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Discharge Planning – **Hywel Dda University Health Board**

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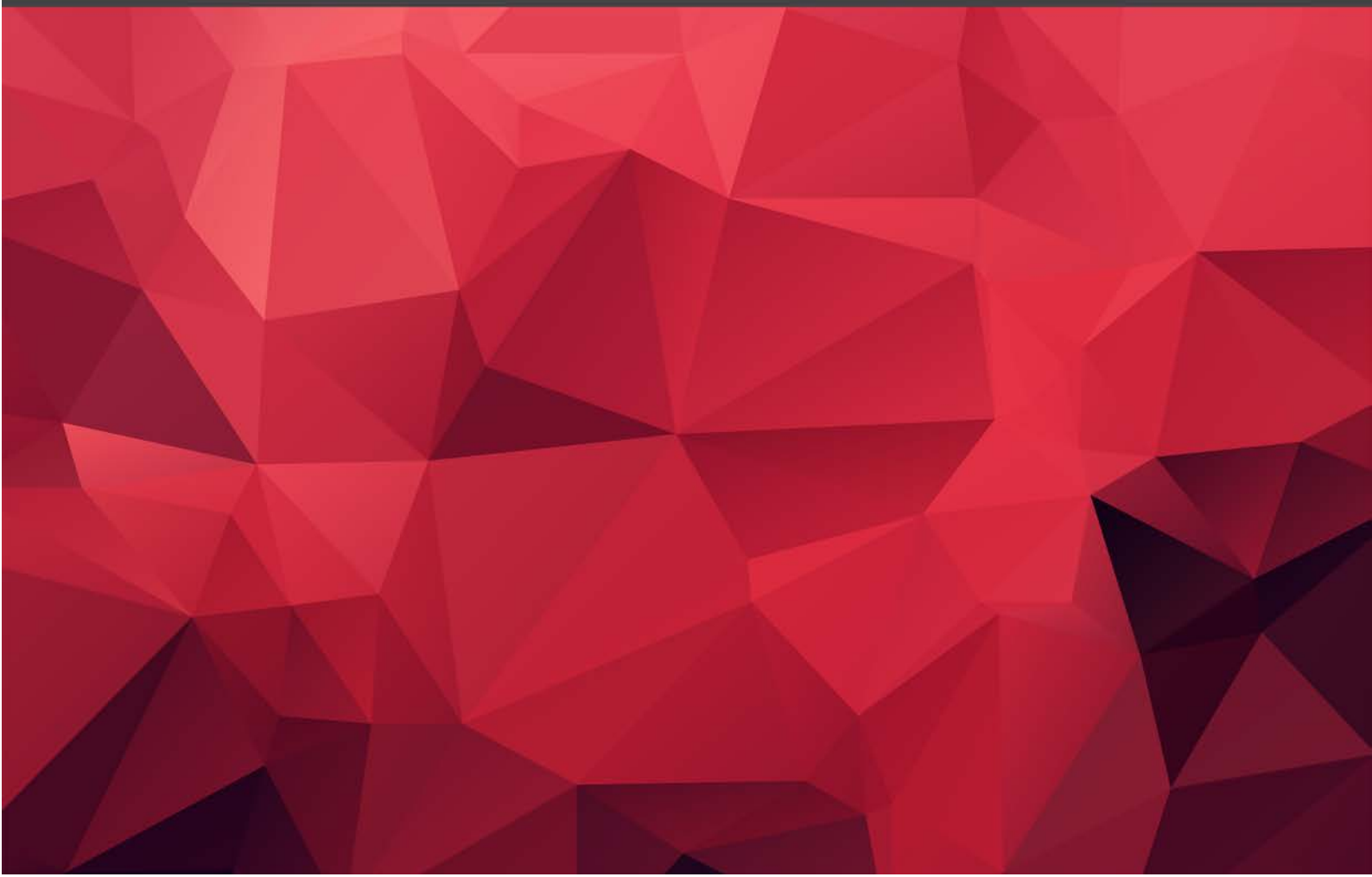


The team who delivered the work comprised Gabrielle Smith and Matthew Brushett.

Contents

There is some improvement in key performance measures but it will be some time before initiatives to improve discharge planning and patient flow take full effect.

Summary report

Background

1 Discharge planning is an ongoing process for identifying the services and support a person may need when leaving hospital (or moving between hospitals). The aim is to make sure that the right care is available, in the right place and at the right time. An effective and efficient discharge process is an important factor in good patient flow and key to ensuring good patient care and the efficient and effective use of NHS resources. Patient flow denotes the flow of patients between staff, departments and other organisations along a pathway of care from arrival at hospital to discharge or transfer.

2 Hospital beds are under increasing pressure, not least because of the loss of 1,800 beds across Wales over the last six years. Poor discharge planning can increase lengths of stay unnecessarily, which in turn can affect other parts of the hospital leading to longer waiting times in accident and emergency (A&E) departments or cancellations of planned admissions.

3 Every year across Wales, there are approximately 750,000 hospital admissions and discharges. The discharge process is relatively straightforward or simple for 80% of patients leaving hospital. These patients return home with no or simple health or social care needs that do not require complex planning and delivery. For the remaining 20%, discharge planning is more complex because of ongoing health and or social care needs, which may be short or long term.

4 For individual patients, many of whom are aged 65 or older, delays in discharge can lead to poorer outcomes through the loss of independence, confidence and mobility, as well as risks of hospital-acquired infections, re-admission to hospital or the need for long-term support.

5 Despite the multiplicity of guidance to support good discharge planning[1 2 3], work undertaken in 2016 by the NHS Wales Delivery Unit (the Delivery Unit) at all Welsh hospitals showed that there are opportunities to improve the discharge planning process, release significant inpatient capacity and improve patients' experiences and outcomes. Specific areas for improvement included:

- better working with community services;
- clearer and earlier identification of the complexity of the discharge to enable better facilitation of the discharge process;

[1] Welsh Health Circular (2005), **Hospital Discharge Planning Guidance**, 2005/035

[2] National Leadership and Innovation Agency for Healthcare (2008), **Passing the Baton**

[3] National Institute of Clinical Excellence (2015), **Transition between inpatient hospital settings and community or care home settings for adults with social care needs**

- greater clarity around discharge pathways[4]; and
- better information and communication with patients and families.

6 The Delivery Unit assessed the written evidence in case notes against specific requirements set out in 'Passing the Baton' (see Footnote 2). The findings for Hywel Dda University Health Board (the Health Board) show that performance in relation to the patient discharge process was variable between hospitals but largely poor when assessed against expected practice. Appendix 1 sets out the findings in more detail.

7 Many of the issues highlighted by the Delivery Unit have been common themes for years, with limited evidence to suggest that discharge planning processes are seeing any real improvement. Given the growing demand on hospital services and continuing reductions in bed capacity, the Auditor General decided it was timely to review whether governance and accountability arrangements are robust enough to ensure that the necessary improvements are made to discharge planning.

8 This review examined whether the Health Board has sound governance and accountability arrangements in relation to discharge planning. Appendix 2 provides details of the audit methodology. The work focused specifically on whether the Health Board has:

- a sound strategic planning framework in place for discharge planning;
- effective arrangements to monitor and report on discharge planning; and
- taken appropriate action to manage discharge planning and secure improvements.

9 In parallel with this work, the Auditor General has also undertaken a review of housing adaptation. That review focuses primarily on local authorities and registered social landlords given their respective responsibilities for managing and allocating Disabled Facilities Grants, Physical Adaptation Grants and other funding streams used to finance adaptations. There are clear links with discharge planning given that delays to fitting or funding housing adaptations can lead to delayed discharges. In addition, Healthcare Inspectorate Wales is examining the quality of communication and information flows between secondary and primary care in relation to patient discharge. The reports, setting out the findings of these two reviews, are intended for publication in autumn 2017.

[4] Defined discharge pathways set out the sequence of steps and timing of interventions by healthcare professionals for defined groups of patients, particularly those with complex needs to ensure patients experience a safe and timely discharge.

Key findings

10 Our overall conclusion is: There is some improvement in key performance measures but it will be some time before initiatives to improve discharge planning and patient flow take full effect. In the following paragraphs we set out our reasoning.

11 **Planning**: The Health Board has clear plans for improving discharge planning underpinned by discharge pathways, policies, and improvement initiatives:

- there are comprehensive plans in place to improve discharge planning supported by a range of improvement initiatives and investment;
- there is scope to strengthen the Discharge and Transfer of Care Policy when it is next updated; and
- formal discharge pathways, developed and agreed with local authority partners, are being rolled out.

12 **Arrangements for supporting discharge**: Dedicated resources are available to support discharge planning and ward staff are confident about what needs to be done, but training on discharge planning is infrequent and discharge lounges appear underutilised:

- dedicated multidisciplinary resources are in place to support discharge planning;
- discharge lounges are available but appear underutilised; and
- ward staff are confident about what needs to be done to support safe and timely discharge and have a good understanding of the landscape of community services, but training on discharge planning is infrequent while some challenges, like reliance on agency staff, make discharge planning more difficult.

13 **Monitoring and reporting**: There is regular scrutiny of performance related to discharge planning ensuring board members feel well informed but improvements in performance are too slow:

- there are clear lines of accountability for discharge planning with regular scrutiny of performance both strategically and operationally;
- a range of information related to discharge planning and patient flow is regularly presented to the Board and Board members feel well informed; and
- performance related to discharge planning and patient flow is improving slowly but there is more to do to reduce lengths of stay and A&E waits.

Recommendations

Exhibit 1: recommendations

The table sets out the recommendations arising from the audit on discharge planning at Hywel Dda University Health Board. The Health Board's management response detailing how it intends responding to these recommendations is included in Appendix 3.

Recommendations	
R1	**Discharge and Transfer of Care Policy:** Our assessment of the Health Board's policy indicates that it could be strengthened when it is next scheduled to be reviewed and updated. The Health Board should include: • the patient discharge leaflet; • the discharge pathways; • a discharge checklist; • reference or web links to the Home of Choice policy; • typical escalation procedures; • arrangements for patients discharged from A&E departments or medical/clinical assessment units; and • roles and responsibilities of ward staff.
R2	**Discharge and Transfer of Care Policy:** One of the indicators for monitoring the impact of the policy is the percentage of patients discharged before 11 am, while the success of the SAFER patient flow model is assessed on discharging 33% of patients from inpatient wards before midday. The Health Board should clarify whether the timeframe for the purpose of monitoring needs to be the same or different, and if so ensure the ability to monitor two separate indicators.

Recommendations	
R3	**Training on discharge planning:** The Discharge and Transfer of Care Policy indicates that all frontline staff should have access to appropriate training. However, there is no regular training on discharge planning and its inclusion in induction programmes is inconsistent, while agency staff are unfamiliar with the discharge process. Meanwhile, several staff felt more training is needed on the Decision Support Tool for the continuing healthcare funding process, which would, in turn, inform discharge planning arrangements. The Health Board should: • include training on discharge planning in induction programmes for staff who will be involved in making discharge arrangements; • offer regular refresher training on discharge planning; • explore opportunities for including the use of the Decision Support Tool in training on discharge planning; and • provide simple guidance for bank and agency nursing staff to enable them to contribute effectively to discharge planning arrangements.
R4	**Discharge lounge:** Discharge lounges appear to support fewer patients than might be expected given their overall capacity and operational hours. Meanwhile, some patients are waiting 12 or more hours overnight in A&E until beds become available. The Health Board should: • actively promote the use of the discharge lounge; • ensure patients being discharged are moved to the discharge lounge as soon it opens; • find out what prevents more patients being moved to the lounge on the day of discharge; and • collate information on the length of time patients remain in the discharge lounge before leaving the hospital to assess whether slow turnover is preventing patients from being moved to the lounge on the day of discharge.
R5	**Performance reporting:** The Health Board has recently launched its unscheduled care campaign. The Health Board should include a summary of the impact of the campaign in the Integrated Performance Report in March 2018.
R6	**Information for monitoring performance or compliance with standards:** The patient administration system does not capture data items that could support monitoring and reporting of compliance with discharge standards and policies. The Health Board should assess if the patient administration system can be used to capture additional data items, such as whether a discharge is simple or complex and the date a patient is ‘medically fit’ for discharge.

Detailed report

The Health Board has clear plans for improving discharge planning underpinned by discharge pathways, policies and improvement initiatives

There are comprehensive plans in place to improve discharge planning supported by a range of improvement initiatives

14 In October 2016, the Cabinet Secretary for Health, Wellbeing and Sport wrote to all NHS Chairs making clear his expectation that unscheduled care improvement plans would incorporate plans to improve discharge processes. The NHS Wales Planning Framework[5] also makes it clear that organisations should specify how their plans support and improve patient flow. The focus should be on reducing admissions for the frail elderly through pro-active assessment and intervention, and discharging patients as early as clinically appropriate without unnecessary waiting.

