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Discharge Planning – **Powys Teaching Health Board**

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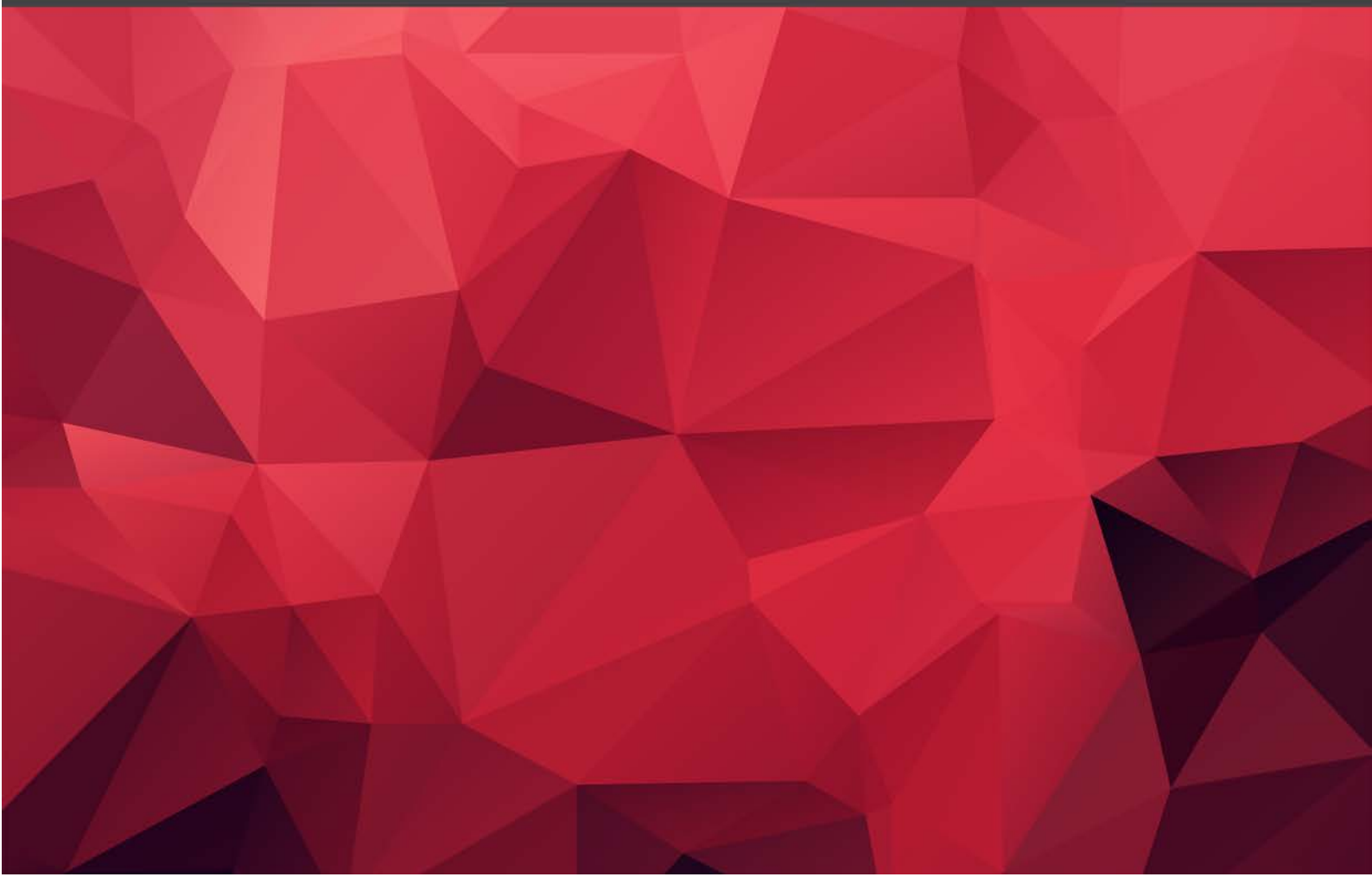

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This document is also available in Welsh.

The team who delivered the work comprised Fflur Jones and Gabrielle Smith.

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The Health Board can demonstrate its intention to improve discharge planning in collaboration with key stakeholders, but staff training is poor, performance monitoring is limited and the absence of formal discharge pathways presents a barrier to improvement.

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 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 straight forward 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;
- greater clarity around discharge pathways,[4] and

[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**

[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.

- 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'[2]. The findings for Powys Teaching Health Board (the Health Board) show that the patient discharge process was variable 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 been undertaking a review of housing adaptation. This 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 has been 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 to be published in autumn 2017.

Key findings

10 Our overall conclusion is: **The Health Board can demonstrate its intention to improve discharge planning in collaboration with key stakeholders, but staff training is poor, performance monitoring is limited and the absence of formal discharge pathways presents a barrier to improvement**. We set out our reasoning in the paragraphs below.

11 **Planning:** The Health Board is taking steps to work with key stakeholders in planning improvements to discharge planning and patient flow but is hindered by the lack of formal discharge pathways:

- the Health Board is committed to working with local stakeholders to improve discharge planning and patient flow;
- there is scope to strengthen the discharge policy; and
- the Health Board has yet to develop and implement formal discharge pathways to support discharge planning.

12 **Arrangements for supporting discharge:** Dedicated resources to support discharge planning are relatively small with availability limited to weekdays while training on discharge planning and knowledge of discharge policies is poor:

- the Health Board has some dedicated resources to support discharge planning but these are available weekdays only; and
- the Health Board is taking steps to improve access to information about community services but there is a lack of training on discharge planning and there is more to do to raise awareness of discharge policies

13 **Monitoring and reporting:** While lines of accountability are clear, performance monitoring for discharge planning is limited and performance against key measures remains challenging:

- there are clear lines of accountability and regular operational scrutiny of discharge planning performance, which includes partners;
- information for monitoring and reporting on performance related to discharge planning and patient flow is limited and compliance with discharge planning procedures is not monitored; and
- work to improve discharge planning is not yet reflected in improvements to key performance measures.

Recommendations

Exhibit 1: recommendations

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

Recommendations	
R1	**Pathway development:** Formal discharge pathways were not in place at the time of audit. While the Health Board has plans to review patient profile pathways, the absence of formal, easily understood and accessible pathways for ward staff increases the risk of inconsistency and discharge delays. **The Health Board should:** a. **Introduce specific discharge pathways that cover all patients;** b. **Ensure discharge pathways are set out in the Health Board's discharge policy;** c. **Ensure pathways are easily understood and easily available to ward staff eg through a flow chart or matrix that is displayed within staff areas of the ward; and** d. **Provide training to ward staff on the application of discharge pathways.**
R2	**Policy review:** We found that the discharge policy under review at time of fieldwork was jointly agreed with key partners but that there is scope to further strengthen the policy against the criteria we applied. **The Health Board should consider the elements where it did not score well while it revises this policy**.
R3	**Training on discharge planning.** We found that training on discharge planning is not consistently available to all relevant staff. **The Health Board should:** a. **Include discharge planning within induction training for all new staff; and** b. **Provide refresher training on discharge planning for all relevant staff, possibly as part of an e-learning course which ward staff may find more accessible.**
R4	**Discharge policy compliance.** Although the discharge policy indicates that regular compliance audits should be undertaken, we found that there has been no such audit within the last five years. The absence of information to monitor compliance with discharge planning processes does not provide assurance to the Health Board that staff are applying the policy as intended. **The Health Board should introduce a regular (three to five year) cycle of audit to ensure compliance with its discharge policy.**
R5	**Discharge reporting.** We found that the Board, and the Finance, Planning and Performance Committee receives regular information relating to delayed transfers of care, but receives limited information specific to discharge planning that would support a better understanding of the reasons behind the Health Board's performance. **The Health Board should strengthen its performance reporting by including further measures within its routine performance report, such as:** • **number and percentage of patients who have an estimated discharge date;** • **readmissions within 28 days of discharge from hospital;** • **percentage of discharges before midday;**

