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Discharge Planning – **Aneurin Bevan University Health Board**

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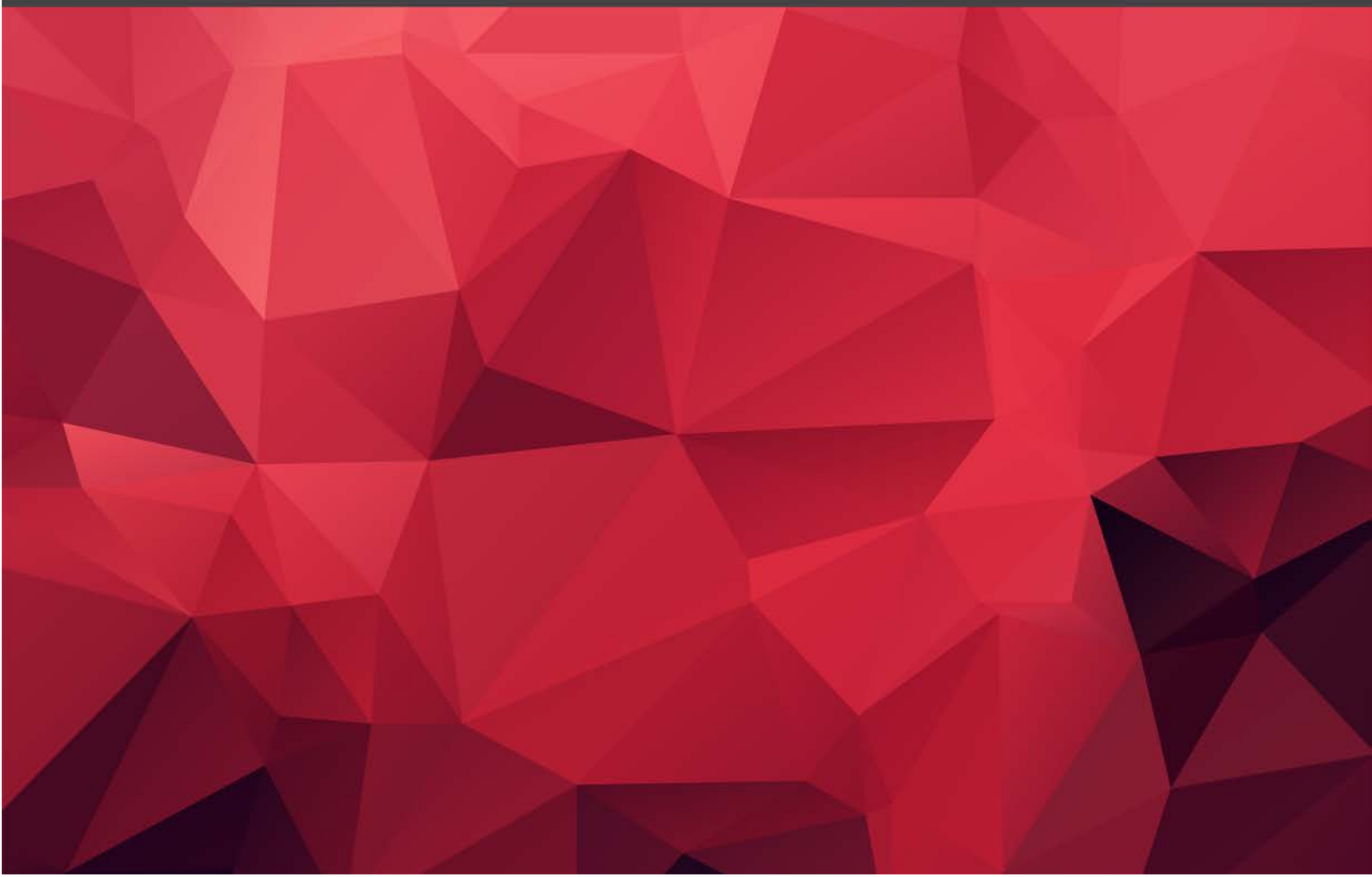

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Summary report

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% of patients, discharge planning is more complex because of ongoing health and or social care needs, whether 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; and
- better information and communication with patients and families.