15 Our audit work assessed the extent to which discharge planning is part of a wider strategic approach to improve patient flow. Effective discharge planning is a fundamental part of the Health Board's unscheduled care programme, which is a cross-system group of managers and clinicians working with partners across the Welsh Ambulance Service NHS Trust and the coterminous local authorities.

16 The unscheduled care programme is underpinned by 13-week rolling plans developed for each hospital and prepared jointly with the respective county teams. The plans are based on learning from internal and external assessments and incorporate the recommendations made by the Delivery Unit. The unscheduled care plans are a key part of the Health Board's annual operational plan, and aspects of corporate programmes.

17 The Health Board's three county-focused winter plans for 2016-17 were intrinsically linked to the 13-week rolling plans for unscheduled care. The plans set out the detailed actions and how these would be resourced to support admission avoidance and enable timely and safe discharge. The winter plans were developed through extensive engagement with key stakeholders both internally and externally, as well as the third sector and independent sectors.

18 At the time of our audit work, the Health Board was introducing, on an incremental basis, a number of initiatives adopted from the NHS (England) Emergency Care Improvement Programme as part of the 13-week rolling plans. Since then, the Unscheduled Care Programme has brought in work being undertaken by the Health Board's frailty group to consolidate these initiatives, such as frailty screening, under one programme, to ensure sustainable improvements are made across the entire unscheduled care system. The Health Board has launched its unscheduled care campaign across all hospitals and wards, which includes:

[5] Welsh Government (2016), **NHS Planning Framework 2017/20**

- the ‘SAFER patient flow model’ which aims to avoid unnecessarily long stays and to improve flow through the hospital (Box 1);
- ‘end PJ Paralysis’ which aims to get patients up and about and out of their pyjamas as soon as they are able to, in order to improve recovery and prevent complications;
- ‘red 2 green’ which is a visual management system to assist in identifying wasted time in a patient’s journey; patients on the red list are no longer benefitting from being in an acute hospital bed while those on the green list are still benefitting from their admission, for example, by receiving therapy for their underlying condition; and
- ‘the last 1000 days’ which reinforces the value of patients’ time as the most important currency in healthcare and to create a sense of urgency to act.

Box 1: the SAFER patient flow model

Box 1 – the SAFER patient flow model

S – 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 assuming ideal recovery and assuming no unnecessary waiting.

F – the **flow of patients** starts as early as possible from A&E and other assessment units to inpatient wards, while wards that routinely receive these patients ensure patients can start arriving by 10 am.

E – 33% of patients are discharged **earlier in the day**, that is before midday.

R – a systematic multidisciplinary team **review** of patients experiencing a length of stay of more than seven days.

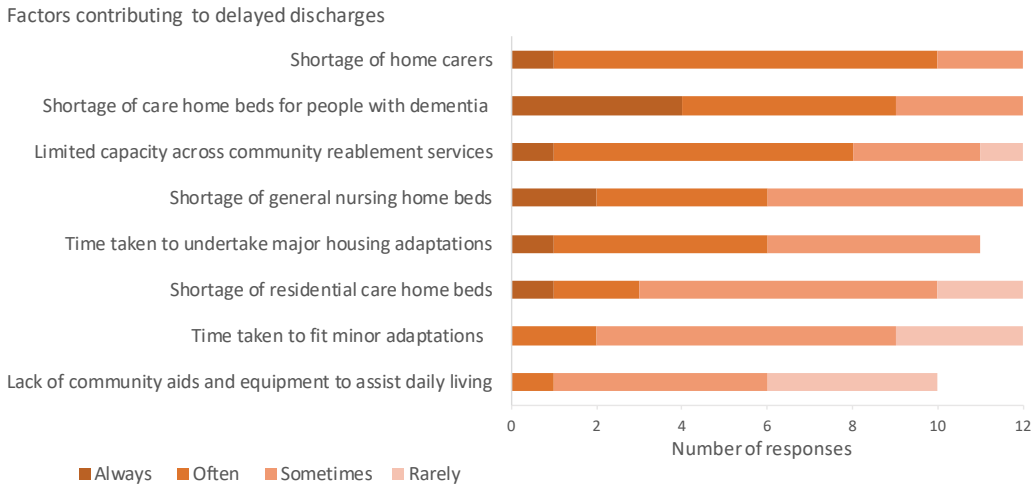
* Clinical criteria are the minimum physiological, therapeutic and functional status the patient needs to achieve before discharge. It should be agreed with the patient and carers where necessary.

19 We asked NHS organisations to what extent a range of external factors was seen to contribute to delayed discharges or transfers of care, to ascertain whether plans sought to address the factors causing the most problems. Exhibit 2 shows that across Wales, a shortage of home carers, a shortage of care home beds for people with dementia, and limited capacity across community reablement services are major factors in causing delays to discharge or transfers of care[6].

[6] Delayed Transfers of Care are inpatients in hospital, who are ready to move on to the next stage of care but are prevented from doing so for one or more reasons.

Exhibit 2: factors contributing to delayed discharges or transfers of care across NHS organisations

The chart shows the extent to which a range of factors are seen to contribute to delays to hospital discharge and transfers of care.



Source: Wales Audit Office analysis of information on discharge planning returned by NHS bodies in 2017[7].

20 It is important to recognise that the Health Board does not have direct control over these factors and it is working with statutory and independent partners to find solutions to meet patients' needs on discharge. These include working with Extra Care Housing to look at provision of intermediate care as part of new builds (housing) and working with local authority partners to review the model of reablement provision. Nonetheless, it is important that the Health Board considers the factors within its immediate control, such as implementing robust policies and procedures on discharge planning.

21 The factors seen to 'always or often' contribute to delayed discharges varied between the Health Board's three county teams (Exhibit 3). For the Carmarthenshire County team, the factors set out in Exhibit 2 were seen as rarely or sometimes contributing to delays with the following factors cited instead:

- delays related to home of choice;
- delays in completing integrated assessments because of a lack of capacity within the therapy, nursing and social work workforce;

[7] We received responses from the seven health boards and Velindre NHS Trust. Betsi Cadwaladr and Hywel Dda University Health Boards organise discharge planning services on a locality or geographical basis and therefore we have more than one data return for these two health boards.

- family disputes and disagreements about decisions made; and
- the risk that reablement services are being used to support people who are waiting for long-term residential care.

22 The Pembrokeshire and Ceredigion County teams were more typical of the responses for the rest of Wales. The Pembrokeshire County team indicated that the availability of transport was often a contributory factor in delayed discharges while the Ceredigion County team did not cite any other factors.

Exhibit 3: factors always or often contributing to delayed discharges across the three counties within Hywel Dda University Health Board

The table shows that the factors always or often contributing to delayed discharges vary between the Hywel Dda University Health Board's three counties.

Factors contributing to delayed discharges	Pembrokeshire	Ceredigion	Carmarthenshire
A shortage of home carers		Yes	Yes
A shortage of care home beds for people with dementia	Yes	Yes	
Limited capacity across community reablement services	Yes	Yes	
A shortage of general nursing home beds		Yes	
The time taken to undertake major housing adaptations	Yes		
A shortage of residential care home beds		Yes	
The time taken to fit minor adaptations	Yes		
A lack of community aids and equipment to assist daily living	Yes		

Source: Wales Audit Office analysis of information on discharge planning returned by NHS bodies in 2017 (See Footnote 7).

23 Our interviews with ward staff and managers highlighted similar factors contributing to delays in discharging patients, which have been reported regularly to the Board and its Committees. These are:

- issues with the provision of timely domiciliary care packages to support discharges or when people step down from intermediate care interventions to domiciliary care;
- some patients waiting too long on the 'medically fit list' because of a lack of nursing care placements;
- reliance on bank and agency nursing staff who are unfamiliar with discharge procedures and pathways (see paragraph 75); and

- the increasing acuity and frailty of people who experience an emergency admission with many of these patients requiring even greater levels of support on discharge.

24 Over the years, the Welsh Government has released funding streams that aim to foster greater collaboration between services, the most recent of which is the Integrated Care Fund (ICF). The ICF, introduced in 2014-15, is a pooled resource and in terms of patient flow, funds initiatives to prevent unnecessary hospital admission, support the independence of older people and reduce delays in discharging patients from hospital. The ICF has been used to support a number of initiatives to strengthen discharge planning and admission avoidance across the Mid and West Wales Regional Partnership. The funding has, for example, supported the development and extension of multi-professional community-based discharge teams or services to prevent avoidable admissions across A&E and assessment units. It has also been used to improve discharge planning, creating a cross-border discharge liaison nurse post with Powys Teaching Health Board, enabled discharge lounges to extend their operating hours and purchased additional intermediate care beds in nursing or care homes for assessment and reablement.

25 Staff that we met told us that without the ICF, they would struggle to develop and embed new ways of working and to resource the winter plans. Equally, ICF was seen as helping to improve working relationships with local authorities because it enabled them to be creative in finding solutions to support people moving from hospital back into the community.

There is scope to strengthen the Discharge and Transfer of Care Policy when it is next updated

26 The discharge process should be seen as part of the wider care process and not an isolated event at the end of the patient's stay. NHS organisations should have policies and procedures for discharge or transfers of care, developed ideally in collaboration with statutory partners. NHS organisations should also have a choice policy for those patients whose onward care requires them to move to a care home, although in many areas choice may be limited.

27 We reviewed the Health Board's 'Discharge and Transfer of Care Policy' using a maturity matrix[8] to assess 17 elements of the policy. Each element assessed is assigned a score from one (less developed) to three (well developed). Exhibit 4 shows our assessment of the Health Board's discharge policy scored against the maturity matrix. Our assessment found a small number of the elements were less developed, scoring one. The policy could be strengthened by including:

- the patient discharge leaflet;

[8] Our maturity matrix is based on the Effective Discharge Planning Self-Assessment Audit Tool developed by the National Leadership and Innovation Agency for Healthcare in 2008.

- the five complex discharge pathways which support the policy;
- a discharge checklist;
- links to the Home of Choice policy;
- typical escalation procedures;
- arrangements for patients discharged from A&E departments or medical/clinical assessment units; and
- ensuring alignment with the initiatives under the unscheduled care campaign.

Exhibit 4: Health Board's performance against discharge policy good practice checklist

The table shows that there is scope to strengthen the Health Board's discharge policy as 13 of the 17 elements assessed scored one or two.

Elements assessed	Score	Auditor observations on the policy
Multi-agency discharge policy	1	The policy is Health Board focused in terms of consultation but it indicates that it will be shared/publicised with WAST, primary care and community resource teams.
Policy reviewed within the last year	3	The Clinical Policy Review Group ratified the policy in May 2016. The policy is reviewed and updated every two years with the next review scheduled for May 2018. However, the timetable for the policy Equality Impact Assessment (EIA) appears out of sync with the policy revision timetable. The EIA was conducted in August 2014 and again in March 2015.
Patient/carer involvement	3	The policy makes clear that patients and their designated representatives should be engaged at the outset in the discharge process but there is nothing to indicate that patients or their representatives were engaged as part of policy development.
Communication	2	The policy indicates that English and Welsh-language needs should be addressed at all times with additional communication mechanisms available, eg interpreters via language line.
Information	2	The policy makes reference to providing opportunities for patients to discuss care with a specific reference to giving patients information on take-home medicines. The draft Home of Choice policy refers to written information packs for patients who require a permanent place in a care home, as well as a 'supporting discharge information' pack which should contain advice regarding the process, timescales and expectations on part of the patient or their representative. At the time of the audit, the Health Board was developing a discharge leaflet/information sheet for patients.

Elements assessed	Score	Auditor observations on the policy
Vulnerable groups eg patients who are homeless	2	The policy clearly defines a vulnerable person and signposts staff to other relevant policies and procedures. The policy covers adults, children and young people but excludes neonates. For children and young people, there is a specific reference to sharing discharge summaries with Health Visitors and School Nurses, as well as GPs. It also signposts staff to directorate or hospital-site service plans for the operational management of discharge or transfer of children and young people. The policy refers to safeguarding procedures and reminds staff to consider referral to the safeguarding team.
Early discharge planning for elective admission	3	The policy states that the predicted length of stay should be determined at the pre-operative stage.
Estimated discharge date (EDD) set within 24 hours of admission	3	The policy sets out criteria for agreeing whether the discharge is simple or complex and reminds staff that all patients should have an EDD within 24 hours of admission.
Avoiding Readmission	1	Although the policy emphasises the need for timely discharge, there is no reference to balancing this with the risk of readmission. The policy indicates that patients with dementia should be transferred only during the day. For those patients who require non-emergency patient transport provided by the ambulance service, the policy indicates that patients should not be transferred outside 8.30 am to 4.30 pm on weekdays unless absolutely necessary, when the ambulance liaison supervisor is available.
Local Agreements and Protocols	2	The policy refers to ward level procedures and protocols for discharge (please note that we did not review ward level documents).
Assessment	2	The policy makes reference to the possible need for continuing healthcare assessments or mental capacity assessments.
Discharge from A&E	1	The policy applies to inpatient admissions only. There is no reference to the process for managing discharges from A&E or medical/clinical assessment units.
Discharge directly from hospital to permanent care home	1	There is no specific reference about not transferring patients directly from hospital to a permanent care home. However, the draft Home Choice Policy makes clear that ‘as a general rule, patients should not be discharged directly from an acute episode of hospital care to a permanent care home placement.’
Links to choice of accommodation policy	3	The policy sets out expectations in relation to arrangements for choosing a care home while making clear that patients do not have the right to remain in an acute hospital bed while arrangements are realised. At the time of our audit work, the Health Board had developed a Home of Choice policy, which was subject to consultation.
Care Options	2	The policy refers to the need to consider all options for patients for whom NHS continuing health care, home choice or mental health advocacy issues apply.