Recommendations	
	• **percentage of unplanned discharge at night; and** • **percentage of discharges within 24 hours and 72 hours of being declared 'medically fit'.**
R6	**Communication with patients:** Although the patient discharge leaflet provided appears to be well developed and comprehensive, staff we spoke to did not routinely use the leaflet in their interactions with patients. **The Health Board should ensure that patients understand the discharge process by:** a. **Ensuring that the patient discharge leaflet is used consistently to keep patients informed;** b. **Ensuring staff on all relevant wards can access the patient discharge leaflet; and** c. **Putting measures in place to understand if patients feel sufficiently informed about the DToC process.**

The Health Board is taking steps to work with key stakeholders in planning improvements to discharge planning and patient flow but is hindered by the lack of formal discharge pathways

The Health Board is committed to working with local stakeholders to improve discharge planning and patient flow

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 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. At the time of our audit work, the Health Board was working to a number of plans that it has developed in collaboration with partners to improve discharge planning and patient flow. These plans are:

- the Joint Unscheduled Care Improvement Plan;
- the Seasonal Plan; and
- the Focus on Flow project plan.

16 The Health Board developed its Joint Unscheduled Care Improvement Plan 2016-19 and its Seasonal Pressures Plan 2016-17 with key stakeholders, including Powys County Council (PCC), the Welsh Ambulance Service and the Powys Association of Voluntary Organisations (PAVO). These two key plans have common aims, which are:

a. to keep people healthy and living independently in their own homes and communities as much as possible by providing services that reduce unscheduled care demand, especially demand for emergency care, and

b. to ensure the timely and safe transfer of care back to people's homes and communities in Powys once an acute episode of care is complete.

17 In order to address the first aim of supporting people in the community and reducing demand on acute services, the Health Board has recently introduced new

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

services or models of care. These include: Community Resource Teams;[6] virtual wards;[7] and the long-term conditions management centre.

18 Actions within the plans related to reducing delayed transfers of care (DTOC) and improving patient flow include: reviewing the Health Board's the jointly agreed choice of accommodation policy; increasing domiciliary care and care home capacity; and developing patient profile pathways.

19 In April 2016, the Health Board established its Focus on Flow Project, as part of its wider Unscheduled Care Programme, to improve patient flow from the time of admission to discharge to the most appropriate destination, be that home, a care home or nursing home. The Focus on Flow project plan builds on data and information including an internal 'point prevalence' study that the Health Board carried out in early 2016. The purpose of the study was to enable the Health Board to better understand how and why patients are admitted to community hospitals in Powys and the potential alternative means of delivering care. The report indicated that the Health Board relies too heavily on care homes during discharge and suggested a need to improve its policies, pathways and processes to ensure timely and high-quality discharges that benefits patients. The Focus on Flow project also incorporates the recommendations from the Delivery Unit's case note review. Some of the actions identified by the Focus on Flow Project include:

- revising the Community Hospital Discharge Policy and Procedure;
- developing a patient flow dashboard to support performance management; and
- revising the role definitions and training needs of ward staff and Integrated Clinical Team Managers.

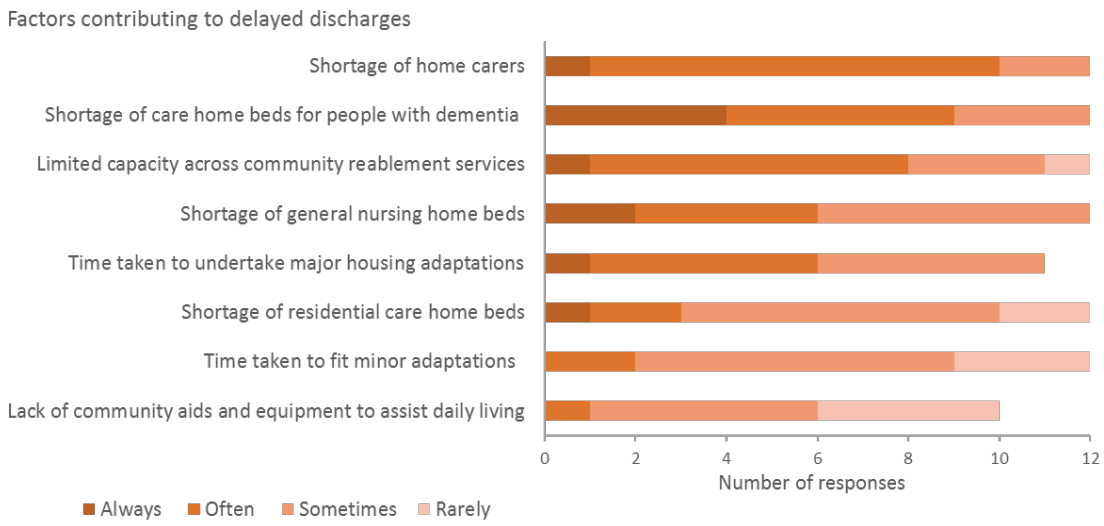
20 We asked NHS organisations what factors contribute to delayed discharges or transfers of care, to ascertain how well their plans seek to address the factors causing most problems. Exhibit 2 shows that across Wales, a shortage of home carers, a shortage of care home beds for people with dementia, and limited capacity across community reablement services are major factors in causing delays to discharge or transfers of care.

[6] Community Resource Teams are teams attached to each GP practice in the Health Board area to reduce admission and to support patients that require care after being discharged

[7] The Virtual Ward provides a service for patients who are at risk of emergency hospitalisation which can be avoided, where the patient is managed in their own home as opposed to on a hospital ward.

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

The chart shows the factors seen to contribute to delayed hospital discharges and transfers of care.



Source: Wales Audit Office analysis of information on discharge planning returned by NHS bodies in 2017[8]

21 The Health Board reported that the following issues often caused delays:

- time to undertake major adaptations
- shortage of home carers
- shortage of residential care home beds
- shortage of care home beds for people with dementia
- shortage of general nursing home beds; and
- limited capacity across community reablement services.

22 It is important to recognise that these are significant issues, over which the Health Board has no direct control. Nevertheless, the Health Board must work with its partners to find solutions to prevent delays to discharge because of these issues.