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

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

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

6 The Delivery Unit assessed the written evidence in case notes against specific requirements set out in 'Passing the Baton'[2]. The findings for Aneurin Bevan University Health Board (the Health Board) show that the patient discharge process was variable and 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 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, the 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 that: The Health Board has well-developed plans for improving discharge planning, however performance fluctuates and there is scope to improve the discharge policy, pathways and training. In the paragraphs below we have set out the main reasons for coming to this conclusion.

11 **Planning:** The Health Board has clear plans for improving discharge planning, but there is scope to improve the discharge policy and document discharge pathways. We reached this conclusion because:

- The Health Board has clear plans for improving discharge planning, which are based on internal and external reviews.

- The Health Board's discharge policy, which is under review, is reasonably well developed but there is scope for improvement.
- Discharge pathways are in place but there was no evidence of documents to support staff to implement them.

12 **Arrangements for supporting discharge:** Nurse-led teams are available to support discharge but only on weekdays; staff training, awareness of the discharge policy and discharge lounge waiting times needs improvement. We reached this conclusion because:

- Dedicated discharge resources are nurse-led but only available during weekdays and there are concerns about long waiting times in discharge lounges.
- There is no training on discharge planning and awareness of the discharge policy is poor, however staff know where to obtain information about community services.

13 **Monitoring and reporting:** The Health Board has strong scrutiny arrangements, however performance fluctuates and there is scope to improve information reported to the board. We reached this conclusion because:

- Whilst partnership governance structures are under review, the Health Board has clear lines of accountability and performance is regularly scrutinised.
- The Health Board collates comprehensive performance data, and whilst board members feel informed they would benefit from more patient flow data.
- Data shows fluctuating performance and whilst discharge processes are being improved it may be too early to see the benefits.

Recommendations

Exhibit 1: recommendations

The table sets out the recommendations arising from the audit on discharge planning at Aneurin Bevan 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 pathways:** Whilst discharge pathways are in place, we found no evidence of documents to support staff to implement them. The Health Board should develop supporting tools for the main discharge pathways in an appropriate format, for example flow-charts or tables. The documents should be developed with partner organisations, appended to the revised discharge policy and displayed prominently.
R2	**Discharge lounge:** Ward staff expressed concerns about patients waiting for long periods of time in discharge lounges, mainly due to issues with non-emergency patient transport and staff not booking the right form of transport. The Health Board should: a) Develop clear transport booking guidance for nurses. b) Foster better communication with non-emergency ambulance service so nurses can communicate predicted waiting times to patients.
R3	**Discharge planning training:** We found induction programmes for nursing, medical and therapy staff did not include training on discharge planning. The Health Board should: a) Include discharge planning on induction programmes for staff that will be involved in discharge planning. b) Offer regular refresher training. c) For consistency, consider offering training to staff from partner organisations, who are involved in discharge planning.
R4	**Information on community services:** We found the Health Board regularly collates information about community services; however waiting times are not included. The Health Board should consider including information about waiting times for needs assessments and for services to commence.

Detailed report

The Health Board has clear plans for improving discharge planning, but there is scope to improve the discharge policy and document discharge pathways

The Health Board has clear plans for improving discharge planning, which are based on internal and external reviews

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[4] also makes clear that organisations should specify how their plans support and improve patient flow. The focus of which 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 Health Board there are three main plans for improving patient flow and discharge planning. These are: the Urgent Care Plan, the Gwent Health and Social Care Community Delayed Transfers of Care (DToC) action plan, and the Integrated Winter Plan. There are links between the plans but their focus differs.