Elements assessed	Score	Auditor observations on the policy
Escalation processes	2	The policy indicates that there are clinical escalation procedures for acute and community directorate teams to follow if discharges are delayed or at risk of delay. The reasons for escalating delays are clearly set out.
Accessible Discharge Protocols	1	Although the policy describes simple and complex discharges, it does not include an easy-to-understand flow chart to support decisions on whether discharges are simple or complex nor the five main discharge pathways. The draft Home of Choice policy includes a flow chart showing the discharge planning process.

Source: Wales Audit Office review of Hywel Dda Vale University Health Board's discharge policy, 2017.

28 The Delivery Unit found limited evidence in patient records that patients' expectations of discharge were discussed with them. At the time of our audit, the Health Board was developing, in conjunction with the patient liaison group, a discharge leaflet/information sheet for patients. The draft leaflet refers to an assessment of discharge needs upon admission, estimated dates of discharge (EDD), transfer to the discharge lounge and several prompts for patients, such as arranging transport home.

29 Roles and responsibilities for effecting safe and timely discharge should be clearly defined in policies and procedures. This is so skills and knowledge are used to good effect and individual staff held to account for the role they play in the process. The discharge policy should set the standards for all staff responsible for discharge.

30 The Health Board's 'Discharge and Transfer of Care Policy' clearly outlines the roles and responsibilities of executive board members and senior managers in relation to the discharge process. This includes both strategic policy development to ensure quality and safety, and the operational implementation and monitoring for compliance. However, there is no specific reference to the roles and responsibilities of ward staff but the policy does set out what ward-based localised discharge protocols should cover, such as planning discharges to occur by 10 am on any day of the week.

31 The Discharge and Transfer of Care Policy does not set a time after which patients would not be discharged or transferred from inpatient wards. We asked staff what was the latest time at which patients would be discharged. Staff told us that in Pembrokeshire, patients that rely on transport from hospital to home, the Pembrokeshire Intermediate Voluntary Organisations Team takes its last call at 8 pm to ensure patients are home by 9 pm and they can make them safe at home. In Ceredigion, staff would only discharge patients late if they were confident that support was available at home. None of the staff we met could recall issues around late discharges.

32 The 'Discharge and Transfer of Care Policy' includes a range of key performance indicators to monitor compliance and to ensure patients are receiving appropriate

care, including increasing the percentage of patients discharged before 11 am. At the next scheduled review of the policy, the Health Board should clarify the timeframe for monitoring time of discharge, because the SAFER patient flow model aims to discharge 33% of patients from inpatient wards before midday and wards are encouraged to discharge patients by 10 am.

Formal discharge pathways, developed and agreed with local authority partners, are being rolled out

33 Hospital discharge planning should be seen as a continuous process that takes place seven days a week. Although not all staff involved in planning a patient's discharge will be available all of the time, communication, planning and co-ordination should continue. Defined discharge pathways that set out the sequence of steps and timing of interventions by healthcare professionals for defined groups of patients, particularly those with complex needs, can help ensure patients experience a safe and timely discharge.

34 In early 2016, community service managers developed five complex discharge pathways in response to the Delivery Unit's report on unscheduled care. The pathways were developed to differentiate the level of support needed for patients on discharge and the standards that should be achieved. The pathways were developed to provide guidance and instruction for ward staff in relation to all complex discharge pathways for patients in conjunction with the Discharge and Transfer of Care Policy.

35 The discharge pathways were developed in collaboration and agreed in principle with the Health Board's three local authority partners. Development took longer than anticipated and the pathways were rolled out in October 2016.

36 As part of our audit work, we looked at the main discharge pathways in place across NHS organisations. We assessed the extent to which there was clarity of purpose and use across the organisation, whether pathways were developed with local authority partners, supported by algorithms and standardised documentation and measures of quality.

37 We reviewed the five complex pathways against the criteria set out in Exhibit 5. Our review shows that the discharge pathways are generally comprehensive identifying the cohort of patients for whom the pathways apply as well as the intended outcome for the patient. The pathways also identify responsibilities of multidisciplinary team members for the various steps in the discharge process, when and how long each step should take place and when to escalate issues affecting timely discharge.

Exhibit 5: elements presented within the Health Board's discharge pathways

The table shows the Health Board's complex discharge pathways are generally comprehensive when assessed against a range of criteria.

Elements	Name of complex discharge pathways					Auditor observations
	Restarting package of care	Top-up care package or new long-term care package	Discharge to assess for reablement	Short stay residential/ nursing care (including community hospital)	Long stay residential nursing care	
Flow diagram/decision tree for identifying appropriate patients	No	No	No	No	No	Although there is no definitive decision tree, each pathway describes the cohort of patients for whom the pathways are suitable.
Specific discharge destination, eg, usual place of residence	Yes	Yes	Yes	Yes	Yes	Each pathway sets out the expected discharge destination.
Clear purpose	Yes	Yes	Yes	Yes	Yes	Each pathway sets out the expected outcome for each patient discharged from hospital.
Generic or condition specific pathway	Generic	Generic	Generic	Generic	Generic	
Transport or transfer logistics clearly acknowledged	Yes	Yes	Yes	Yes	Yes	Staff are referred to the transport arrangement section of the Discharge and Transfer of Care Policy, which makes clear that prior to requesting transport a decision is needed on the category or type of transport required.
Applies across all hospital sites	Not specified	Not specified	Not specified	Not specified	Not specified	Although not explicitly stated, it is clear from interviews with staff that discharge pathways should apply across the main hospitals.

Elements	Name of complex discharge pathways					Auditor observations
	Restarting package of care	Top-up care package or new long-term care package	Discharge to assess for reablement	Short stay residential/ nursing care (including community hospital)	Long stay residential nursing care	
Applies 24 hours a day, 365 days per year	Not specified	Not specified	Not specified	Not specified	Not specified	Although not explicitly stated, it is clear from interviews with staff that discharge pathways should apply 24 hours a day, seven days a week, 365 days per year. The Discharge and Transfer of Care Policy indicates that all inpatient discharges should take place on weekends as well as weekdays. However, there is no specific reference to discharges that might take place at night or weekends and how the pathways apply at these times when the availability of many community services is limited.
Developed with NHS partners e.g. neighbouring Local Health Boards, WAST or Velindre	No	No	No	No	No	Pathways developed by the county and community services management teams but hospital-based staff not involved.
Developed with local authority partners and applies equally across partners	Yes	Yes	Yes	Yes	Yes	Pathways developed by the county and community service management teams in collaboration with local authority partners. Pathways had to be agreed by these partners before being adopted and rolled out.
Supported by generic discharge documentation	Not specified	Not specified	Not specified	Not specified	Not specified	Staff reported that there was a lack of standardised documentation for discharge planning.
Supported by generic assessment documentation	Not specified	Not specified	Not specified	Yes*	Yes*	* These pathways make clear what assessments should be carried out, by whom and within what timescales.

Elements	Name of complex discharge pathways					Auditor observations
	Restarting package of care	Top-up care package or new long-term care package	Discharge to assess for reablement	Short stay residential/ nursing care (including community hospital)	Long stay residential nursing care	
Referral processes are clear	Yes	Yes	Yes	Yes	Yes	Each pathway provides the indicative timescale for carrying out the sequence of tasks, including liaising with current care providers, as well as referrals to community based services.
Agreed standards for response times for assessing need	Yes	Yes	Yes	Yes	Yes	Each pathway provides the indicative timescale for carrying out the sequence of tasks set out in the pathway.
Agreed standards for response times for service delivery	Yes	Yes	Yes	Yes	Yes	There are clear escalation processes in place if there is any deviation from the standards set out in the pathway.
Agreed standards for quality and safety	No	No	No	No	No	
Standards for information sharing with clinical/care staff in the community eg discharge letters	Yes*	Yes*	Yes	Yes	Yes	Expectation that the discharge summary letter is sent to the patient's GP or the GP providing general medical services to the residential care or nursing home within one hour of discharge. * For these two pathways, social workers should be informed within 24 hours of the discharge.

Exhibit source: Wales Audit Office review of Hywel Dda University Health Board's discharge pathways, 2017

38 The discharge pathways indicate that discharge summaries should be sent to a patient's GP within one hour of discharge. Several staff told us that the quality of discharge information between secondary and primary care can sometimes be problematic with GPs complaining about the timeliness and legibility of the discharge letters, particularly when they are unaware of a patient's admission. We did not assess the quality and timeliness of the discharge information, which is the

subject of HIW's review. However, the Health Board is slowly rolling out the electronic discharge advice letter system on a small number of wards. A total of eight wards (two at each main hospital) currently use the system with plans for eight more wards by the end of December 2017.

39 Staff told us that they were not sure how effective the discharge pathways are because the pathways were so new and systems were not yet in place to monitor compliance with the standards or steps in the pathway. Staff were confident that assessing compliance and success of the 'restart pathway' was easier to do by reconciling the number of packages of care restarted, and recent indications from social service colleagues suggest that the 'restart pathway' is working. Ward staff also reported that care providers had found it useful talking directly to ward staff because it saved them time.

40 Ward staff were confident that patients with end of life care needs could be fast tracked on a daily basis if necessary. These patients are managed separately to the medically fit or red and green list. Should these patients need continuing healthcare (CHC) support, staff told us that funding decisions could be fast tracked without the need for a CHC panel to approve it. Community nursing services provide care support for these patients working closely with the out-of-hours service.

41 The conventional approach to discharging patients, particularly the frail elderly, is to complete a series of ward-based assessments to identify the kind of support needed at home. These assessments are completed typically after the patient is declared 'medically' fit for discharge. Once assessments are completed, patients are then discharged when all appropriate support services or other resources are in place, which may take a significant amount of time. This is known as the 'assess to discharge' pathway or model.

42 The Welsh Government has been encouraging a 'discharge to assess' pathway or model[9] [10]. This is where patients are discharged home once they are 'medically' fit for discharge and no longer need a hospital bed. On the day of discharge, members of the appropriate community health and social care team will then assess the patients' support needs at home. This enables patients to access the right level of home care and support in real time, and removes the need for patients to be inappropriately kept in a hospital bed while waiting for assessments and services to be put in place.

43 The Delivery Unit found the use of 'discharge to assess' pathways was limited, and recommended that NHS organisations implement them. We found that half (four out eight) of NHS organisations had implemented a 'discharge to assess' model, although in some organisations, the model had been implemented only at specific hospital sites. One of the Health Board's discharge pathways is a 'discharge to assess' pathway where patients are discharged home with reablement support for

[9] Welsh Government (2010), **Setting the Direction: Primary & Community Services Strategic Delivery Programme**

[10] Welsh Government (2011), **Sustainable Social Services**

a period of six weeks to enable longer-term needs to be assessed within their own homes.

44 In addition, frailty work led by an elderly care physician and support worker on two wards at Prince Philip and one ward at Glangwili is building and strengthening relationships with two local authority care homes in Carmarthenshire. When residents of the care home are admitted and ready for discharge, the care homes will accept the residents back without the need for reassessment by their staff. Staff reported that this approach is helping to reduce lengths of stay. Private care homes have begun to express an interest in this model.

Dedicated resources are available to support discharge planning and ward staff are confident about what needs to be done, but training on discharge planning is infrequent and discharge lounges appear underutilised

Dedicated multidisciplinary resources are in place to support discharge planning

45 A discharge liaison team is a specialist team aimed at supporting the safe and seamless discharge or transfer of care of patients moving from hospital to community service provision. These teams can provide valuable support and knowledge to ward staff and offer help to facilitate complex discharges.

46 We sought information from every NHS organisation about whether they operate discharge liaison services/teams and the scope of these services/teams. Across Wales, we found that all NHS organisations, with the exception of Velindre NHS Trust, operate one or more discharge liaison teams. All teams operate weekday office hours only with the latest finishing time at 5.30 pm. Seven out of the 15 teams reported that they manage both simple and complex discharges.

47 The Health Board provides four discharge teams that are aligned to the four main hospitals but managed as part of community services on a county-wide basis. For the purposes of this report, we have referred to the Health Board's teams as discharge liaison teams. The four teams are:

- the Transfer of Care Advice and Liaison Service (TOCALS) covering Glangwili and Prince Philip Hospitals;
- the Assessing Alternatives to Admission (AA2A) team covering Bronglais, which includes a jointly funded post between the Health Board and Powys Teaching Health Board; and
- the discharge liaison nurse service in Pembrokeshire.