23 As part of our review, we spoke to a representative from the Powys Community Health Council (CHC). While the CHC has received 307 complaints where elements related to patient discharges during 2016-17, 280 of them were

[8] 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.

specifically with regard to care home availability. The CHC representative expressed frustration that some such complaints can take over a month to resolve while the patient is in hospital unnecessarily.

24 The Health Board also indicated that other issues have led to delays in discharging patients. These include agreeing funding of top-up fees and disputes over care homes prioritising placements for self-funding patients over placements funded by social services.

25 The Seasonal Pressures Plan and Joint Unscheduled Care Improvement Plan sought to address some of the issues highlighted above, for example by:

- establishing an enhanced Brokerage Service to provide regular information on bed availability within care homes and the ability to spot purchase additional beds where necessary;
- extending the use of Community Resource Teams to support care homes; and
- developing a Rapid Response Reablement service as an alternative to hospital-based care.

26 Over the years, 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 that prevent hospital admission, support the independence of older people and reduce DToCs. Initially, the fund was released on a one-off basis, but in 2015-16 was changed to a recurrent fund.

27 Confirmation that ICF is recurrent has given partners, including the Health Board, greater confidence to plan long-term. In Powys, partners agree and evaluate ICF funded initiatives annually through the Regional Partnership Board governance structure. In Mid and West Wales, the ICF programme has three components: prevention in the community; reablement at the core; and reducing admissions and accelerating discharge. The Health Board and the Local Authority have agreed the ICF for a number of schemes aimed at providing alternative health services in the community, reducing delayed transfers of care through step up and step down services, and supporting the Health Board and the Local Authority to work together more effectively. For example, Powys received £4 million to support the integration of a new IT system that supports health and social care to professionals work together to provide care closer to people's homes. Staff we spoke to as part of our fieldwork noted how well these schemes work. One example in particular was the use of funding for a pilot project during the winter period in 2016-17 to include an Occupational Therapist post within the Care Transfer Co-ordinator (discharge liaison) team, to support the link between hospitals and re-ablement.

There is scope to strengthen the discharge policy

28 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 and or transfers of care, developed ideally in collaboration with statutory partners. In addition, NHS organisations should 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.

29 We reviewed the organisation's policy on discharge and transfers of care using a maturity matrix[9]. The maturity matrix assesses 17 elements of the policy, with each element assigned a score from one (less developed) to three (well developed). Exhibit 3 shows how the Health Board's draft discharge policy scored against the maturity matrix.

Exhibit 3: Health Board's performance against discharge policy good practice checklist

The table shows how the Health Board's discharge policy scored against a good practice checklist.

Elements assessed	Score	Auditor observations on the policy
Multi-agency discharge policy	3	Policy developed in consultation with key stakeholders, including operational Health Board staff, Council staff, carers and third sector staff.
Policy reviewed within the last year	3	The Health Board reviews and updates policies in three-year rolling cycles and the discharge policy was due for review in 2018. The Health Board was reviewing the policy at the time of our fieldwork as part of the Focus on Flow Project.
Patient/carer involvement	3	The policy places an emphasis on involving patients and their families throughout the discharge process. For example, it mentions giving information and advice in the most appropriate format within 24 hours of admission. There is appropriate cross-reference to legislative framework, for example, the policy makes it clear that if a patient has a full-time carer, the carer may also need an assessment.
Communication	3	There are references to advocates throughout the policy. The policy stresses the importance of communication with the individual, family and carers.

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

Elements assessed	Score	Auditor observations on the policy
Information	3	The policy details actions to ensure patients get clear and accurate information about the discharge processes, including notifying patients of the Estimated Date of Discharge (EDD) as soon as possible.
Vulnerable groups eg patients who are homeless	3	Policy has a section on vulnerable adults, including information on who might be classified as vulnerable, at risk of abuse and homeless and notes that a social worker will be allocated to a patient where appropriate.
Early discharge planning for elective admission	3	Policy states that 'Planning for hospital discharge must begin at, or in the case of elective admissions before, admission to hospital'.
Estimated discharge date set within 24 hours of admission	3	The policy clearly states that all patients will have an estimated date of discharge within 24 hours of admission.
Avoiding Readmission	1	There is no reference to avoiding readmission within the policy. While the policy emphasises the need for prompt discharge, it does not balance this with the risk of readmission.
Assessment	2	Policy refers to the fact that assessment involves both professionals and the patient with needs. It asks staff to think through how needs have arisen, and how different needs interact with each other.
Discharge from A&E	N/A	Not applicable as the Health Board does not provide A&E services.
Discharge to care home	2	Covers discharge back to a care home for vulnerable adults at risk of abuse, discharge for patients without capacity and notes that older people entering care homes or in receipt of intermediate care services should have received a comprehensive older person assessment. Please note that the separate Choice of Accommodation policy makes clear that the aim of discharge is to enable patients to return to their home when it is possible and appropriate to do so.
Links to choice of accommodation policy	1	Policy does not reference the choice of accommodation policy.
Care Options	1	Policy does not refer to a range of suitable, care options, such as CRTs, to ensure safe and timely discharge.

Elements assessed	Score	Auditor observations on the policy
Escalation processes	1	There are no escalation processes detailed within the policy if discharges are delayed or at risk of delay. There is a separate escalation plan but there is no cross-reference or linkage between the two.
Accessible Discharge Protocols	1	The choice of accommodation policy includes a discharge planning flow chart for discharging patients to a care home, but this is limited in scope and is not included or referenced in the discharge policy

Source: Wales Audit Office review of Powys Teaching Health Board's discharge policy, 2017

30 Out of the 15 elements that we assessed that are relevant to Powys, the Health Board's policy scored '3' on eight elements. The Health Board could strengthen the discharge policy for those elements that scored '1', for example by appropriate cross referral to the choice of accommodation policy and escalation policy. In addition, the policy contains limited guidance to support discharge planning, for example it contains no formal discharge pathways or discharge checklists. The discharge policy sets out the need for compliance audits but the Health Board has not undertaken a compliance audit within the last five years.

31 The choice of accommodation policy was approved in February 2016 and complements the discharge policy. Both polices make clear that their aim is to reduce the amount of time patients spend unnecessarily in hospital waiting for discharge. The choice of accommodation policy indicates that the primary aim when planning discharge from hospital must always be to enable patients to return to their home whenever possible and appropriate.

32 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 can be held to account for their role in the process. The discharge policy should set the standards for all staff responsible for discharge.

33 At the Health Board, we found that a section within the discharge policy briefly outlines the roles and responsibilities of professionals and teams involved in discharge planning. This includes the Health Board's health and social services staff, multi-disciplinary team and care co-ordinators/responsible nurse. However, the descriptions provided within the discharge policy are limited in detail. For example, it does not cover how, and to whom staff should escalate issues related to discharging patients.

The Health Board has yet to develop and implement formal discharge pathways to support discharge planning

34 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 coordination 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.