- The Gwent Health and Social Care Community DToC Action Plan focuses on preventing hospital admissions and reducing DToCs. The plan details initiatives, which are themed around admissions avoidance, early identification of patients with complex needs, discharge planning, improving delivery and management of care and maximising the independent sector.
- The Urgent Care Plan focuses on improving in-patient processes, in particular tier one targets on patient waiting times and ambulance handover times.
- Aneurin Bevan's Integrated Winter Plan sets out the joint approach that the Health Board and its partners will take to manage winter pressures. The plan was developed in partnership with the five local authorities in Gwent and the Welsh Ambulance NHS Trust (WAST).

16 The Urgent Care Plan was developed in September 2016, so at the time of our review it was relatively new. The plan is based on learning from internal and external reviews, namely the Health Board's internal assessment of performance, the Delivery Unit's review of discharge planning and the 2015-16 winter plan review. The plan clearly details the reasons for change, these being evaluations of

[4] Welsh Government, NHS Planning Framework 2017-20, 2016

previous pilot projects showing little evidence of impact, inconsistent roll out of improvement work and the need to target poor performance. The document also references the need to deliver the Health Board's urgent care profile as set out in the Integrated Medium Term Plan (IMTP).

17 There are three phases to the Urgent Care Plan. Phase one initiatives are quick wins and include:

- rolling out the model ward programme to ensure consistent application of the patient flow bundle, which in turn will reduce length of stay;
- recruiting a team of discharge coordinators to improve ward discharge arrangements and reduce delays;
- employ operational flow managers to improve site management; and
- instil a system which values a patients time, 'red and green days'[5].

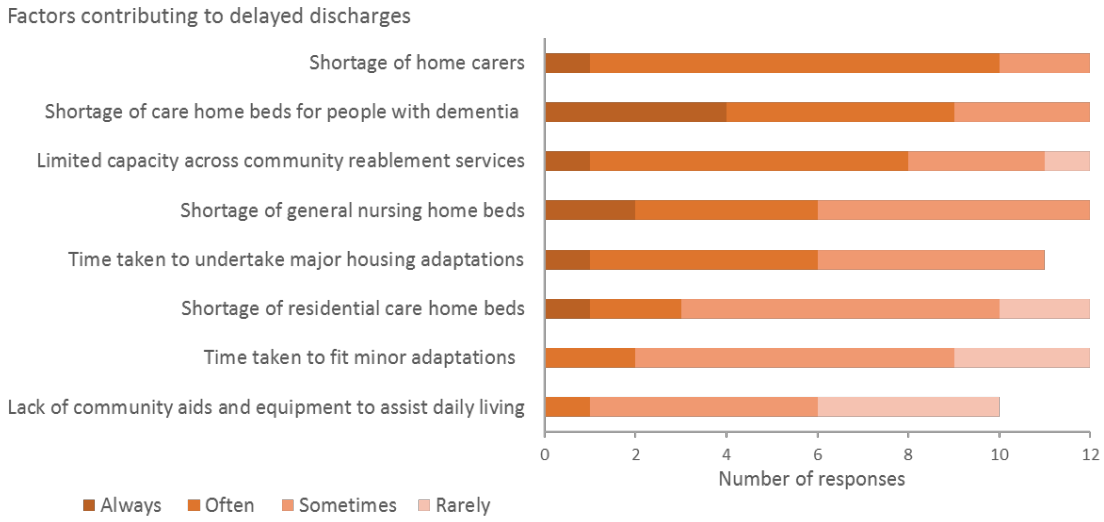
18 The second phase of the plan shows areas where opportunities for improvement have been identified and progressed but further development work is required before it can be implemented. Initiatives listed, which specifically relate to discharge planning, include weekend discharge planning, discharge letters, and standard operating procedures for social care allocation, assessment and confirmed dates of discharge.

19 The first two phases tackle urgent care issues where the cause is already known, however phase three focuses on diagnosing issues where the cause is still unclear.

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 problem. 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 transfer of care.

[5] A Red day is when a patient is waiting for an action to progress their care and/or this action could take place out of the current setting, meaning a Red day is of no value to the patient. A Green day is of value to the patient, for example the patient may have received an intervention or received care that can only be delivered in a hospital bed.