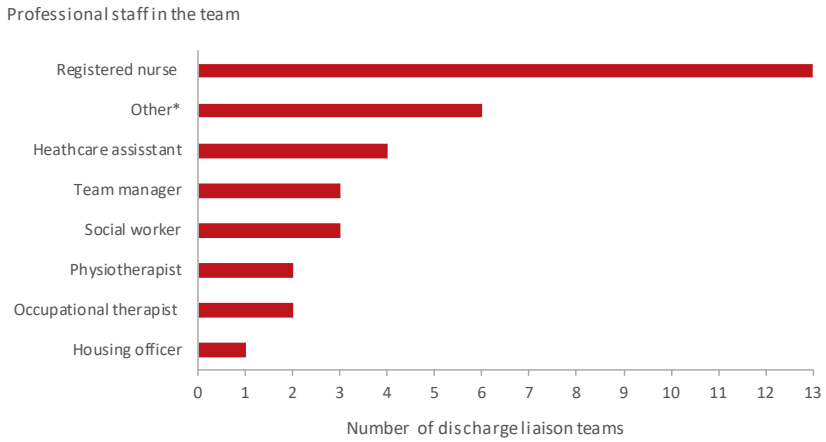
48 The teams operate between 8.00 am or 8.30 am until 5.00 pm each weekday, including bank holidays. At weekends, ward staff are expected to expedite

discharge plans already agreed while continuing to plan discharges to avoid unnecessary stays in hospital and improve patient flow. At the time of our audit, the physiotherapists in the Glangwili team were providing targeted intervention at the weekend, with plans underway to test occupational therapy input at the weekend. Since our audit work, the AA2A team has moved to a seven-day model and nurse-led discharge is being tested at weekends on wards at Bronglais.

49 Typically, discharge liaison teams are made up of nursing staff, but to better manage complex discharges, ideally, teams should be multidisciplinary. Exhibit 6 shows the different professional staff that make up discharge liaison teams across Wales. Only four teams are multidisciplinary with the remaining teams comprised of nursing staff. Discharge liaison teams range in size from two whole-time equivalent (WTE) staff to 29 WTE staff with the bigger teams working across multiple hospital sites. The average number of WTE staff per team was seven.

Exhibit 6: different professional staff deployed across discharge liaison teams in Wales at 30 September 2016

The chart shows that across Wales discharge liaison teams are comprised largely of nursing staff.



*Other includes pharmacist and administrative

Source: Wales Audit Office analysis of information collected on discharge liaison teams, 2017[11]

[11] The seven health boards in Wales operate discharge liaison teams. We received 15 data returns from discharge liaison teams although not all data returns were complete. Most discharge liaison teams are managed as separate services although in two health

50 Three of the Health Board's discharge liaison teams – Glangwili, Prince Philip and Bronglais – are multi-disciplinary, comprising nurses, occupational therapists, physiotherapists, social workers and healthcare assistants. At the time of our audit, there were 13 WTE staff deployed (excluding vacancies) across the Glangwili and Prince Philip teams and 4.7 WTE staff at Bronglais. The multidisciplinary composition reflects the remit of these teams in preventing avoidable admissions at the 'front door', particularly for frail older people, by referring them to appropriate community support, as well as supporting complex discharge planning for those patients who require admission. The Withybush team was much smaller – 2.4 WTE staff – and focused on supporting inpatient discharges from acute and community hospitals. At Withybush, a separate team based in A&E – the Multi-Assessment Support Team (MAST) – identifies those patients where acute admission is preventable with appropriate support in the community. Information about MAST is not included in our analysis of information provided by discharge liaison teams.

51 The combined cost of 13 of the 15 discharge liaison teams totalled £2.9 million between 1 October 2015 and 30 September 2016 with individual team costs ranging from £43,000 to £692,000. The average cost per discharge liaison team in Wales was £244,000. At the Health Board, the cost of the discharge liaison teams totalled £942,000, ranging from £98,000 to £692,000 (Exhibit 7).

Exhibit 7: cost of the Health Board's discharge liaison teams between 1 October 2015 and 30 September 2016

The table shows the cost of discharge liaison teams at Hywel Dda University Health Board between 1 October 2015 and 30 September 30 2016.

Discharge liaison team	Cost of the discharge liaison service (£)
Withybush Hospital	97,631
Bronglais Hospital	153,321
Glangwili and Prince Philip Hospitals	692,443
Total cost	942,395

Source: Wales Audit Office analysis of information collected on discharge liaison teams, 2017.

52 Gaps in information on staffing, activity and service costs make it difficult to establish the relative value for money of the discharge liaison teams between or within NHS organisations. Only four of the fifteen discharge liaison teams across Wales provided the information that we requested. Based on the information provided by these four teams, we compared the number of discharges between 1 October 2015 and 30 September 2016 with the WTE number of staff. The number

boards teams are managed as an integrated service. Other staff include for example administrative staff and pharmacists.

of discharges per WTE staff ranged from 50 discharges to 250; the average was 117 discharges per WTE staff.

53 At Bronglais, the discharge liaison team supported 95 discharges per WTE staff. We do not have complete information for the other three teams. However, the Glangwili and Withybush discharge liaison teams indicated that they managed one-fifth of all hospital discharges between 1 October 2015 and 30 September 2016.

54 We are unable to conclude whether there is a positive correlation between the WTE number of staff in these teams with timely and safe discharges. The Health Board does, however, collect information on the number of people supported by the TOCAL and AA2 teams to avoid an admission, or discharged within 72 hours, which has been highlighted in performance reports and unscheduled care plans.

55 The Delivery Unit's 2015 follow-up review of unscheduled care at the Health Board showed that the role of discharge liaison nurses varied across the four sites. As part of our audit work, we asked discharge liaison teams to describe how frequently, from always to never, they carried out a range of activities to support discharge planning. The Health Board's four teams always or often undertook the same activities as other teams across Wales (Exhibit 8) but there were notable exceptions between the county teams. These are:

- the Glangwili team reported always providing training and development for clinical staff to effect timely discharge, while the other three teams sometimes or rarely undertake this activity. Interviews with ward staff and the discharge liaison teams indicated that opportunities for informal training arise during board rounds on the wards or assessment units in A&E departments[12].
- the Glangwili team sometimes provides housing options advice and support to patients and their families.
- the Bronglais team sometimes works with operational managers to develop performance measures on hospital discharge.
- the Withybush team sometimes signposts patients and their families to advice and support for maintaining independence at home.

[12] A board round provides an opportunity for the multi-disciplinary team to discuss what needs to happen for each patient to meet their estimated date of discharge, referrals for assessment can be made and actions can be followed through.

Exhibit 8: the number of discharge liaison teams reporting always or often undertaking a range of activities

The table compares the number of discharge liaison teams at the Hywel Dda University Health Board and across Wales reporting always or often undertaking a range of activities.

Discharge planning activities	Number of teams reporting always or often undertaking activities	
	Health Board	All Wales
Participate in ward rounds or multi-disciplinary meetings	4	5
Support staff to identify vulnerable patients who could be delayed	4	8
Ensure individual discharge plans are in place for patients with complex needs	4	9
Liaise with other public bodies to facilitate hospital discharge and avoid readmission	4	9
Provide a central point of contact for health and social care practitioners	4	10
Work with operational managers to develop performance measures on hospital discharge	3	4
Validate data on delayed transfers of care (DTOC)	4	13
Provide training and development for clinical staff to effect timely discharge	1	5
Update bed managers with information on hospital discharges	4	10
Provide housing options advice and support to patients and their families	3	4
Signpost patients and their families to advice and support for maintaining independence at home	3	5
Total number of teams	4	15

Source: Wales Audit Office analysis of information collected on discharge liaison teams, 2017

56 Appendix 4 shows the extent to which, from always to never, a range of activities is carried out by discharge liaison teams across Wales. The discharge liaison teams are also responsible for steps in some of the discharge pathways where patients require short or long-term care in a community hospital residential or nursing home.

Discharge lounges are available but appear underutilised

57 A discharge lounge can also support effective discharge planning and patient flow by releasing beds promptly for other patients being admitted. Discharge lounges provide a suitable environment in which patients can wait to be collected, by either their family or hospital transport, or for medication to be dispensed.

58 We asked NHS organisations about their discharge lounge facilities. Across Wales, we found that all health boards, excluding Powys, operate discharge lounges in their acute hospitals. At the time of our audit work, discharge lounges across Wales had the capacity to support 192 patients at any one time who were awaiting discharge; the average capacity per discharge lounge was 11. Across Wales, discharge lounges operate between 8 and 12 hours weekdays only and are generally staffed by registered nurses and healthcare support workers. There are also food and toilet facilities available for patients.

59 The Health Board operates discharge lounges at its four district general hospitals on weekdays, with the exception of bank holidays. Three discharge lounges operate from 8.30 am for up to 9.5 hours. The Bronglais discharge lounge operates for six hours from 9 am. The Health Board's draft discharge leaflet/information sheet informs patients that they might be asked to wait in the discharge lounge from about 10 am on the day of discharge. Three discharge lounges, however, can accommodate patients from 8.30 am. Since our audit work, the Health Board has revised the electronic version of the discharge leaflet/information sheet to inform patients that discharge lounges are available from 8.30 am. The Health Board intends updating the printed version at the next print run.

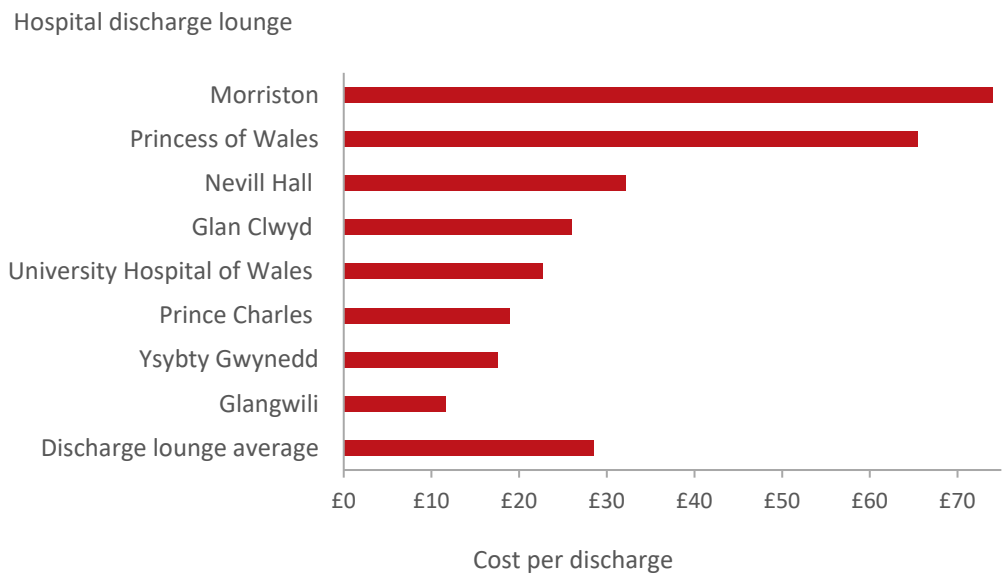
60 The capacity of each lounge to accommodate patients ranges from four at Bronglais, to nine at Withybush, ten at Prince Philip and 12 at Glangwili. These numbers include support for one to two patients who need to be in bed while waiting to be discharged. Guidance for each discharge lounge is in place setting out the scope of its work, roles and responsibilities, and inclusion and exclusion criteria. The guidance also indicates that patients should be transferred to the discharge lounge by 11 am if they are waiting for transport.

61 We requested information on staffing, costs and activity for discharge lounges. The information from NHS bodies was more complete than that for the discharge liaison teams. The number of staff deployed across hospital discharge lounges ranges from less than one WTE staff to five WTE staff; the average was three WTE staff. The combined cost for 12 of the 14 discharge lounges totalled £1 million with individual service costs ranging from £25,000 to £139,000. The average cost per discharge lounge was £86,600.

62 Exhibit 9 shows the variation in the cost per discharge supported by discharge lounges, which ranged from £12 to £74 per discharge. We do not have complete information for three of the Health Board's discharge lounges and are unable to provide comparative information. Based on the information provided for Glangwili Hospital, the cost per discharge was £12 compared with the discharge lounge average of £28.

Exhibit 9: comparison of the cost per discharge managed by individual hospital discharge lounges across Wales between 1 October 2015 and 30 September 2016

The chart shows the variation in the cost per discharge managed by the hospital discharge lounges across Wales, which ranges from £12 to £74 per discharge.