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

36 The Health Board did not provide us with documented discharge pathways that show the sequence of steps needed to safely discharge patients to their appropriate destination, and we were therefore unable to review them. Discharge pathways usually take the form of a flowchart or table, have a clear purpose and discharge destination information and ideally:

- acknowledges transport or transfer logistics;
- applies 24 hours a day, 365 days per year;
- has been developed with partner organisations (local authority and NHS bodies);
- is supported by generic discharge and assessment documentation;
- has clear referral processes;
- has agreed standards for: response times for assessing need, response times for service delivery and quality and safety; and
- has standards for information sharing with clinical/care staff in the community e.g. discharge letters.

37 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.

38 The Welsh Government has been encouraging a 'discharge to assess' pathway or model[10] [11.] 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.

39 The Delivery Unit found the use of 'discharge to assess' pathways was limited, and recommended that NHS organisations implement them. We found that half (4 out of 8) of NHS organisations had implemented a 'discharge to assess' model, although in some organisations, the model had been implemented only at specific hospital sites. The Health Board has yet to introduce a 'discharge to assess' pathway, but has plans to introduce it under the Focus on Flow Project.

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

[11] Welsh Government, **Sustainable Social Services**, 2011

Dedicated resources to support discharge planning are relatively small with availability limited to weekdays, while training on discharge planning and knowledge of discharge policies is poor

The Health Board has some dedicated resources to support discharge planning but these are available weekdays only

The Health Board's discharge liaison team is comparatively smaller than teams at other health boards and like those teams, it operates weekdays only

40 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.

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

42 The Health Board has an established team of Care Transfer Co-ordinators (CTCs). CTCs support patients treated in Powys community hospitals, as well as neighbouring Health Board District General Hospitals (DGHs) to go home, to a community hospital or to a care home, as well as managing reablement at home. The CTC function is not a stand-alone service; instead it works with multidisciplinary teams across the community hospitals and DGHs to prevent patients unnecessarily taking up community beds.

43 Typically, discharge liaison teams consist of nursing staff but to better manage complex discharges ideally teams should be multidisciplinary. Exhibit 4 shows the different professions within discharge liaison teams across Wales. The data show fewer than half the teams are multi-disciplinary with most teams nurse led. Discharge liaison teams range in size from two whole-time equivalent (WTE) staff to 29 WTE staff with bigger teams working across multiple hospital sites. The average number of WTE staff per team was seven.

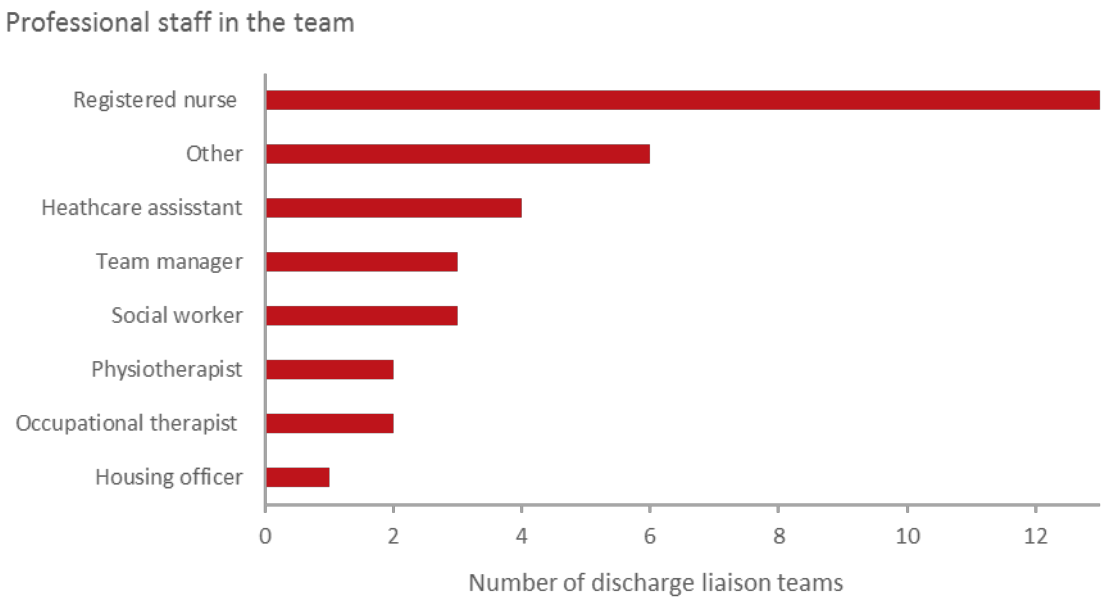
44 Although we requested information on the size of the CTC team, we did not receive it. Staff, however, told us that there are 5.5 WTE staff working in the CTC team, an increase from 3.5 WTE staff in 2015-16. The CTC team includes 0.2 WTE staff who are jointly funded with Hywel Dda University Health Board to work with

Bronglais Hospital staff to repatriate patients back to Powys when it is appropriate to do so. The Health Board have indicated that cross-border partnership working is a challenge, and that steps such as this jointly funded post, along with discussions through the Mid-Wales Healthcare Collaborative, will help address this challenge.[12]

45 Despite the size of the team, its remit is broadly similar to teams at other Health Boards. Staff from the CTC team told us that they feel stretched in relation to workload. Some staff raised concerns that long-term sickness absence or vacancies within the team can cause significant strain and limit its ability to work effectively. CTC team members felt they often do not have the time to attend multidisciplinary (MDT) meetings. The Health Board's Integrated Medium Term Plan (IMTP) for 2017-20 sets out its commitment to evaluate the role of CTCs during 2017-18 and it may need to consider the capacity of the team when it undertakes this evaluation.

Exhibit 4: different professional staff deployed across discharge liaison teams at 30 September 2016

The chart shows that across Wales discharge liaison teams are primarily nurse-led with very few multidisciplinary teams.



[12] The Mid-Wales Healthcare Collaborative works to implement recommendations from the Welsh Government-commissioned review to identify issues and potential solutions for providing accessible, high quality, safe and sustainable healthcare services, which are best suited to meet the specific needs of those living in Mid Wales, published in 2014.

Source: Wales Audit Office analysis of information collected on discharge liaison teams, 2017[13]

46 The Health Board's CTC team is not multi-disciplinary nor multi-agency but nurse-led. As part of ICF moneys, the Health Board ran a pilot project over the winter period in 2016-17 to use Occupational Therapists within the care transfer co-ordinator team, to support the linkage between hospitals and reablement. Staff told us that they felt this arrangement worked well but the scheme was not extended into 2017-18. There is a Hospital Discharge Liaison Nurse who links Powys Adult Social Care Services with the District General Hospitals that serve Powys and you can ask to speak to them.

47 The combined cost of 13 of the 15 discharge liaison teams totalled £2.9 million with individual team costs ranging from £43,000 to £692,000. Powys Teaching Health Board did not provide us with data on the cost of the CTC team. As a result, we are unable to compare this cost with the average cost per discharge liaison team of £244,000 across Wales.

48 Gaps in information on staffing, activity and service costs makes 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 with the WTE number of staff. The number of discharges per WTE staff ranged from 50 discharges to 250; the average was 117 discharges per WTE staff. We did not receive information on the number of discharges managed by the Health Board's CTC team so we are unable to comment on the capacity of the team.