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



Source: Wales Audit Office analysis of information on discharge planning returned by NHS bodies in 2017[6]

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

- the time taken to undertake major housing adaptations;
- a shortage of home carers;
- a shortage of care home beds for people with dementia; and
- limited capacity across community reablement services.

22 In addition, the Health Board highlighted issues such as families not identifying a care home place both because of a lack of choice (particularly EMI nursing) and waiting until continuing health care (CHC) funding has been agreed. The latter is particularly problematic when there is not enough evidence in assessments to support CHC eligibility. Days are also lost in referral times and allocating social workers because of capacity issues within social services and staff not following correct processes, which maybe because staff do not understand discharge planning processes.

[6] 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.

23 Actions within the DToC action plan seek to address a number of the issues highlighted. For example, to reduce inappropriate referrals and improve efficiency, an occupational therapist and social worker are working alongside a patient flow coordinator to identify appropriate patients; this is being piloted on two wards at the Royal Gwent Hospital. To help staff manage discharges where the family is reluctant to identify a care home or where there is a lack of choice, actions include developing a commissioning strategy for older people and amending the choice of accommodation policy. In addition, the plan identifies the need to review the CHC process, with partner local authorities, to identify opportunities to make the process more effective. The DToC action plan we reviewed was updated in November 2016, at the time initiatives were at various stages.

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)[7]. The ICF, introduced in 2014-15 is a pooled resource and in terms of patient flow, funds initiatives that prevent hospital admission, supports the independence of older people and reduces DToCs. Initially, the fund was released on a one-off basis, but in 2015-16 became a recurrent fund. During June and July 2017, the Gwent Regional Partnership Board and its leadership group agreed to review ICF funded projects. Whilst the regional partnership board has to agree ICF proposals, partners are looking to introduce a more strategic approach to commissioning services.

25 Examples of 2015-16 ICF funded initiatives, which aim to improve discharge planning and patient flow include:

- step up/step down beds in all five local authority areas;
- a community neuro-rehabilitation service to support early discharge for stroke patients;
- community coordinators in all five local authority areas, to prevent social isolation;
- funding 15 discharge coordinators; and
- funding hospital transport which is not provided by WAST. Although not the primary purpose, the service has also been used to transport some patients that the WAST discharge contract cannot accommodate on the day (known as hospital handback).

[7] Previously called the Intermediate Care Fund.

The Health Board's discharge policy, which is under review, is reasonably well developed but there is scope for improvement

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 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.

27 We reviewed the organisation's policy on discharge and transfers of care using a maturity matrix[8]. 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 discharge policy scored against the maturity matrix.

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

The table shows that the Health Board's discharge policy is reasonably well developed but there is scope for improvement.

Elements assessed	Score	Auditor observations on the policy
Multi-agency discharge policy	2	The policy states that it applies to all health and social care professionals. It specifically mentions local authorities, third and voluntary sector. It also says that the policy statement needs to be written 'with' service users. Whilst the policy applies to all it is unclear whether it was developed with partners and service users.
Policy reviewed within the last year	3	Policy issue date, 26 June 2015, and review date 26 June 2017 clearly labelled on the front page.
Patient/carer involvement	3	Policy is clear that patient and family/carer involvement is important throughout the discharge process. The policy statements states that 'successful discharge will be based upon a multi-disciplinary approach involving the patient/parent and their carer(s) as equal partners where appropriate'.
Communication	3	Strong emphasis on communication with patient/family/carer throughout the policy. Reference made to ensuring information is available in accessible formats and different languages.