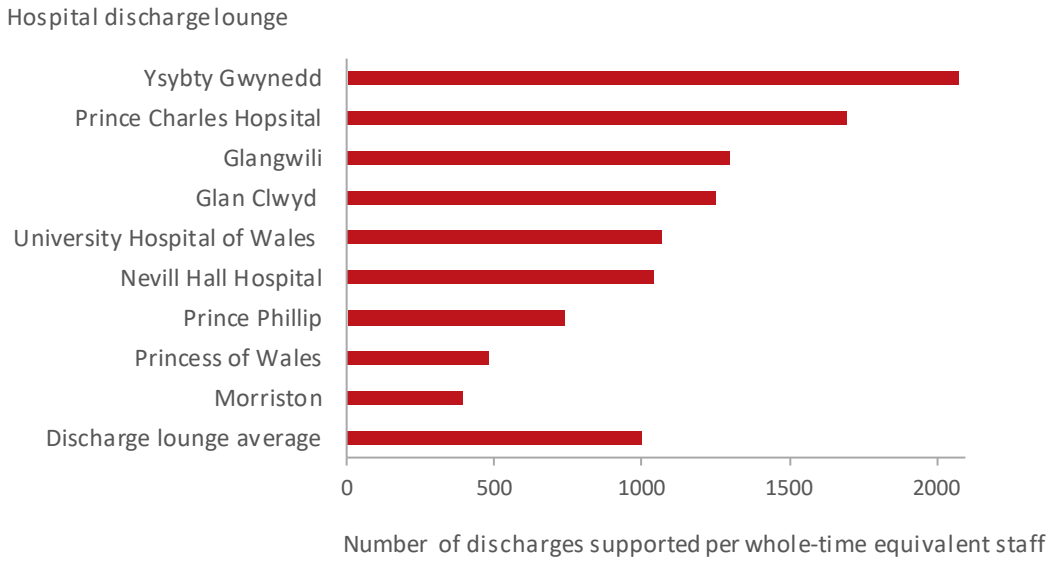
Source: Wales Audit Office analysis of information collected on hospital discharge lounges, 2017[13].

63 Again, we compared the number of discharges supported through the discharge lounge with the WTE number of staff. Based on the information provided by eight of the 14 discharge lounges, the number of discharges per WTE staff varied between 1 October 2015 and 30 September 2016, from just under 400 per WTE staff to just over 2,000 per WTE. We have information for two of the four discharge lounges at the Health Board, which shows that the discharge lounge at Glangwili managed more discharges (1,300 per WTE staff) compared with the discharge lounge average (1,000 per WTE staff) while Prince Philip managed fewer (734 per WTE staff) (Exhibit 10).

[13] We received information from 14 discharge lounges but only eight returns provided all relevant information to compare costs per discharge from the discharge lounge.

Exhibit 10: number of discharges per WTE staff supported through hospital discharge lounges in Wales between 1 October 2015 and 30 September 2016

The chart shows the number of discharges per whole-time equivalent staff varies across hospital discharge lounges in Wales, from just under 400 per WTE staff to just over 2,000 per WTE staff.



Source: Wales Audit Office analysis of information collected on hospital discharge lounges, 2017 (See Footnote 12).

64 We also compared the number of patients supported each day through the discharge lounges at Prince Philip and Glangwili between 1 October 2015 and 30 September 2016. The Prince Philip and Glangwili discharge lounges supported on average six patients and 10 patients per day respectively, fewer than the overall capacity and what might be possible given the operating hours of each lounge.

65 Our analysis of the number of patients supported by the Glangwili discharge lounge in April 2017 shows that an average of nine patients were supported each day. Just over a fifth (22%) of these patients were moved into the lounge before 10 am and more than half (55%) moved into the lounge between 10 am and 1 pm. We were told that information on total time spent waiting in the discharge lounge before leaving the hospital is not currently collated. We are unable to comment on whether more patients could be moved to the discharge lounge or whether delays prevent this happening, but information within the 13-week rolling plan for quarter four of 2016-17 indicates that the service was constrained by the ability of portering staff to transfer patients.

Ward staff are confident about what needs to be done to support safe and timely discharge and have a good understanding of the landscape of community services, but training on discharge planning is infrequent while some challenges, like reliance on agency staff, make discharge planning more difficult

66 Generally, responsibility for assessment and discharge planning rests with the ward team. Ward staff should be engaged in the discharge planning process and see it as part of the care continuum with ward staff and operational managers held to account for effective discharge planning. Staff need a good understanding of discharge policies and pathways, access to appropriate levels of training, and knowledge of the range of services available in the community to support discharge.

Training on discharge planning is infrequent

67 Front line staff should receive regular training appropriate to their role in the discharge process. This training should be part of both induction programmes, and regular specific updates, particularly where related policies rely on assessment and care planning. Ideally, training is provided on a multi-agency and or multi-professional basis to ensure discharge planning is everyone's business.

68 Exhibit 11 shows that across Wales, only half of NHS organisations include discharge planning in nurse induction programmes and offer regular refresher training. At the Health Board, discharge planning is part of induction programmes in Pembrokeshire for new starters in nursing, medicine, physiotherapy and occupational therapy. However, refresher training is offered less than biennially across all three counties.

Exhibit 11: availability of training on discharge planning for nursing staff

The table shows which NHS organisations provide training for discharge planning as part of nurse induction programmes and whether regular refresher training is provided for nursing staff.

NHS organisation	Training on discharge planning included in nurse induction programmes for new starters	Refresher training on discharge planning provided
Abertawe Bro Morgannwg	No	Yes
Aneurin Bevan	No	No
Betsi Cadwaladr (hospitals) • Ysbyty Gwynedd • Wrexham Maelor • Glan Clwyd	 Yes Yes Yes	 Yes Yes No
Cardiff and Vale	No	Yes
Cwm Taf	No	Yes
Hywel Dda (county teams) • **Pembrokeshire** • **Ceredigion** • **Carmarthenshire**	 **Yes** **No** **No**	 **No** **No** **No**
Powys	No	No
Velindre	Yes	Yes

Source: Wales Audit Office analysis of information on discharge planning returned by NHS bodies in 2017 (See Footnote 7)

69 The Health Board's Discharge and Transfer of Care Policy clearly states that the Health Board will 'ensure that all frontline staff have access to appropriate training in the management of patient discharge and transfer' with training addressed through the availability of the policy and through various training opportunities, such as internal training and induction programmes, e-learning resources or access to the 'Effective Discharge Planning' module provided by Swansea University.

70 Training was provided to ward managers when the discharge pathways were rolled out with ward managers responsible for cascading the training to their teams.

Ward staff are confident about what needs to be done to support safe and timely discharge, but this is made difficult by a number of challenges like a reliance on temporary staff

71 In its review, the Delivery Unit found a culture of risk aversion across Wales with staff speaking openly of a 'cwtch' culture[14] and insufficient time dedicated to managing the discharge process. As part of our audit work, we met with ward-based nursing staff and members of the discharge liaison teams[15] to talk about issues related to discharge planning at a ward level.

72 Ward managers that we met were clear about their role and that of their team in discharge planning, but felt that the time needed to plan patient discharges was often underestimated. We were told that discharge planning starts at the point of a patient's admission and that ward staff strive to discharge patients as soon as possible. Ward staff are required to complete a multi-page assessment document for each patient, including information for discharge. However, many pages of the assessment document were reported to be left blank, particularly in relation to a patient's usual or normal functional ability and how they manage at home. We were also told that assessments started by staff in A&E or assessment units were often left incomplete.

73 Meanwhile, members of the discharge liaison teams told us that when they attended board rounds they were surprised at ward staff lack of knowledge about individual patients' usual home circumstances or their usual physical and mental wellbeing. As part of its annual operating plan for 2017-18, the Health Board is taking action to embed a consistent and high quality board round process through ongoing training, which should help address some of these issues.

74 Ward managers told us that there is a need to build the confidence of more junior registered nursing staff to enable them to contribute fully at multidisciplinary team meetings. Meanwhile, staff from the discharge liaison teams feel that more training is needed on the decision support tool process for continuing healthcare funding, which could help in discharge planning processes.

75 The large number of nursing vacancies across the Health Board means that there is a reliance on agency nurses who are unfamiliar with the discharge processes and the availability of community services. Ward managers reported having to spend a lot of time supporting agency staff through the process or making discharge arrangements themselves.

76 Ward managers and community managers told us that increasing numbers of patients with complex needs are admitted to hospital, which makes it challenging to set realistic goals with patients and families about support on discharge. Ward

[14] The Delivery Unit described a cwtch culture ('cwtch' is the Welsh word for hug) whereby some staff were reluctant to discharge patients to their own home because they thought patients might be at risk. Whilst staff may be acting out of kindness, they may not be acting in patients' best interest.

[15] Participants included ward sisters, head of nursing, members of the discharge liaison teams, locality managers and community service managers.

managers and discharge liaison teams cited examples of family disputes where families did not respect a patient's choice.

77 Ward managers also cited a number of challenges to ensuring timely discharge which chime with the factors highlighted in paragraphs 19 to 22. The challenges include:

- a lack of capacity within local social service departments to carry out timely assessments;
- a lack of capacity within care homes and nursing homes across the whole week to assess patients being prepared for transfer or staffing problems that might mean patients cannot be transferred on certain days of the week;
- repatriating patients to hospitals closer to home in neighbouring health boards, particularly to community hospitals where there is no medical cover out of hours;
- delays where there is reliance on social workers from out of the area;
- an inability to transfer patients to tertiary care services in neighbouring health boards because these beds are full;
- the requirement to reassess patients already in receipt of packages of care but hospitalised for longer than two weeks so that new packages of care can be put in place; and
- care agencies not accepting new patients on a Friday because they did not want to start a new package of care over the weekend.

There is a good understanding of the landscape of primary and community services to support patients on discharge

78 Having a good understanding of the range and capacity of community health and social care services is an important part of ensuring timely discharge. Health bodies should hold up-to-date information about the availability of community services that can help patients once they have been discharged. These services can be available through NHS organisations, local authorities and third-sector organisations.

79 We asked health bodies, the types of information they collated on community services. Exhibit 12 shows that few organisations compile information about community services provided by other NHS organisations and housing options. In addition, relatively few collate information about waiting times for needs assessment and waiting times before services commence. At the Health Board, information on community services is collated both manually and electronically with information on availability usually available on a weekly basis.

Exhibit 12: number of health bodies which reported collating a range of information on community services

The table shows the number of health bodies that collate a range of information about community services.

	Range of services	Availability of services	Eligibility criteria	Referral process	Waiting time for needs assess ment	Waiting time for services to commence
Health Board's own community services	8	8	9	9	4	4
Community services provided by other NHS bodies	3	3	3	3	2	2
Social care services	9	9	9	10	6	3
Third sector	10	8	10	8	3	2
Housing options	4	2	4	6	2	2
Independent sector eg care home beds	7	6	9	9	2	2

Source: Wales Audit Office analysis of information on discharge planning returned by NHS bodies in 2017 (See Footnote 7).

80 Community managers told us that information on the capacity of community services, including community hospital beds, is largely collated by hand and captured in an Excel spreadsheet that is forwarded each morning to the County Directors. A daily dashboard using the RAG colour coding system is also compiled to illustrate the ability of community services, such as reablement, social care, acute response teams and joint equipment stores to respond to referrals for assessments. Until recently, the capacity of district nursing services was not included because caseloads were seen as capable of expanding, but recent reports have begun to highlight the size of the caseload. Information on the availability of beds in nursing and residential homes is collated weekly. This information is also shared with discharge liaison teams and hospital managers to inform them of the capacity in the community to discharge patients.

81 Meanwhile, ward staff reported that they generally know what services are available in the community although there is no formal directory. However, ward staff were less knowledgeable about the capacity of community services to support patients on discharge and expressed concerns that the Health Board's community services did not always have adequate capacity. If unsure what services are available, ward staff told us that they will contact discharge liaison teams whom they believe have the information because they are part of the wider community service and have a good understanding of what is possible in terms of support for

patients. Discharge liaison teams themselves report having a good understanding of the range of voluntary organisations to which patients can be signposted.

There is regular scrutiny of performance related to discharge planning ensuring board members feel well informed but improvements in performance are too slow

There are clear lines of accountability for discharge planning with regular scrutiny of performance both strategically and operationally

82 If arrangements are to be effective, there needs to be clear lines of accountability, and regular scrutiny of discharge planning performance. This is important to ensure there is a sustained focus to improve discharge processes and to maintain patient flow through hospitals.

83 At the Health Board, strategic responsibility for discharge planning is delegated to the Director of Operations/Deputy Chief Executive with these responsibilities set out clearly in the Discharge and Transfer of Care Policy. The unscheduled care programme board is a working group reporting to the executive team and it is chaired by the Director of Operations/Deputy Chief Executive. The unscheduled care programme board meets monthly to scrutinise progress against the 13-week plans with progress against actions coded using the RAG rating scheme. Operationally, the County Directors and Hospital General Managers are accountable for the delivery of these plans and the related performance measures, and at the end of every 13-week cycle an evaluation report is prepared.

84 All operational managers have access to a suite of performance reports available on the Health Board's Information Reporting Intelligence system (IRIS). The system can provide data for both the unscheduled care and planned care systems. The performance assurance tool collates a range of data from IRIS for specific sites on a daily, weekly or monthly basis, for example, comparing the balance of admissions and discharges, trends in time of admission or A&E waiting time breaches.