49 We asked discharge liaison teams to describe how frequently they carried out a range of activities to support discharge planning. Appendix 4 shows a summary of the types of activities carried out by discharge liaison teams across Wales. At the Health Board, despite the fact that the CTC team is a relatively small resource, it carries out the same diverse range of activities as other discharge liaison services. For example, the CTC team always validate DToC data and updates bed managers with information on hospital discharges. The team often undertakes the following activities, which are broadly in line with other discharge liaison teams:

- participates in board rounds and MDT meetings;
- supports staff to identify vulnerable patients where discharge could be complex;
- liaises with other public bodies to facilitate successful hospital discharge and minimise readmission;

[13] The seven health boards in Wales operate discharge liaison teams. Three health boards - Abertawe Bro Morgannwg, Hywel Dda and Betsi Cadwaladr University Health Boards - operate separate teams for each hospital site. We received 15 data returns from discharge liaison teams although not all data returns were complete.

- provides a central point of contact for health and social care during the discharge process;
- provides housing options advice; and
- signpost patients and their families to advice.

50 In addition, the team sometimes undertakes the following activities:

- ensures individual discharge plans are in place for patients with complex discharge needs;
- works with operational managers to develop performance measures for discharge; and
- provides training and development for clinical staff to effect discharge.

51 Staff told us that the CTC team had not been evaluated since it was established more than seven years ago. The Health Board's Integrated Medium Term Plan (IMTP) for 2017-20 set out its commitment to evaluate the role of CTCs during 2017-18. In addition, at the time of our audit work, the Health Board planned to revise the role definitions and training needs of the CTC team, as part of its Focus on Flow Project.

Discharge lounges are not currently available

52 A discharge lounge can support effective discharge planning and patient flow by releasing beds promptly for other patients to be admitted. A discharge lounge provides a suitable environment in which patients can wait to be collected by their families or by hospital transport or while waiting for medication to be dispensed. We asked NHS organisations about their discharge lounge facilities. Across Wales, we found that all health boards, except Powys, operate discharge lounges in their acute hospitals.

53 Some staff told us that it would be helpful if discharge lounges were available across the Health Board's community hospitals. The Health Board has no plans to introduce discharge lounges in the near future because of the lack of space within community hospitals, but staff often make use of hospital day rooms to support patient flow when community beds are needed.

The Health Board is taking steps to improve access to information about community services but there is a lack of training on discharge planning and there is more to do to raise awareness of discharge policies

54 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.

There is no specific training for staff on discharge planning and knowledge of discharge polices is poor

55 As part of our audit work, we met with ward staff to talk about a range of issues related to discharge planning. The staff that we met were clear about their role in discharge planning. While staff were aware of the choice of accommodation policy, they were unaware of the discharge policy or the written procedures for discharge planning. Although the discharge policy was being reviewed at the time of our audit work, we would expect ward staff to be aware of and applying the existing policy. We would also expect ward staff to know the policy was subject to review. The ward staff that we met were also unaware of any written discharge pathways but assumed that they existed.

56 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.

57 The discharge policy notes the Health Board will need to provide training to ensure that staff implement the policy effectively, yet our audit work suggests that this is not the case for most staff. Neither ward staff nor CTCs could recall receiving any training specific to the discharge planning process or its associated policies. More recently, the Health Board has introduced mandatory leadership training for its senior nurses. The training aims to support senior nurses to develop leadership skills, increase the recognition of their role in patient care and to be assertive and confident when managing difficult conversations with patients and or their families. While this is a positive step, the training covers only a small proportion of ward-based staff. There is a need to increase the confidence of all ward staff, as well as the CTC team, in applying the principles and processes of discharge planning.

58 Exhibit 5 shows that across Wales, fewer than half of the NHS organisations include discharge planning within nurse induction programmes and more than half offer regular refresher training. At the Health Board, induction programmes for nursing and medical staff do not include training on discharge planning, nor do they receive refresher training.

Exhibit 5: 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 regularly for nurses[1]
Abertawe Bro Morgannwg	No	Yes
Aneurin Bevan	No	No
Betsi Cadwaladr		
• Ysbyty Gwynedd	Yes	Yes
• Wrexham Maelor	Yes	Yes
• Glan Clwyd	Yes	No
Cardiff and Vale	No	Yes
Cwm Taf	No	Yes
Hywel Dda		
• Withybush	Yes	No
• Ceredigion	No	No
• Camarthen	No	Yes
Powys	**No**	**No**
Velindre	Yes	Yes
[1]Refresher training is provided at least annually or biennially for nursing staff		

Source: Wales Audit Office analysis of information on discharge planning returned by NHS bodies in 2017 (See Footnote 8)

Positive changes are being made to improve discharge processes but there is some way to go before staff feel confident in managing complex discharges

59 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. Some staff told us that this risk aversion arises because many patients live in very remote, rural areas, and staff fear for the wellbeing of patients once discharged from hospital. Others told us that they felt

[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 interests.

uncomfortable arranging discharges to care or nursing homes because patients are often placed far away from their homes and families due to limited placements.

60 The Delivery Unit found limited evidence in patient records that patients' expectations of discharge were discussed with them. Although the patient discharge leaflet provided to us appears to be well developed and comprehensive, staff we spoke to did not routinely use the leaflet in their interactions with patients. The leaflet clearly indicates the patient's admission date and the Estimated Date of Discharge. It explains the discharge process to the reader and makes clear that patients cannot stay in hospital when they no longer have a medical need to do so. The Health Board should ensure that this document is used consistently in order to keep patients informed.

61 Following the Delivery Unit review, the Health Board held an event in December 2016 to feedback the findings and to discuss how best to address them. The focus of the event was to increase staff understanding of the challenges faced by the Health Board for discharge planning. We found a consensus amongst staff at both strategic and operational levels that there has been an increased focus on discharge planning following the event which has resulted in some positive changes, including:

- an update to the Focus on Flow Project which adopted the Delivery Unit's recommendations as part of its action plan;
- introduction of flow boards, which provide a template for ward staff to publicly display a specific range of information for each patient and allow staff to cross-refer more easily; and
- the decision to work towards a specific average length of stay target of 21 days, as opposed to working towards a simple improvement target (although Exhibit 11 indicates that the Health Board could be more ambitious).

62 At the time of our audit work, the Health Board was continuing to implement these actions and it is too soon to comment on their impact. However, staff were confident that the increased focus on discharge planning was having a positive impact. For example, flow boards were rolled out to all community hospitals by March 2017 and staff held largely positive views on their impact, stating that they encourage ownership for the continuum of a patient's care by ward staff, and that they improve MDT working by reducing the need for paper referrals.

The Health Board is taking steps to the availability of information about community services to support discharge

63 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. We asked health bodies the types of information they collated on

community services. Exhibit 6 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.

Exhibit 6: number of health bodies who reported collating a range of information on community services

Table shows the number of health bodies collating a range of information about community services.