[8] 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	One of the policy objectives places emphasis on staff to understand the importance of communication and information sharing between different organisations involved in the discharge process.
Vulnerable groups eg patients who are homeless	2	Policy states that, 'Patient's, who are homeless, should be identified as soon as possible on or before admission, so that the appropriate agencies in both health and social care are involved at an early stage'. For cross border issues directs staff to - '"who pays" Commissioner Guidance for England and Wales. Only makes reference to All Wales protection of vulnerable adults in 'discharge plan' section.
Early discharge planning for elective admission	3	Policy states: 'the discharge care pathway begins before admission whether it is in primary care, social or community services or at preadmission clinic'.
Estimated discharge date (EDD) set within 24 hours of admission	2	Says EDD will be set as soon as possible after admissions or before for elective procedures.
Avoiding Readmission	2	No specific reference to measures to avoid readmission. But policy clearly states that patients should not be discharged late at night/early morning without agreement with family/carer.
Local Agreements and Protocols	3	Reference and links to: local choice policy, LA eligibility criteria for free home care and briefly mentions processes for aids/adaptations.
Assessment	3	Reference to Integrated Assessment (and performance measure), and reference and links to NHS Funded Care Home guidance, NHS CHC framework and WAG NHS guidance for meeting CHC needs.
Discharge from A&E	1	No mention of discharge from A&E.
Discharge to care home	1	Not mentioned in discharge policy. But the Choice Policy does state that patients should be supported to go home or equivalent with package of care, and states as a general rule people should not be discharged from acute hospital to a care home.
Links to choice of accommodation policy	3	The policy refers to the Health Board's Local Choice (of accommodation) policy.
Care Options	3	Policy states that discharge planning meetings will be used to determine where/how a patient is discharged – options include home with a package of care, intermediate, residential, specialised or nursing facilities.

Elements assessed	Score	Auditor observations on the policy
Escalation processes	2	Refers to using appropriate escalation processes to inform the senior nurse. But does not specify what happens if the senior nurse cannot solve issues.
Accessible Discharge Protocols	1	No pathways or flow charts included.

Source: Wales Audit Office review of Health Board's discharge policy, June 2015

28 Out of the 17 criteria we tested against, the Health Board's policy scored level 3 on nine of the 17 elements and level 2 on five, meaning that the Health Board has a reasonably well-developed discharge policy but there are opportunities for improvement. We found some areas of the Health Board's discharge policy that were less well developed. While the choice of accommodation policy states that patients should not be discharged from an acute hospital to a care home, this is not stressed within the discharge policy. The policy does not include flow or process charts to help staff implement the discharge policy, and there is no information about discharging patients from accident and emergency. Good practice dictates that a patient's estimated date of discharge should be set within 24 hour of being admitted, the Health Board's policy does not set a timeframe instead stating that it should be set as soon as possible after admission (and before admission for elective procedures). The discharge policy applies to all those involved in discharge planning, but it is unclear whether it was developed and agreed with partner organisations.

29 The Health Board reported that the discharge policy is being reviewed, with the aim of developing it into an all-in-one reference for discharge planning. The current version of the document briefly explains the various processes within the discharge care pathway, and for medicine and equipment management. The policy also details where it will be approved (clinical forum) and lists those responsible for disseminating it. In addition, the document lists qualitative and quantitative performance measures to monitor policy compliance.

30 In August 2015, the Health Board and the five local authorities in Gwent agreed the choice of accommodation policy, the policy's review date is April 2017. The DToC action plan update, from November 2016, states that staff training on the policy is ongoing, particularly around having difficult conversations with patients and carers. As detailed above the choice policy makes clear that a patient should not be discharged from an acute hospital to a care home.

31 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.

32 At the Health Board, we found that a section within the discharge policy clearly outlines the responsibilities of those involved in discharge planning. These include strategic leaders, operational staff and multidisciplinary teams[9].

Discharge pathways are in place but there was no evidence of documents to support staff to implement them

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 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.

34 As part of our work, we looked at the main discharge pathways in place. 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.

35 The Health Board does not know how many generic discharge pathways are in operation, however, stated the main ones are:

- discharge or transfer from acute to community hospitals for patients to undertake rehabilitation, and
- transfer to community setting for district nursing and frailty input.

36 The Health Board also does not know how many condition specific pathways are in operation but listed the main ones as the stroke, CHC complex care and frailty team pathways.