85 Within each hospital site, there are a number of arrangements in place for scrutinising performance in relation to discharge planning and patient flow. These include daily senior level reviews of the medically fit list, that is patients who are medically fit for discharge, weekly DTOC meetings between senior representatives from the Health Board and respective local authorities, and weekly patient flow meetings where operational staff account for the delays in discharging patients.

A range of information related to discharge planning and patient flow is regularly presented to the Board and Board members feel well informed

86 Having the right information on discharge planning performance is crucial for both monitoring and reporting. Delayed transfers of care are the only national measure, for both NHS organisations and local authorities, and as such are regularly monitored, reported and scrutinised. There are no other national measures related to discharge planning, and information about the quality and effectiveness of discharge planning is not readily available.

87 However, to understand delays in discharging patients from hospital, good practice dictates that NHS organisations should have a suite of performance measures, including information about patients' experience and outcomes from the discharge process. These can be a mixture of hard and soft measures.

88 As part of our review, we looked at the type of information monitored and reported to the Board or its committees, as well as operational groups, on performance related to discharge planning and how well patients are flowing through the hospital system. Exhibit 13 sets out the performance indicators regularly reported to the Board through the Integrated Performance Report.

Exhibit 13: range of performance information regularly reported to the Board

The table shows the information on performance related to discharge planning and patient flow regularly presented to the Board at Hywel Dda University Health Board.

Discharge planning	Patient flow
• Numbers of DTOCs for both mental and non-mental health facilities. • Number of DTOCs per 10,000 head of local authority population for mental health (all ages). • Number of DTOCs per 10,000 head of local authority population for non-mental health (age 75+).	• Percentage of patients who had procedures postponed on more than one occasion for non-clinical reasons with less than eight days' notice and are subsequently carried out within 14 calendar days or at patient's earliest convenience. • Percentage of patients waiting 4 hours or less in A&E. • Number of patients waiting 12 hours or more in A&E. • Percentage of patients waiting more than one hour for ambulance handover. • Percentage of patients waiting less than 26 weeks for elective treatment. • Number of patients waiting more than 36 weeks for treatment. • Average lengths of stay for emergency medical admissions.

Source: Wales Audit Office review of papers presented to the Board at Hywel Dda University Health Board

89 In March 2017, the Board received a report on the findings of the Fundamentals of Care audit carried out in October 2016. A new question was added to the patient survey to seek the patients' perspective on whether they were adequately prepared for discharge home. Ninety per cent of the patients responded that this was always or usually the case. In addition:

- 86% of patient records had written evidence of a discharge assessment and plan; and
- 87% of patient records had written evidence that the patient's family or carer had been involved in discharge planning.

90 The Board's Business Planning and Performance Assurance Committee also receives a similar Integrated Performance Report as the Board, which includes additional information on discharge and patient flow including:

- readmissions within 30 days of discharge for a basket of chronic conditions;
- percentage of deaths within 30 days of emergency admission for specific health conditions or health event;
- numbers of inpatients at Glangwili Hospital with long lengths of stay, that is over 28 days, and associated bed days; and
- information drawn from the coterminous County Council dashboards related to outcomes for people who have received a period of reablement.

91 The Health Board's Integrated Performance Report provides:

- a good understanding of the reasons and challenges affecting patient flow across hospital sites and reasons for DTOC;
- the trends in performance and the reasons for variation in performance; and
- the action being taken to improve discharge planning and patient flow performance and the likely timescale and planned improvement trajectory, for example, by reviewing patients with long lengths of stay with community service colleagues or twice-weekly reviews of all inpatients to enable repatriation back to their local hospital or health board of residence.

92 As part of our 2016 structured assessment work, we asked board members across the seven health boards and Velindre NHS Trust the extent to which they agreed with a number of statements about patient flow and discharge planning. Our survey found that of the Hywel Dda Board members responding to the survey:

- seven of the 14 agreed or strongly agreed that the Board and its committees regularly scrutinised the effectiveness of discharge planning compared with just over half (56%) across Wales. One board member commented that there was regular scrutiny by the Board or its Committees while the unscheduled care board provided an opportunity for a 'deep dive' into performance on a monthly basis.
- 12 out of 14 (85%) agreed or strongly agreed that they received sufficient information to understand the factors affecting patient flow compared with 75% of board members across Wales.

- 13 out of 14 (93%) agreed or strongly agreed that they understood the reasons for delays in discharging patients from hospitals within the organisation compared with 82% of board members across Wales. However, one board member commented that there was 'much talk about the factors and little change in the arrangements'.

93 Once the unscheduled care campaign becomes embedded, the Health Board will need to provide assurance to the Board and its committees that the unscheduled care campaign has had the desired effect in improving patient flow and outcomes for patients. The August 2017 Integrated Performance Report presented to the Business Planning and Performance Assurance Committee shows that there is some way to go before the intended impact is achieved. The SAFER patient flow model aims to discharge a third of patients before midday; data for Bronglais Hospital show that only 4% of patients discharged leave before midday with 20% leaving by 2.30 pm.

94 We also asked NHS organisations what information could be captured on their patient administration systems. Exhibit 14 shows that most organisations' patient administration systems have the ability to capture a range of data to support monitoring. However, less than half can record whether the discharge is simple or complex while a third can record the date a patient is declared medically fit; neither of these items can be captured by the Health Board's system.

Exhibit 14: data fields on NHS organisations' patient administration systems related to the discharge process

The table shows that most NHS organisations' patient administration systems can record a small range of data related to the discharge process to support operational monitoring.

Data fields on patient administration systems related to the discharge process	Number of NHS organisations responding positively
Expected date of discharge	12
Date of discharge from hospital	12
Time of discharge from hospital	12
Discharge destination eg home, residential, care home, etc.	12
Date the patient was declared medically fit for discharge	8
Whether the discharge is simple or complex	5

Source: Wales Audit Office analysis of information on discharge planning returned by NHS bodies in 2017 (See Footnote 7)

95 The Health Board's unscheduled care plans set out an ambitious list of performance measures that would enable compliance with the discharge policy and improvement initiatives to be monitored more generally. As well as the usual DTOC and length-of-stay measures, the indicators listed in the Discharge and Transfer of Care Policy, but yet to be reported systematically, include:

- increasing the percentage of wards using expected dates of discharge;
- increasing the percentage of patients having an EDD in place within 24 hours of admission; at Glangwili Hospital, healthcare support workers have been trained to update the Myrddin system out of hours when administrative support is not available;
- increasing the percentage of patients discharged before 11 am;
- the percentage of patients discharged to their usual place of residence; and
- completeness and timeliness of discharge letters.

96 The Health Board's recent update report on the annual operational plan indicates that an outcomes framework for unscheduled care would be approved in early September. The framework is intended to provide a 'whole system' performance management framework for measuring impact at a locality level alongside existing performance measures, such as DTOCs, lengths of stay and 12-hour A&E waits.

Performance related to discharge planning and patient flow is improving slowly but there is more to do to reduce lengths of stay and A&E waits

97 The Delivery Unit's follow-up review of unscheduled care took place at the Health Board in summer 2015. The Health Board's unscheduled care programme was established to address the Delivery Unit's recommendations for improving patient flow through reductions in A&E waiting times, DTOCs and lengths of stay. There are signs of improvement across a small number of performance measures related to discharge and patient flow but faster progress is needed.

98 Exhibit 15 shows that the total number of DTOCs[16] (excluding those in mental health facilities) reduced by 25% from 306 in 2015-16 to 229 in 2016-17. However, the proportion of patients whose discharge or transfer was delayed by more than three weeks is rising.

[16] A census of inpatients, who are ready to move onto the next stage of care but are prevented from doing so, is taken on the third Wednesday of each month.

Exhibit 15: change in number of delayed transfers of care (excluding mental health facilities) by length of delay between 2015-16 and 2016-17

The table shows that delayed transfers of care are reducing at Hywel Dda University Health Board but an increasing proportion of patients are delayed by more than three weeks.

Length of delay	Percentage (%) of delayed transfers of care (DTOC)	
	2015-16	2016-17
0-3 weeks	66	56
4-6 weeks	21	26
7-12 weeks	11	14
13-26 weeks	1	3
26+ weeks	0	0
Total number of DTOCs	306	229

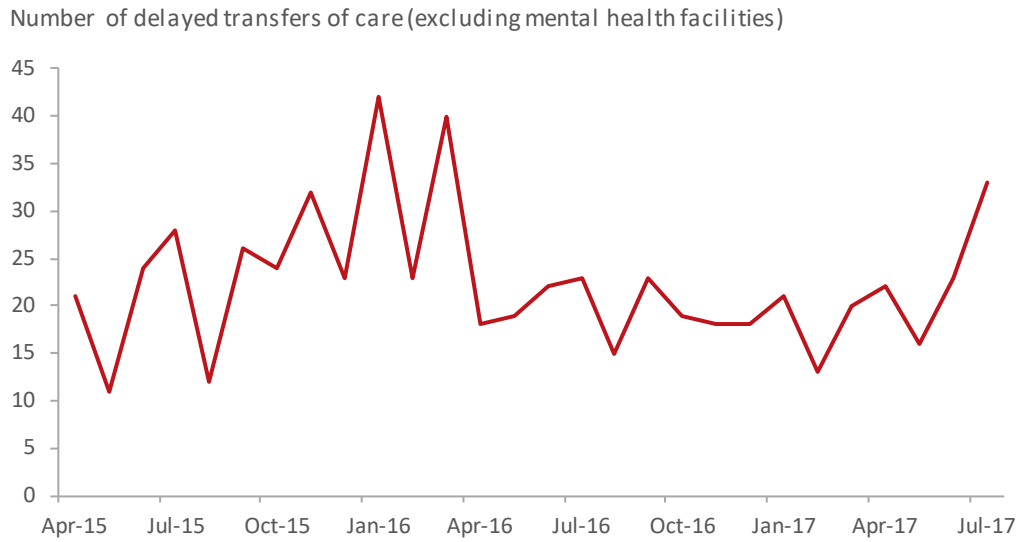
Source: Wales Audit Office analysis of the NHS Wales delayed transfers of care database, September 2017.

99 Exhibit 16 shows the trend in the number of DTOCs (excluding those in mental health facilities) since April 2015. There were smaller fluctuations in the monthly number of DTOCs during 2016-17 compared with the previous year. Average monthly DTOCs reduced from 25 in 2015-16 to 19 in 2016-17. Average monthly DTOCs for quarter one of 2017-18 continue to show small fluctuations although in July there was a spike in numbers not seen since the beginning of 2016.

100 Healthcare reasons accounted for nearly half (48%) of the delays at the Health Board in 2015-16 while one in three (32%) were attributed to community care reasons. By the end of 2016-17, the reasons for delay were reversed with 33% attributed to healthcare reasons and 42% attributed to community care reasons.

Exhibit 16: trend in delayed transfers of care (excluding mental health facilities) between April 2015 and July 2017

The chart shows the trend in the number of delayed transfers of care at the Health Board with smaller fluctuations during 2016-17 although there was a spike in July 2017 not seen for more than a year.



Source: Wales Audit Office analysis of the NHS Wales delayed transfers of care database, September 2017

101 No patients should wait more than 12 hours in A&E departments to be admitted, transferred or discharged. Patients waiting 12 or more hours in A&E is often indicative of problems with patient flow. The Health Board faces a number of challenges affecting 12-hour waits, not least difficulties recruiting and retaining medical and nursing staff across the whole of its unscheduled care system. In addition, there is limited hospital bed capacity to move those patients waiting to be admitted from A&E to an inpatient ward. Developments aimed at improving discharge planning and recent success in filling some vacant posts are expected to help improve performance.

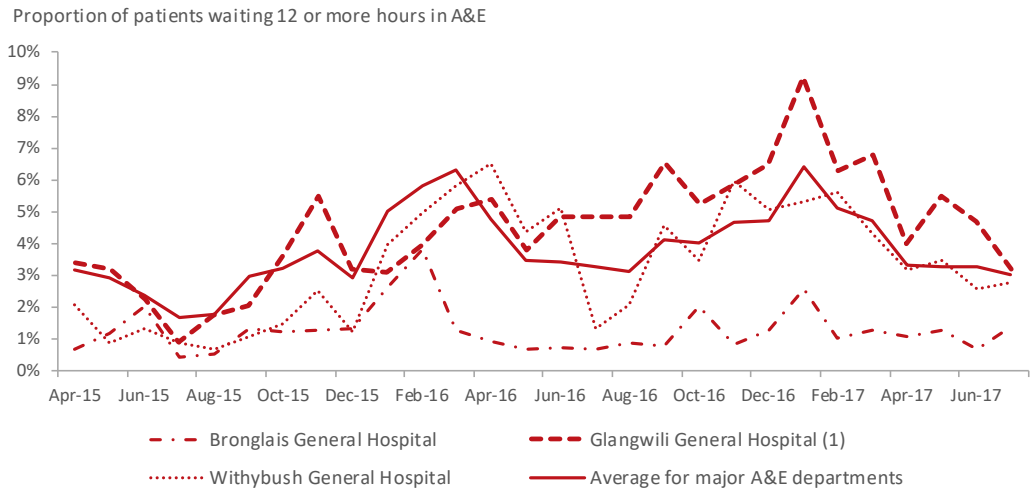
102 Across Wales, A&E attendances increased by 5% between 2015-16 and 2016-17 but the number of patients waiting 12 hours or more reduced by 0.4%. At the Health Board, A&E attendances increased by 5% but so did the number of patients waiting 12 hours or more (up by 3%). The proportion of patients waiting 12 or more hours varies across the Health Board's A&E departments. During 2016-17, 1% of patients waited 12 or more hours at Bronglais compared with 2% at Withybush and 3% at Glangwili.