	Range of services	Availability of services	Eligibility criteria	Referral process	Waiting time for needs assessment	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 8)

64 We asked ward staff about their knowledge of the range of community services to support patients on discharge. Ward staff told us that they have a general understanding of the services available in the community, which is developed and kept up-to-date through regular contact between ward sisters and services such as reablement and domiciliary care. Nursing staff were confident that they could get information if needed from therapy staff and the CTC team as both staff gather up-to-date information about community services through their respective roles. However, therapy staff are not readily available on all wards and CTC capacity is limited. Staff were unclear how to access up-to-date information on community

services, for example through a directory of community services. Some mentioned the 'Dewis Cymru'[15] website but stated that this is not yet well developed.

65 The PAVO compiles a list of accessible voluntary services but it does not cover all services and does not link in with all relevant partners. The Health Board recognises that being unable to access a comprehensive and up-to-date database is a weakness for staff. The Health Board has recently developed Powys People Direct, which acts as a Single Point of Access for children, vulnerable adults and families, however this does not cover all services. The Health Board remains committed to working with organisations such as PAVO and Dewis Cymru to link information together and provide an effective database for staff and patients.

While lines of accountability are clear, performance monitoring for discharge planning is limited and performance against key measures remains challenging

There are clear lines of accountability and regular operational monitoring of discharge planning performance, which includes partners

66 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.

67 At the Health Board, operational responsibilities for discharge planning are set out in the discharge policy and choice of accommodation policy. Day-to-day accountability for discharge planning lies with the Integrated Clinical Team Managers. Any issues with discharge that require escalation are reported to the two Locality General Managers. The Locality General Managers in turn report to the Director of Primary and Community Care/Deputy Chief Executive, who is the executive lead for discharge planning (as part of improving patient flow).

68 The Health Board holds daily bed management calls with the local authority and other key partners where they share and discuss information on particular patients awaiting discharge. The Health Board also hold weekly meetings on DToC, which include Integrated Clinical Team Managers, CTCs, ward sisters and representatives from social services and brokerage. These weekly DToC meetings, which are chaired by the Head of Nursing, allow staff to discuss particularly challenging cases and enable staff to work together to resolve issues. The Head of

[15] Dewis Cymru is a website that was developed to help people find information about organisations and services that can help them take control of their own well-being.

Nursing will then escalate any remaining issues from this call to the Locality General Managers, and further escalation would take the form of the structure outlined above.

69 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 board member survey found that 6 out of 12 of the board members (50%) who responded agreed or strongly agreed that the Board and its committees regularly scrutinise the effectiveness of discharge planning. This compares to 56% across Wales.

70 As good discharge planning relies on partner organisations working together, as well as internal challenge, joint scrutiny arrangements should also be in place. The Director of Primary and Community Care/Deputy Chief Executive represents the Health Board on the Powys Regional Partnership Board. The Partnership Board updated and published its key aims in November 2016. While discharge planning is not cited as one of the Partnership Board's key priorities, it has asked that related groups provide an annual report on improvements to intermediate care services for older people, including reablement capacity and processes and hospital discharge pathways. The Partnership Board has also requested two presentations on the subject of the 'What Matters' conversation[16] but there is a lack of clarity about who will provide these updates or by when.

Information for monitoring and reporting on performance related to discharge planning and patient flow is limited and compliance with discharge planning procedures is not monitored

71 Having the right information on discharge planning performance is crucial for both monitoring and reporting. Delayed transfers of care is the only national measure, for both NHS organisations and local authorities, and as such is 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.

72 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.

[16] The 'What Matters Conversation' is a conversation that takes place between ward staff and a patient which aims to understand what matters most in terms of a patient's well-being. It is recorded on paper by ward staff. Good practice states the conversation should take place at the point of admission and updated throughout a patient's stay. It can be used to refer a patient to another service such as social services.

73 As part of our review, we looked at the type of performance information reported to operational groups and the Board or its sub-committees which help inform discharge planning performance and how well patients are flowing through the hospital system. Exhibit 7 sets out the performance indicators and updates reported to the Finance, Planning and Performance Committee and the Board at Powys.

Exhibit 7: range of performance information reported to the Finance, Planning and Performance Committee and the Board during 2016-17

The table shows the information on performance related to discharge planning and patient flow presented to the Finance Planning and Performance Committee and the Board at Powys Teaching Health Board between May 2016 and June 2017.

Discharge planning	Patient flow
• Notice on the introduction of electronic discharge systems at Shrewsbury and Telford Hospital Trust. • Delayed transfer of care for patients receiving care from mental and learning disability services. • Seasonal pressures plan for 2016-17, which notes that the CTC team is helping to reduce rates of inappropriate transfers to community hospitals. • Working with social services to overcome lack of capacity causing flow challenges. • Patient experience story.	• Percentage of new patients spending no longer than 4 hours in minor injury units (MIU). • Number of patients spending 12 hours or more in MIUs. • 95% of patients waiting less than 26 weeks for treatment where Powys is the service provider. • DToC delivery per 10,000 LHB population – non mental health (75 years and over).

Source: Wales Audit Office review of papers presented to the Board at Powys Teaching Health Board

74 In response to our board member survey:

- 8 out of 12 board members (66%) agreed or strongly agreed that they received sufficient information to understand the factors affecting patient flow, compared to an all-Wales average of 75%; and
- 10 out of 12 board members (83%) agreed or strongly agreed that they understood the reasons for delays in discharging patients from hospitals within my organisation, compared to an all-Wales average of 82%.

75 Information that would prove helpful to understand discharge planning performance in particular but not currently reported either operationally or strategically includes:

- number and percentage of patients who have an estimated discharge date;
- readmissions within 28 days of discharge from hospital;

- percentage of discharges before midday;
- percentage of unplanned discharges at night; and
- percentage of discharges within 24 hours and 72 hours of being declared ‘medically fit’.

76 The Health Board’s Focus on Flow Project was previously part of the Health Board’s Primary and Community Care Delivery Programme. However, at the time of our fieldwork, the Health Board made a decision to strengthen the programme’s governance structure. The project is now managed by the Unscheduled Care Programme Board, which is chaired by the Deputy Director of Primary, Community & Mental Health Services and reports to the Primary and Community Care and Mental Health Services Directorate Steering Group each quarter.

77 The discharge policy states that it monitors compliance with the policy but there is no record of such an audit being reported to the Board or its committees. Furthermore, staff were not aware that an audit had taken place in the last five years. The Focus on Flow project notes that patient record audits will be required to ensure that staff embed good discharge planning in daily practice. It also states that there should be audit and evaluation by the Flow Board to improve multi-disciplinary working. Audits such as these, as well as audits of the discharge policy will be vital in providing assurance to the Health Board that staff are consistently implementing the improvements it is trying to achieve. These audits will need to be sufficiently regular to ensure that staff across the Health Board embed improvements as part of normal practice.

78 We asked NHS organisations what information could be captured on their patient administration systems. Exhibit 8 shows that most organisation’s patient administration systems have the ability to capture a range of data to aid discharge planning. However, less than half can record whether the discharge is simple or complex.

Exhibit 8: 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. However, less than half of the systems can capture whether the discharge is simple or complex.