37 The Health Board did not provide documented discharge pathways that show the sequence of steps needed to safely discharge patients to their appropriate destination, 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 and ideally set out the following:

- acknowledges transport or transfer logistics;
- specifies which hospitals the pathway applies to;
- applies 24 hours a day, 365 days per year;
- developed with partner organisations (local authority and NHS bodies);
- supported by generic discharge and assessment documentation;

[9] Discharge policy outlines responsibilities for the Executive Nurse Director, clinical directors, general managers, divisional nurses, service managers, senior nurse, heads of service, ward and departmental managers, complex discharge managers/discharge practitioners/liaison nurses/case managers and multi-disciplinary team.

- 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 eg discharge letters.

38 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.

39 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.

40 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 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 reported that it has not implemented a discharge to assess model, but is exploring ways to trial the model with partner local authorities. The availability of staff in the community to identify patients, appropriately assess them and manage their conditions at home was cited as a barrier to putting the model into practice.

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

[11] Welsh Government, Sustainable Social Services, 2011

Nurse-led teams are available to support discharge but only on weekdays; staff training, awareness of the discharge policy and discharge lounge waiting times needs improvement

Dedicated discharge resources are nurse-led but only available during weekdays and there are concerns about long waiting times in discharge lounges

Whilst not multidisciplinary, the nurse-led discharge liaison service has administrative support to improve efficiency and like services at other health boards, the service operates weekdays only

41 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.

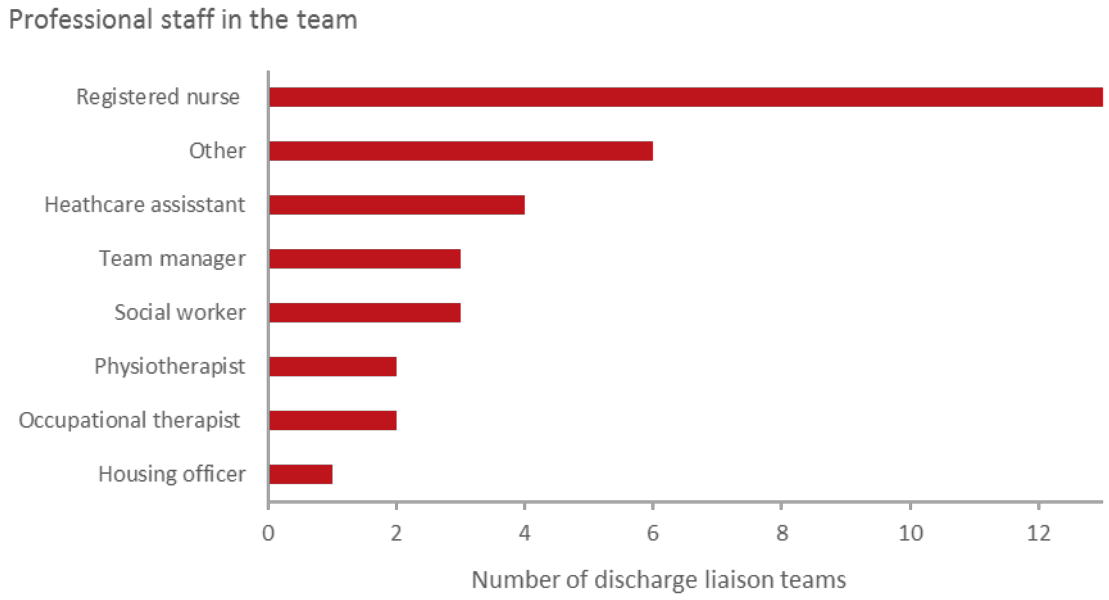
42 We sought information from every NHS organisation about whether they operate discharge liaison services and the scope of the services remit. Across Wales, we found that all NHS organisations, with the exception of Velindre NHS Trust, run one or more discharge liaison teams. All teams operate during 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.