103 Exhibit 17 compares the proportion of patients waiting 12 hours or more at the Health Board's A&E departments with the Wales average (4%). Performance has been consistently worse than the Wales average since April 2016 but there are

signs of improvement. Data for 2017-18, show that the proportion of patients waiting 12 or more hours is reducing across all the Health Board's A&E departments despite an increase in the average daily attendance.

Exhibit 17: proportion of Health Board patients waiting more than 12 hours in accident and emergency compared to the all-Wales average between April 2015 and July 2017

The chart compares the proportion of patients waiting 12 hours or more at Hywel Dda University Health Board's accident and emergency departments with the Wales average; over the last year, performance was consistently poorer at Glangwili.



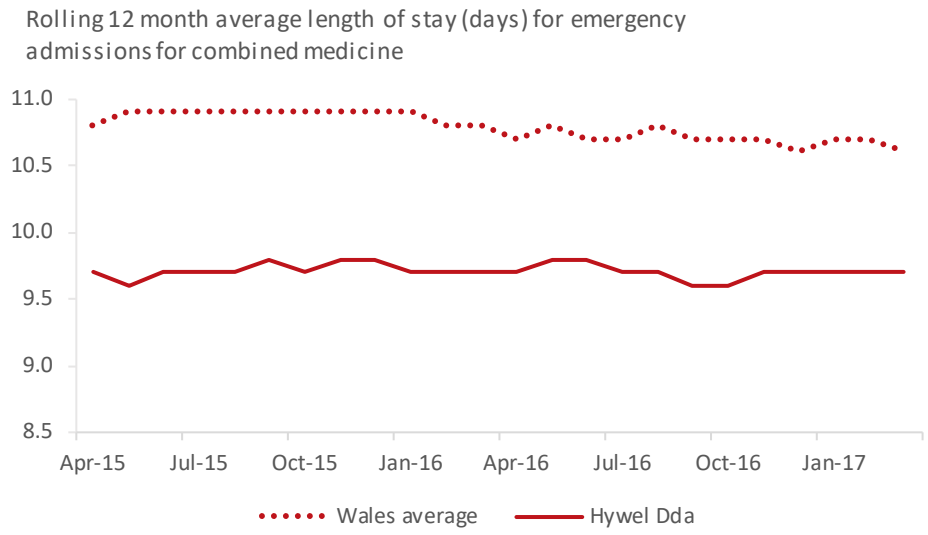
Source: Wales Audit Office analysis of the Performance against 12 hour waiting times target by hospital, NHS Wales Informatics Services, September 2017.

104 NHS bodies are expected to reduce lengths of stay for emergency medical admissions. Performance is measured on a rolling 12-month basis (the performance reported for any single month therefore representing the average over the previous 12 months rather than the in-month performance). Exhibit 18 shows little change in the rolling average length of stay[17] for emergency medical admissions over the last two years at the Health Board with average lengths of stay well below the Wales average.

[17] The performance reported for any single month represents the average over the previous 12 months rather than the in-month performance.

Exhibit 18: trend in the 12-month rolling average length of stay (days) for emergency admissions for combined medical wards between April 2015 and March 2017

The charts shows small fluctuations in the rolling average length of stay for emergency medical admissions to Hywel Dda University Health Board and across Wales; average lengths stay at the Health Board are well below the Wales average.



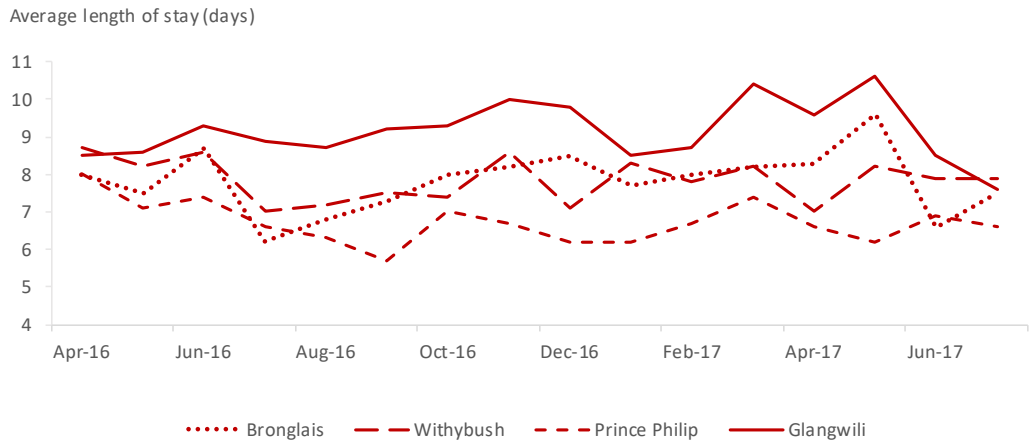
Please note that the Y-axis does not start at zero.

Source: Wales Audit Office analysis of NHS Wales efficiency data provided by the NHS Wales Informatics Service, March 2017

105 Exhibit 19 shows the monthly fluctuations in the average length of stay for medical emergency admissions between the Health Board's district general hospitals. Average lengths of stay are longer at Glangwili but in July 2017, the average length was the lowest (7.6 days) it has been since April 2016.

Exhibit 19: trend in average length of stay for medical emergency admissions at the Health Board's district general hospitals

The charts shows the trend in average length of stay for medical emergency admissions at Hywel Dda University Health Board's four district general hospitals.



Please note that the Y-axis does not start at zero.

Source: Wales Audit Office analysis of Hywel Dda University Health Board Integrated Performance Report (August 2017).

Appendix 1

NHS Wales Delivery Unit's quantitative findings from discharge planning audits at the Health Board's acute hospitals

Exhibit 20: the RAG status[18] of the Delivery Unit's assessment of written evidence in case notes against specific requirements set out in Passing the Baton[19]

The table shows that written evidence in relation to the patient discharge process was variable between hospitals and largely poor when assessed against expected practice.

Discharge process	Expected practice	Glangwili Hospital	Bronglais Hospital	Withybush Hospital	Prince Philip Hospital
Stage 1 All discharges, within 24 hours of admission	Simple/complex discharge is identified on, or shortly after, admission to hospital.				
	A conversation will be had with the patient to establish how they were managing before admission, so that any discharge requirements can be identified, and planned for, from the admission date.				
	A conversation will be had with the patient's main carer (where appropriate) to establish any discharge requirements early in the hospital admission.				
	Long-term conditions will be identified on admission, and the patient's perception of their current status established.				
	Existing care co-ordination and support in the community is identified.				

[18] The RAG (red, amber green) traffic light system provides a simple colour-coding system to visualise where performance is less than optimal; for example, green would indicate that these activities were undertaken in all cases.

[19] See Footnote 2.

Discharge process	Expected practice	Glangwili Hospital	Bronglais Hospital	Withybush Hospital	Prince Philip Hospital
Stage 1 All discharges, within 24 hours of admission	Patients and their families are provided with written information on what they should expect from the discharge process, and what is expected from them.				
Stage 2 Complex discharges	Early conversations take place with existing service provision to identify and pro-actively address any developing issues.				
	Existing care co-ordinator is identified.				
	In complex discharges, the patient and carer are given the contact details of the named professional who will act as their care co-ordinator.				
	In complex discharges, a Multi Disciplinary Team (MDT) case conference is arranged to consider assessments and agree a discharge plan with the patient/carer.				
Stage 3 All discharges	An Estimated Date of Dishcarge (EDD) is set.				
	The EDD takes account of both acute and rehabilitation phases, where applicable.		Not applicable		
Stage 4 All discharges	The EDD is clearly communicated to the patient and their family/carers.				
	Discharge plans are reviewed daily and there is evidence of actions completed.				
	Potential constraints are identified and actioned/escalated.				
	The patient and their family/carers are regularly updated on progress with the discharge plan.				

Discharge process	Expected practice	Glangwili Hospital	Bronglais Hospital	Withybush Hospital	Prince Philip Hospital
Complex discharges	Alternative community pathways are considered to facilitate early discharge and optimise independence.				
	The 'discharge/transfer' to assess model is considered in all complex discharges.				
	Timely MDT assessment is collated by the care co-ordinator.				
	A tailored discharge plan is co-produced with the patient/carer, reflecting their strengths and what is most important to them.				
	Third-sector provision is considered where appropriate.				
	Where required (eg to discuss onward placement or to determine Continuing Healthcare (CHC) eligibility) MDT meetings are arranged in a timely manner.				
	If a care home placement is required, the patient and carer are provided with 'Clear information on the category of home they should by looking for			Not applicable	Not applicable
	Information on care homes in the area			Not applicable	Not applicable
	Information on the Choice Policy			Not applicable	Not applicable
	Information on where they can access help in looking for a suitable home if they require it (eg third sector)			Not applicable	Not applicable
Stage 5 All discharges	A checklist is completed to ensure that the practicalities of discharge are addressed.				

Source: NHS Wales Delivery Unit, Discharge Audit at Hywel Dda University Health Board, 2015

Appendix 2

Audit methodology

Our review of discharge planning took place across Wales between February and June 2017. Details of our audit approach are set out below.

Exhibit 21: audit methodology

The table shows the range of activities undertaken as part of the audit process.

Method	Detail
Data Collection Form – Discharge Planning (Health-Board-level information)	We sought corporate-level information about the extent of shared priorities for discharge and transfers of care; the services or teams available to support timely discharge; the landscape of community-based services; training to support discharge planning; performance management related to discharge planning; and the extent to which information about housing adaptation services is shared with NHS organisations. The information returned has supported both the discharge planning audit and the Auditor General's study on housing adaptations. The Health Board submitted completed data forms – one for each county.
Data Collection Form – Discharge Lounge	We asked NHS organisations that operated a discharge lounge service to tell us about each one. We sought information about the following: operational hours; staffing profile; numbers of patients accommodated; and the environment for patients. The Health Board submitted four forms, one for each acute hospital.
Data Collection Form – Discharge Liaison Team	We asked NHS organisations to tell us about the discharge liaison team where these existed. We sought information about the following: operational hours; the staffing profile; team/service costs and types of activities. Where multiple discharge liaison teams operate, one form was completed for each main acute hospital provided the teams operated independently of each other. If the discharge liaison team service operated as a single integrated service, one form was completed. The Health Board submitted four forms as each hospital has its own discharge liaison service.

Method	Detail
Document request	We reviewed documents produced by the Health Board that covered strategies and plans for managing patient flow and unscheduled care, policies related to discharge and transfer of care and 'home of choice', discharge pathways, action plans to improve discharge planning processes and patient flow, and performance reports, including those related to patient experience or information on complaints and incidents related to the discharge process. We also relied on information set out in the reports prepared for the Welsh Government by each health board or regional partnership summarising how the Integrated Care Fund was used and its impact in 2015-16.
Interviews	We interviewed a number of staff including: • the Chief Operating Officer; • the Hospital General Managers responsible for unscheduled care; • members of all discharge liaison teams, including the service leads and managers, intermediate care co-ordinators, discharge liaison nurses, social service leads, etc; • County Director and Community Service Manager; • the Head of Occupational Therapy (OT) Services and community lead for OT services; and • ward managers from the four main hospitals and a Head of Nursing.
Use of existing data	We used existing sources of information wherever possible such as the Delivery Unit's work on discharge planning from 2016, data from the StatsWales website for numbers of DTOC, hospital beds, patients spending 12 hours or more in A&E departments and lengths of stay.

Source: Wales Audit Office

Appendix 3

The Health Board's management response to the recommendations

Exhibit 22: management response

The table on the next page sets out the report's recommendations and the actions that the Health Board intends to take to address them.

