterioration).

DRD definition

The day on which a patient is assessed as having NCtR is also their Discharge Ready Date (DRD) – see the DRD guidance (https://www.england.nhs.uk/long-read/discharge-ready-date-guidance-examples-and-frequently-asked-questions/). NHS England's Guidance for the Discharge Ready Date Monthly Publication (https://www.england.nhs.uk/statistics/wp-content/uploads/sites/2/2023/12/DRD-Guidance-1.pdf) states that the DRD records the start date of the final period that the patient no longer meets the 'Criteria to Reside' (CtR) in a hospital bed for their episode of care.

Annex E: specific acute treatment function codes

100: General surgery

101: Urology

102: Transplantation surgery

103: Breast surgery

104: Colorectal surgery

105: Hepatobiliary and pancreatic surgery

106: Upper gastrointestinal surgery

107: Vascular surgery

108: Spinal Surgery Service

109: Bariatric Surgery Service

110: Trauma and orthopaedics

111: Orthopaedic Service

113: Endocrine Surgery Service

115: Trauma Surgery Service

120: Ear, nose and throat

130: Ophthalmology

140: Oral surgery

141: Restorative dentistry

142: Paediatric dentistry

143: Orthodontics

144: Maxillo-facial surgery

145: Oral and Maxillofacial Surgery Service

150: Neurosurgery

160: Plastic surgery

161: Burns care

170: Cardiothoracic surgery

171: Paediatric surgery

172: Cardiac surgery

173: Thoracic surgery

174: Cardiothoracic transplantation

180: Accident and emergency

190: Anaesthetics

191: Pain management

192: Critical care medicine

200: Aviation and Space Medicine Service

211: Paediatric urology

212: Paediatric transplantation surgery

213: Paediatric gastrointestinal surgery

214: Paediatric trauma and orthopaedics

215: Paediatric ear nose and throat

216: Paediatric ophthalmology

217: Paediatric maxillo-facial surgery

218: Paediatric neurosurgery

219: Paediatric plastic surgery

220: Paediatric burns care

221: Paediatric cardiac surgery

222: Paediatric thoracic surgery

230: Paediatric Clinical Pharmacology Service

240: Paediatric Palliative Medicine Service

241: Paediatric pain management

242: Paediatric intensive care

250: Paediatric Hepatology Service

251: Paediatric gastroenterology

252: Paediatric endocrinology

253: Paediatric clinical haematology

254: Paediatric audiological medicine

255: Paediatric clinical immunology and allergy

256: Paediatric infectious diseases

257: Paediatric dermatology

258: Paediatric respiratory medicine

259: Paediatric nephrology

260: Paediatric medical oncology

261: Paediatric metabolic disease

262: Paediatric rheumatology

263: Paediatric diabetic medicine

264: Paediatric cystic fibrosis

270: Paediatric Emergency Medicine Service

280: Paediatric interventional radiology

300: General medicine

301: Gastroenterology

302: Endocrinology

303: Clinical haematology

304: Clinical physiology

305: Clinical pharmacology

306: Hepatology

307: Diabetic medicine

308: Blood and marrow transplantation

309: Haemophilia service

310: Audiological medicine

311: Clinical genetics

313: Clinical immunology and allergy service

314: Rehabilitation Service

315: Palliative medicine

316: Clinical immunology

317: Allergy Service

318: Intermediate care

319: Respite care

320: Cardiology

321: Paediatric cardiology

322: Clinical microbiology

323: Spinal injuries

324: Anticoagulant Service

325: Sport and exercise medicine

326: Acute Internal Medicine Service

327: Cardiac rehabilitation

328: Stroke medicine

329: Transient ischaemic attack

330: Dermatology

333: Rare Disease Service

335: Inherited Metabolic Medicine Service

340: Respiratory medicine

341: Respiratory physiology

342: Programmed pulmonary rehabilitation

343: Adult cystic fibrosis

347: Sleep Medicine Service

348: Post-COVID-19 Syndrome Service

350: Infectious diseases

352: Tropical medicine

361: Nephrology

370: Medical oncology

371: Nuclear medicine

400: Neurology

401: Clinical neurophysiology

410: Rheumatology

420: Paediatrics

421: Paediatric neurology

422: Neonatology

430: Geriatric medicine

431: Orthogeriatric Medicine Service

450: Dental medicine specialties

451: Special Care Dentistry Service

460: Medical ophthalmology

461: Ophthalmic and Vision Science Service

502: Gynaecology

503: Gynaecological oncology

505: Fetal Medicine Service

663: Podiatric surgery

670: Urological Physiology Service

673: Vascular Physiology Service

675: Cardiac Physiology Service

677: Gastrointestinal Physiology Service

800: Clinical oncology (previously radiotherapy)

811: Interventional radiology

812: Diagnostic imaging

822: Chemical pathology

834: Medical virology

Annex F: acute discharge situation report collection template

Please note that all questions need inputting. Where there are unknown fields, users are expected to submit zeros.