43 At the Health Board, we found it has a team of Discharge Liaison Nurses (DLN), who cover all hospital sites and work across all specialities. The Strategic Lead for Patient Flow oversees the service, and the Divisional Nurse for Community Services is responsible for operational management. The Discharge Liaison Nurses manage all complex hospital discharges.

44 Typically, discharge liaison teams are made up 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 shows 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.

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

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



Source: Wales Audit Office analysis of information collected on discharge liaison teams, 2017[12]

45 At the Health Board, the team of Discharge Liaison Nurses is made up of three band seven nurses and four band six nurses, and five Patient Flow Coordinators (PFC) support the team. The PFCs undertake administration associated with discharge planning, which frees up time for DLNs to attend multidisciplinary team meetings and board rounds, which helps support timely discharge. The Patient Flow Coordinators were introduced in October 2016, following a review of the DLN service in March 2016. Although only in place for a short time, the Health Board reported that they have noticed a reduction in length of stay and reduced, avoidable, delays in referrals and assessments. As outlined in the Urgent Care Plan, in January 2017, the Health Board introduced Discharge Coordinators, who are non-clinical, ward based staff. In community hospitals Discharge Coordinators are an extra resource to help manage arrangements for

[12] 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.

complex cases, in acute hospitals their focus is on all patients. However, the Discharge Coordinators are not part of the DLN service. The ward staff we spoke to felt the patient flow and discharge coordinators provided a valuable service, but were unclear about the difference between the two roles.

46 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. At the Health Board, the cost of the discharge liaison team was £290,425 between October 2015 and September 2016 compared with the average cost per discharge liaison team of £244,000.

47 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 do not have information on the number of discharges managed by the Health Board's discharge liaison team so we are unable to comment on the capacity of the team.

48 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, the Discharge Liaison Nurse service always carries out the following activities and this is broadly in line with other discharge liaison teams:

- ensure individual discharge plans are in place for patients with complex needs;
- liaise with other public bodies to facilitate hospital discharge and avoid readmission;
- provide a central point of contact for health and social care practitioners during discharge planning process;
- validate on delayed transfers of care;
- provide training and development for clinical staff to affect timely discharge;
- update bed managers with information on hospital discharges; and
- signpost patients and their families to advice and support for maintaining independence at home.

49 However the DLN service rarely work with operational managers to develop performance measures on hospital discharge, unlike 47% of other discharge liaison teams who always or often undertake this activity. 54% of discharge liaison services always or often provide housing options advice and support; the DLN service rarely does this.

50 The majority of discharge liaison services always or often support staff to identify vulnerable patients who could be delayed (87%) and participate in ward rounds and/or multidisciplinary team meetings (73%). The DLN service sometimes

undertakes these activities; the introduction of the Patient Flow Coordinators will mean discharge liaison nurses have more time to attend ward rounds and multidisciplinary team meetings.

Discharge lounges have long opening hours, but operate weekdays only; concerns were raised about long waiting times and issues with patient transport

51 A discharge lounge can also support effective discharge planning and patient flow by providing a suitable environment in which patients can wait to be collected by their families or by hospital transport. Thus releasing beds promptly for other patients being admitted. Some patients may also be sent to the lounge whilst they wait for medication to be dispensed.