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 own home, residential care home, transfer to another hospital, 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 8)

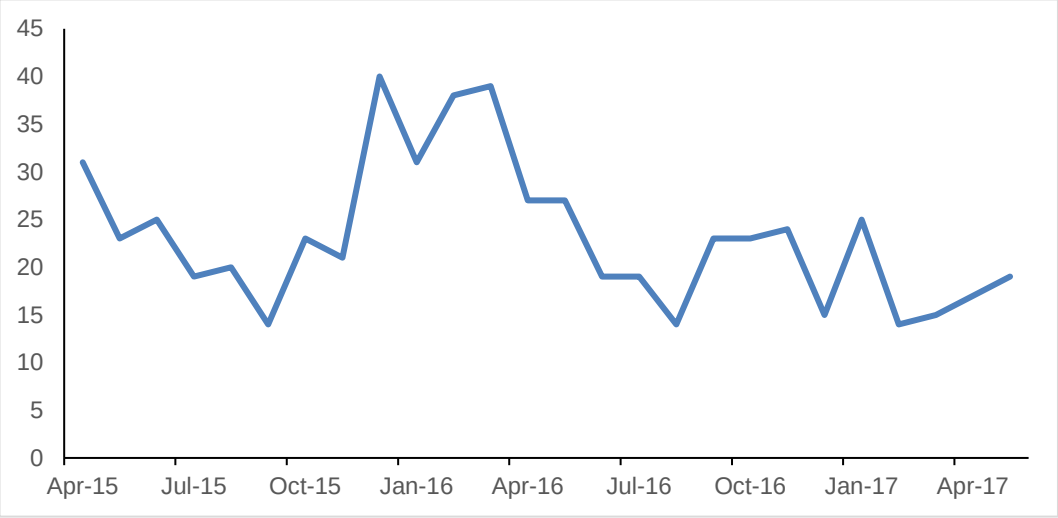
79 The Health Board told us that its clinical workstation is able to record all of the data presented in Exhibit 8, although it is unclear how the organisation captures data on whether a discharge is simple or complex in the absence of formal discharge pathways. There is no current performance dashboard for discharge planning, although this is an outstanding action included within the Focus on Flow project. Ward staff welcome the development of a performance dashboard, as they hope it will lead to more robust and accessible information. Staff told us that the current systems in place to monitor patients is not completely effective, as it can often lead to patients' details being duplicated on the system, and information must be retrieved manually from the system in order to provide to senior staff for monitoring. A more robust dashboard system will allow the Health Board to review and share information more effectively with key partners.

Work to improve discharge planning is not yet reflected in improvements to key performance measures

80 The Delivery Unit undertook its review of discharge planning at the Health Board in mid-2016. Since then, the Health Board has developed and implemented its Focus on Flow Project, which incorporated the Delivery Unit's recommendations. It is too soon to comment on the impact of these changes on performance in relation to discharge planning. Exhibit 9 shows fluctuation in the numbers of DToCs reported each month between April 2015, a year before the Delivery Unit's review of discharge planning and in May 2017, a year later. Despite the small numbers involved, there has been a downward trend in numbers of DTOCs since 2016 with small fluctuation across 2017 following a peak in January, which could be attributed to seasonal pressures.

Exhibit 9: trend in delayed transfers of care (excluding mental health facilities) between April 2015 and May 2017

The chart shows the general downward a fluctuating trend of small numbers in delayed transfers of care within Powys Teaching Health Board between April 2015 and May 2017



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

81 Although the total number of DTOCs (excluding those in mental health facilities) reduced by 19% from 312 in 2015-16 to 254 in 2016-17, the number of patients delayed 13 weeks or more is rising (Exhibit 10).

Exhibit 10: 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 the change in the number of delayed transfers of care by length of delay at Powys Teaching Health Board with numbers of patients delayed 13 weeks or more rising.

Length of delay	Number of delayed transfers of care (DTOC)	
	2015-16	2016-17
0-3 weeks	185	139
4-6 weeks	76	43
7-12 weeks	43	31
13-26 weeks	8	22
26+ weeks	0	3
Total DTOCs	312	254

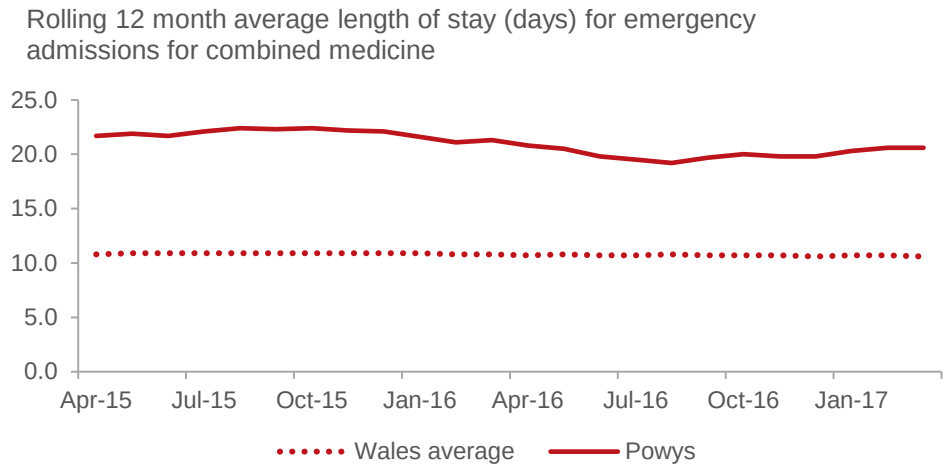
Source: Wales Audit Office analysis of the NHS Wales delayed transfers of care database, May 2017

82 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 11 shows little change in the rolling average length of stay[17] for emergency medical admissions over the last two years with average lengths of stay consistently double the Wales average. It should be noted that the Wales average figure includes both acute and community hospitals, whereas for Powys it includes only community hospitals, which often have higher rates of Average Length of Stay than acute hospitals. However, while the Health Board has recently committed to working towards an Average Length of Stay target of 21 days, the graph indicates that the Health Board could be more ambitious, as its levels have remained consistently around 21 days over the period captured.

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

Exhibit 11: 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 over the last two years with average lengths stay consistently more than 10 days higher than the Wales average.



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

Appendix 1

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

Exhibit 12: 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 when assessed against expected practice.

Discharge process	Expected practice	Community hospitals
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.	
	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 is given the contact details of the named professional who will act as their care co-ordinator.	

[18] The RAG (red, amber green) traffic light system provides a simple colour-coding system to visualise where performance is less than optimal.