Collection of data for Questions 1 to 9 should take place seven days a week. These relate to metric IDs DIS001 to DIS007 in the SDCS template.

Collection of data for Questions 10 to 12 should take place once per week, on the same day each week, ideally on a Friday. These relate to metric IDs DIS008 to DIS010 in the SDCS template.

The 21+ days cohort is a subset of the 14+ days cohort, which in turn is a subset of the 7+ days cohort, which in turn is a subset of total patients – these are not mutually exclusive.

Where a patient is assessed as having no criteria to reside, a discharge ready date should be recorded: NHS England discharge ready date guidance (https://www.england.nhs.uk/long-read/discharge-ready-date-guidance-examples-and-frequently-asked-questions/).

Acute discharge situation report questions

1. The total number of patients who meet the criteria to reside that day (DIS001_TOTAL).

2. The number of patients who do not meet the criteria to reside that day (DIS002_TOTAL).

3. Of the total number of patients discharged between 00:00 and 23:59, the number of patients who used a personal health budget to facilitate their discharge from hospital (DIS003_PHB)

- Data for this question relates to one-off personal health budgets within hospital discharge pathway guidance (https://www.england.nhs.uk/publication/one-off-personal-health-budgets-within-hospital-discharge-pathway/).

4. Of the total number of patients who do not meet the criteria to reside that day:

a. The number of patients who have been discharged by 17:00 hours (DIS004a_TOTAL).

b. The number of patients discharged between 17:01 and 23:59 hours (DIS004b_TOTAL).

5. Of the patients discharged that day:

a. The number of patients discharged by 17:00 hours to the following locations (DIS004a).

b. The number of patients discharged between 17:01 and 23:59 hours to the following locations (DIS004b).

6. The total number of patients with a length of stay of 21 days and over who meet the criteria to reside that day (DIS005_TOTAL).

7. The number of patients with a length of stay of 21 days and over who do not meet the criteria to reside that day (DIS006_TOTAL).

8. Of the total number of patients with a length of stay of 21 days and over who do not meet the criteria to reside that day:

a. The number of patients who have been discharged by 17:00 hours (DIS007a_TOTAL).

b. The number of patients discharged between 17:01 and 23:59 hours (DIS007b_TOTAL).

9. Of the patients with a length of stay of 21 days and over discharged that day:

a. The number of patients discharged by 17:00 hours to the following locations (DIS007a).

b. The number of patients discharged between 17:01 and 23:59 hours to the following locations (DIS007b).

Answers provided for questions 6, 7, 8 and 9 must be a direct subset of the number of patients reported for questions 1, 2, 4 and 5 respectively.

10. Of the total number of patients who have a length of stay of 21 days and over and who have been assessed as not meeting the criteria to reside.

a. The number of additional days in total they have remained in hospital since not meeting the criteria to reside decision was made (DIS008a).

b. A breakdown showing why patients continue to remain in hospital, despite not meeting the criteria to reside, against each of the reasons for delay (DIS008b).

11. Of the total number of patients who have a length of stay of 14 days and over and who have been assessed as not meeting the criteria to reside.

a. The number of additional days in total they have remained in hospital since not meeting the criteria to reside decision was made (DIS009a).

b. A breakdown showing why patients continue to remain in hospital, despite not meeting the criteria to reside, against each of the reasons for delay (DIS009b).

12. Of the total number of patients who have a length of stay of 7 days and over and who have been assessed as not meeting the criteria to reside.

a. The number of additional days in total they have remained in hospital since not meeting the criteria to reside decision was made (DIS010a).

b. A breakdown showing why patients continue to remain in hospital, despite not meeting the criteria to reside, against each of the reasons for delay (DIS010b).

Answers provided for question 10 must be a direct subset of the number of patients reported for question 11 and answers provided for question 11 must be a direct subset of the number of patients reported for question 12.

Publication reference: PRN01252

Date published: 30 April, 2024
Date last updated: 31 May, 2024