Ref	Recommendation	Intended outcome/benefit	High priority (yes/no)	Accepted (yes/no)	Management response	Completion date	Responsible officer
R1	**Discharge and Transfer of Care Policy:** Our assessment of the Health Board's policy indicates that it could be strengthened at the next scheduled review. The Health Board should include: a. the patient discharge leaflet; b. the discharge pathways; c. a discharge checklist; d. reference or web links to the Home of Choice policy e. typical escalation procedures; f. arrangements for patients discharged from A&E departments or medical/clinical assessment units; and g. roles and responsibilities of ward staff.	Related policies and supporting documents become integral and located in one place. The roles and responsibilities of ward staff in the discharge process are made explicit. There is clarity about requirements for discharging patients from A&E and assessment units.	No	Yes	Actions identified: All recommendations will be considered as part of the next policy review which is due to be undertaken by May 2018.	May 2018	Assistant Director Operational Nursing and Quality Acute Services

Ref	Recommendation	Intended outcome/benefit	High priority (yes/no)	Accepted (yes/no)	Management response	Completion date	Responsible officer
R2	**Discharge and Transfer of Care Policy:** One of the indicators for monitoring the impact of the policy is the percentage of patients discharged before 11 am while the success of the SAFER patient flow model is assessed on discharging 33% of patients from inpatient wards before midday. The Health Board should clarify whether the timeframe for the purpose of monitoring needs to be the same or different, and if so, ensure the ability to monitor two separate indicators.	Staff work to the same deadline by which to discharge patients. There is consistency in comparative measures when assessing improvements to discharges earlier in the day.	Yes	Yes	All Acute sites are implementing the SAFER patient bundle as part of their ongoing unscheduled care actions. The Service Improvement (SI) teams are working with ward level teams to ensure that SAFER is well communicated and embedded as part of the daily ward routine. The times in the policy will be updated as the next refresh in May 2018 (see above).	Work started but to be fully embedded by summer 2018 May 2018	SI Team Assistant Director Operational Nursing and Quality Acute Services

Ref	Recommendation	Intended outcome/benefit	High priority (yes/no)	Accepted (yes/no)	Management response	Completion date	Responsible officer
R3	**Training on discharge planning:** The Discharge and Transfer of Care Policy indicates that all frontline staff should have access to appropriate training. However, there is no regular training on discharge planning and its inclusion in induction programmes is inconsistent while agency staff are unfamiliar with the discharge process. Meanwhile, several staff felt more training is needed on the Decision Support Tool for the continuing healthcare funding process, which would, in turn, inform discharge planning arrangements. The Health Board should: a. include training on discharge planning in induction programmes for staff who will be involved in making discharge arrangements; b. offer regular refresher training on discharge planning; c. explore opportunities for including the use of the Decision Support Tool in training on discharge planning; and d. provide simple guidance for bank and agency nursing staff to enable them to contribute effectively to discharge planning arrangements.	New staff have the right skills and knowledge to effectively plan discharge. Discharge policies and procedures are consistently applied. Staff have up-to-date knowledge of discharge processes and procedures. Staff are confident in using the decision support tool to record evidence of an individual's care needs in relation to continuing healthcare funding. Bank and agency nursing staff can contribute effectively to discharge planning arrangements.	Yes	Yes	As part of the wider Health Board's Unscheduled Care Program actions relating to discharge processes including discharge to assess and CHC processes are being considered mainly as part of a work stream/component 6 – 'Get Me Home Safely' but also in work stream/component 5b – 'Inpatient Care' which focuses on ensuring that the discharge process is commenced early in the admission.	Fully embedded by November 2018	Work stream lead – 6 Get Me Home Safely

Ref	Recommendation	Intended outcome/benefit	High priority (yes/no)	Accepted (yes/no)	Management response	Completion date	Responsible officer
R3	**Training on discharge planning:** The Discharge and Transfer of Care Policy indicates that all frontline staff should have access to appropriate training. However, there is no regular training on discharge planning and its inclusion in induction programmes is inconsistent while agency staff are unfamiliar with the discharge process. Meanwhile, several staff felt more training is needed on the Decision Support Tool for the continuing healthcare funding process, which would, in turn, inform discharge planning arrangements. The Health Board should:# a. include training on discharge planning in induction programmes for staff who will be involved in making discharge arrangements; b. offer regular refresher training on discharge planning; c. explore opportunities for including the use of the Decision Support Tool in training on discharge planning; and d. provide simple guidance for bank and agency nursing staff to enable them to contribute effectively to discharge planning arrangements.	New staff have the right skills and knowledge to effectively plan discharge. Discharge policies and procedures are consistently applied. Staff have up-to-date knowledge of discharge processes and procedures. Staff are confident in using the decision support tool to record evidence of an individual's care needs in relation to continuing healthcare funding. Bank and agency nursing staff can contribute effectively to discharge planning arrangements.	Yes	Yes	Multi disciplinary workshops were held to develop key actions underpinning these components with actions subject to consultation with staff and other stakeholders. The workshops highlighted that each component is not a discrete step and there are overlaps between components and actions which will need to be reflected carefully as workstream actions progress. The high level actions have been agreed by the Unscheduled Care Board in November. A clinical workstream leader will develop, with an associated multi disciplinary group, clear terms of reference, deliverables and timescales and an associated unscheduled care plan will be implemented.	Fully embedded by November 2018	Work stream lead – 6 Get Me Home Safely

Ref	Recommendation	Intended outcome/benefit	High priority (yes/no)	Accepted (yes/no)	Management response	Completion date	Responsible officer
R3	**Training on discharge planning:** The Discharge and Transfer of Care Policy indicates that all frontline staff should have access to appropriate training. However, there is no regular training on discharge planning and its inclusion in induction programmes is inconsistent while agency staff are unfamiliar with the discharge process. Meanwhile, several staff felt more training is needed on the Decision Support Tool for the continuing healthcare funding process, which would, in turn, inform discharge planning arrangements. The Health Board should: a. include training on discharge planning in induction programmes for staff who will be involved in making discharge arrangements; b. offer regular refresher training on discharge planning; c. explore opportunities for including the use of the Decision Support Tool in training on discharge planning; and d. provide simple guidance for bank and agency nursing staff to enable them to contribute effectively to discharge planning arrangements.	New staff have the right skills and knowledge to effectively plan discharge. Discharge policies and procedures are consistently applied. Staff have up-to-date knowledge of discharge processes and procedures. Staff are confident in using the decision support tool to record evidence of an individual's care needs in relation to continuing healthcare funding. Bank and agency nursing staff can contribute effectively to discharge planning arrangements.	Yes	Yes	Processes and commissioning to support implementation of Discharge to Assess pathways is an identified action. Training of staff both at induction and refresher training will be a key action for local teams as part of the rollout and embedding of the complete discharge pathway. Alongside the training consideration will need to be given to providing clear and simple information on the discharge for all staff to ensure that any bank and agency staff can effectively support the discharge process and that out of normal working hours discharge processes are supported.	Fully embedded by November 2018	Work stream lead – 6 Get Me Home Safely

Ref	Recommendation	Intended outcome/benefit	High priority (yes/no)	Accepted (yes/no)	Management response	Completion date	Responsible officer
R4	**Discharge lounge:** Discharge lounges appear to support fewer patients than might be expected given their overall capacity and operational hours. Meanwhile, some patients are waiting 12 or more hours overnight in A&E until beds become available. The Health Board should: a. actively promote the use of the discharge lounge; b. ensure patients being discharged are moved to the discharge lounge as soon as it opens; c. find out what prevents more patients being moved to the lounge on the day of discharge; and d. collate information on the length of time patients remain in the discharge lounge before leaving the hospital to assess whether slow turnover is preventing patients from being moved to the lounge on the day of discharge.	Productivity is improved relative to the resource investment. Increasing throughput will ensure beds are available for new admissions as early in day as possible.	Yes	Yes	As part of the wider Unscheduled care program actions relating to utilisation and consistency of discharge lounges are being addressed in workstream/component 5b – Inpatient Care. The workshop identified that not only is the utilisation of discharge lounges variable, there is no consistency around environment, opening hours, staffing levels etc. A key action is to instigate a project to maximise potential of discharge lounges across the HB, this will be developed as part of this work stream. Acute sites are reviewing the data collected relating to patients being discharged from the discharge lounge, on a monthly basis, but this is a manual collection.	Work started but to be fully embedded by Summer 2018	Work stream lead – 5b Inpatient Care

Ref	Recommendation	Intended outcome/benefit	High priority (yes/no)	Accepted (yes/no)	Management response	Completion date	Responsible officer
R4	**Discharge lounge:** Discharge lounges appear to support fewer patients than might be expected given their overall capacity and operational hours. Meanwhile, some patients are waiting 12 or more hours overnight in A&E until beds become available. The Health Board should: a. actively promote the use of the discharge lounge; b. ensure patients being discharged are moved to the discharge lounge as soon as it opens; c. find out what prevents more patients being moved to the lounge on the day of discharge; and d. collate information on the length of time patients remain in the discharge lounge before leaving the hospital to assess whether slow turnover is preventing patients from being moved to the lounge on the day of discharge.	Productivity is improved relative to the resource investment. Increasing throughput will ensure beds are available for new admissions as early in day as possible.	Yes	Yes	Further work is needed to agree a common data set; this includes length of stay in the discharge lounge. This metric will form part of the workstream developing a wider set of metrics looking at each component within the unscheduled care system. This work is currently ongoing and the Health Board is working with Welsh Government and NHS Delivery Unit colleagues to align our local work with national work. Embedding the SAFER patient bundle will encourage use of the discharge lounge, in a timelier manner.	Work started but to be fully embedded by Summer 2018	Work stream lead – 5b Inpatient Care

Ref	Recommendation	Intended outcome/benefit	High priority (yes/no)	Accepted (yes/no)	Management response	Completion date	Responsible officer
R5	**Performance reporting:** The Health Board has recently launched its unscheduled care campaign. The Health Board should include a summary of the impact of the campaign in the Integrated Performance Report at March 2018.	The Board members are provided with assurance that the unscheduled care campaign has achieved its goals.	No	Yes	Work is ongoing to develop a set of metrics across all the component parts of the wider unscheduled care pathway and we are working closely with Welsh Government and NHS Delivery Unit colleagues to ensure alignment to metrics being developed nationally to support both the national unscheduled care programme and also the integrated older persons pathway. Monthly updates will be provided to the unscheduled care board, regional partnership board and the operational teams across both health & social care. A summary of the impact of the actions will be included in the Integrated Performance report in March 2018.	March 2018	Director of Operations

Ref	Recommendation	Intended outcome/benefit	High priority (yes/no)	Accepted (yes/no)	Management response	Completion date	Responsible officer
R6	**Information for monitoring performance or compliance with standards:** The patient administration does not capture data items that could support monitoring and reporting of compliance with discharge standards and policies. The Health Board should assess if the patient administration system can be used to capture additional data items, such as whether a discharge is simple or complex and the date a patient is 'medically fit' for discharge.	There would be less reliance on paper lists. Instead agreed data items could be captured and reported electronically.	No	Yes	Work is currently ongoing with social care colleagues to capture consistent discharge information via SharePoint relating to those patients over 7 days length of stay (LOS) and classed as requiring additional support. Once the format is agreed by both organisations roll out will be implemented across the region. The information department are reviewing if there any free fields within the current Myrddin patient administration system that could be utilised to record a simple/complex discharge and allow reports to be run against this field. Currently the type of discharge should be recorded in the Fundamentals of Care documentation; a further recent audit in partnership with the NHS Delivery Unit noted that recording of this remains poor. Actions to improve the understanding, indentifying and recording the type of discharge will form part of the work stream – 5b Inpatient Care.	Summer 2018. Work started but to be fully embedded by Summer 2018	Head of Integrated Services Work stream lead – 5b Inpatient Care

Appendix 4

Activities undertaken by discharge liaison teams across Wales

As part of this review, we asked health boards to what extent, from always to never, their discharge liaison teams undertake a range of discharge planning activities. Exhibit 23 shows the reported frequency with which the 15 discharge liaison teams across Wales undertake these activities.

Exhibit 23: the frequency with which discharge liaison teams across Wales reported undertaking a range of activities

The table shows the reported frequency with which the 15 discharge liaison teams across Wales undertake a range of activities.

Discharge planning activities	Reported frequency with which discharge liaison teams undertake the following activities				
	Always	Often	Sometimes	Rarely	Never
Participate in ward rounds or multi-disciplinary meetings	33%	40%	20%	7%	0%
Support staff to identify vulnerable patients who could be delayed	53%	40%	7%	0%	0%
Ensure individual discharge plans are in place for patients with complex needs	60%	27%	13%	0%	0%
Liaise with other public bodies to facilitate hospital discharge and avoid readmission	60%	27%	7%	7%	0%
Provide a central point of contact for health and social care practitioners	67%	33%	0%	0%	0%
Work with operational managers to develop performance measures on hospital discharge	27%	20%	40%	7%	7%

Discharge planning activities	Reported frequency with which discharge liaison teams undertake the following activities				
	Always	Often	Sometimes	Rarely	Never
Validate data on DTOC	87%	7%	0%	0%	7%
Provide training and development for clinical staff to effect timely discharge	33%	13%	40%	13%	0%
Update bed managers with information on hospital discharges	67%	20%	0%	7%	7%
Provide housing options advice and support to patients and their families	27%	27%	20%	7%	20%
Signpost patients and their families to advice and support for maintaining independence at home	33%	27%	27%	7%	7%

Source: Wales Audit Office analysis of information on discharge planning returned by NHS bodies in 2017 (See Footnote 11).

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