[19] National Leadership and Innovation Agency for Healthcare, **Passing the Baton**, 2008

Discharge process	Expected practice	Community hospitals
	In complex discharges, and 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 discharge (EDD) is set.	
	The EDD takes account of both acute and rehabilitation phases, where 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.	
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 (e.g. to discuss onward placement or to determine 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.	
	Information on care homes in the area.	
	Information on the Choice Policy.	
	Information on where they can access help in looking for a suitable home if they require it (eg third sector).	
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 Powys Teaching Health Board, 2016

Appendix 2

Audit method

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

Exhibit 13: 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 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 the completed data collection form.
Data Collection Form – Discharge Lounge	We asked NHS organisations that operated a discharge lounge services to tell us about each discharge lounge. We sought information about operational hours, the staffing profile, numbers of patients accommodated and the environment for patients. The Health Board did not submit a form as they do not have any discharge lounges.
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 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 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 one form for the Care Transfer Co-ordinator team; the service covers all hospital sites.
Document request	We reviewed documents from the Health Board which covered strategies and plans for managing patient flow and unscheduled care, policies related to discharge and transfer of care and home of choice, discharge

Method	Detail
	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 discharge processes. We also relied on information set out in the reports prepared for Welsh Government by each health board or regional partnership summarising how the Intermediate Care Fund was used and its impact in 2015-16.
Interviews	We interviewed a number of staff including: • Director of Primary and Community Care and Deputy Chief Operating Officer • Head of Nursing • Integrated Clinical Team Managers (south west and mid Powys) • Two Care Transfer Co-ordinators • Ward Managers (one group from north Powys and one from south Powys) • Head of Operations for Adult Services, Powys County Council • Locality General Managers (north and south Powys) • Head of Therapies • Community Health Council representative
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 delayed transfers of care, hospital beds, staff, admissions, patients spending 12 hours or more in accident and emergency departments and lengths of stay.

Appendix 3

The Health Board's management response to the recommendations

Exhibit 14: management response

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	**Pathway development:** Discharge pathways were not in place at the time of audit. While the Health Board has plant to review patient profile pathways, the absence of formal, easily understood and accessible pathways for ward staff increases the risk of inconsistency and discharge delays. The Health Board should: a. Introduce specific discharge pathways that cover all patients; b. Ensure discharge pathways are set out in the Health Board's discharge policy; c. Ensure pathways are easily understood and easily available to ward staff eg through a flow chart	Accessible and easily understood pathways that cover all necessary information and that staff feel confident in applying when discharging patients.	Yes	Yes	Discharge from a community hospital can only be through two routes: 1. Home or normal place of residence 2. New Care Home Both are covered by the discharge checklist and are processed via the Patient flow board and supplemented with the weekly MDT. The ongoing flow work will be developing the D2A models and integrated working. This may not have been apparent when the audit was started	March 2018	Heads of Nursing

Ref	Recommendation	Intended outcome/ benefit	High priority (yes/no)	Accepted (yes/no)	Management response	Completion date	Responsible officer
	or simplicity matrix that is displayed within staff areas of the ward; and d. Provide training to ward staff on the application of discharge pathways.				but is a core part of the modernising flow programme **Actions:** • Introduce specific discharge pathways that cover discharge to either Home or normal place of residence or New Care Home; • Ensure these discharge pathways are set out in the Health Board's discharge policy; • Ensure pathways are easily understood and easily available to ward staff displayed within staff areas of the ward; • Provide training to ward staff on the application of discharge pathways.		

Ref	Recommendation	Intended outcome/ benefit	High priority (yes/no)	Accepted (yes/no)	Management response	Completion date	Responsible officer
R2	**Policy review:** We found that the discharge policy under review at time of fieldwork was jointly agreed with key partners but that there is scope to further strengthen the policy against the criteria we applied. The Health Board should consider the elements where it did not score well while it revises this policy.	A discharge policy that details all the necessary information to guide staff in discharging patients safely, and in a timely manner to the most suitable location.	Yes	Yes	**Actions:** Review: • Discharge policy • Choice Policy	March 2018	Heads of Nursing
R3	**Training on discharge planning.** We found that training on discharge planning is not consistently available to all relevant staff. The Health Board should: a. Include discharge planning within induction training for all new staff; and b. Provide refresher training on discharge planning for all relevant staff, possibly as part of an e-learning course which ward staff may find more accessible.	Consistent application of the discharge policy by all Health Board staff.	Yes	Yes	**Actions:** The following training to be delivered: • Discharge planning within induction training for all new staff; • Refresher training on discharge planning for all relevant staff.	March 2018	Heads of Nursing

Ref	Recommendation	Intended outcome/ benefit	High priority (yes/no)	Accepted (yes/no)	Management response	Completion date	Responsible officer
R4	**Discharge policy compliance.** Although the discharge policy indicates that regular compliance audits should be undertaken, we found that there has been no such audit within the last five years. The absence of information to monitor compliance with discharge planning processes does not provide assurance to the Health Board that staff are applying the policy as intended The Health Board should introduce a regular (three to five year) cycle of audit to ensure compliance with its discharge policy.	Assurance to a relevant body within the Health Board that actions taken to improve discharge planning and compliance with the discharge policy are being implemented and embedded.	Yes	Yes	**Actions:** • Introduce a regular cycle of audit to ensure compliance with the discharge policy.	March 2018	Heads of Nursing
R5	**Discharge reporting.** We found that the Board, and the Finance, Planning and Performance Committee receives regular information relating to delayed transfers of care, but receives limited information specific to discharge planning that would support a better understanding of the reasons behind the Health Board's performance. The Health Board	A Board that is well sighted of the performance of the Health Board with regard to discharge planning, is aware of the	Yes	Yes	This is currently recorded per month on the Health & Care standards tool **Actions:** • Explore the development of a process performance	March 2018	Heads of Nursing

Ref	Recommendation	Intended outcome/ benefit	High priority (yes/no)	Accepted (yes/no)	Management response	Completion date	Responsible officer
	should strengthen its performance reporting by including further measures within its routine performance report, such as: • number and percentage of patients who have an estimated discharge date; • readmissions within 28 days of discharge from hospital; • percentage of discharges before midday; • percentage of unplanned discharge at night; and • percentage of discharges within 24 hours and 72 hours of being declared 'medically fit'.	experience that patients have during the discharge planning process and is sighted of any negative effect on patient outcome as a result of discharge planning.			indicators report to be available on IFOR • Implementation of stronger performance around understanding our ALOS better.		
R6	**Communication with patients:** Although the patient discharge leaflet provided appears to be well developed and comprehensive, staff we spoke to did not routinely use the leaflet in their interactions with patients. The Health Board should ensure that patients understand the discharge process by:	Patients that feel well-informed about their circumstances, needs and any significant changes that they should be aware of	Yes	Yes	**Actions:** • Review and develop ward admission packs.	March 2018	Heads of Nursing

Ref	Recommendation	Intended outcome/ benefit	High priority (yes/no)	Accepted (yes/no)	Management response	Completion date	Responsible officer
	a. Ensuring that the patient discharge leaflet is used consistently to keep patients informed; b. Ensuring staff on all relevant wards can access the patient discharge leaflet; and c. Putting measures in place to understand if patients feel sufficiently informed about the DToC process.	during the discharge planning process.					

Appendix 4

Activities undertaken by discharge liaison teams

As part of this review, we asked health boards how frequently their discharge liaison teams undertake various a range of discharge planning activities. Exhibit 15 shows the frequency with which the 15 discharge liaison teams across Wales undertake the activities listed.

Exhibit 15: frequency with which the discharge liaison teams undertake a range of activities

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

Activity	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%
Validate data on delayed transfers of care.	87%	7%	0%	0%	7%

Activity	Always	Often	Sometimes	Rarely	Never
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 8)

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