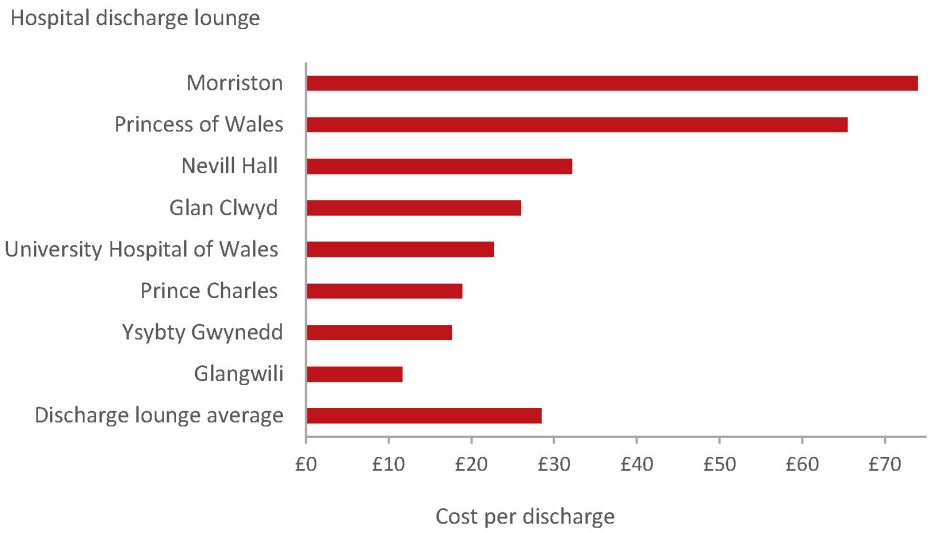
52 We asked NHS organisations about their discharge lounge facilities. Across Wales, we found that all health boards, except Powys, operate discharge lounges in their acute hospitals. At the time of our audit work, discharge lounges had capacity to support 192 patients waiting discharge; the average capacity per discharge lounge was 11. Across Wales, discharge lounges operate for between 8 and 12 hours on weekdays and are generally staffed by registered nurses and healthcare support workers. There are also food and toilets facilities available for patients.

53 The Health Board runs discharge lounges at the Royal Gwent Hospital (RGH) and Nevill Hall Hospital (NHH) during weekdays. RGH has capacity for 16 patient and operates between 8am and 8pm, and NHH can accommodate 10 patients and operates between 9.30am and 5.30pm. Between October 2015 and September 2016, 2,087 patients were managed through the discharge lounge at NHH, the figure for RGH is unknown.

54 We also requested information on staffing, costs and activity for discharge lounges. This information 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 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. At Aneurin Bevan, the discharge lounge service costs £167,206. The cost per discharge for Nevill Hall Hospital was £32 compared with the discharge lounge average of £28 (Exhibit 5).

Exhibit 5: comparison of the cost per discharge managed by individual discharge lounges between 1 October 2015 and 30 September 2016

The chart shows the variation in the cost per discharge managed through the discharge lounge ranging from £12 to £74 per discharge.



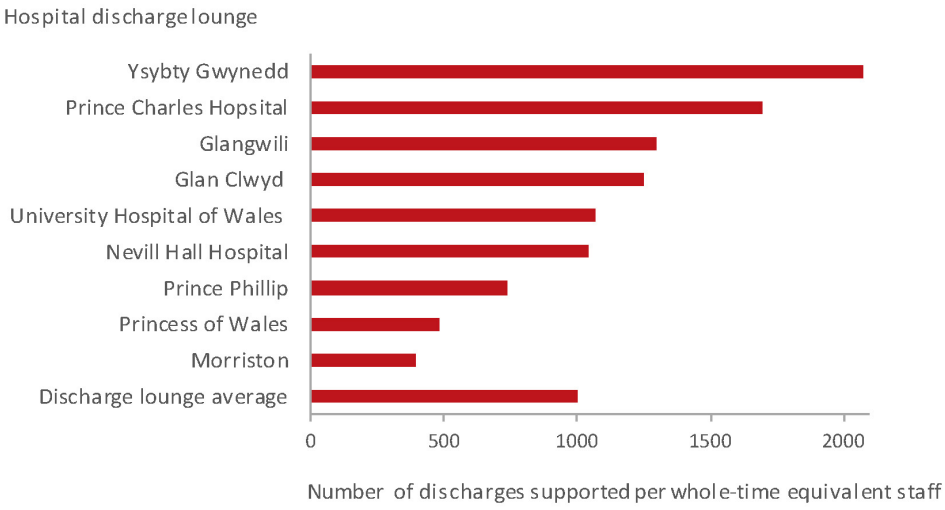
Source: Wales Audit Office analysis of information collected on hospital discharge lounges, 2017[13]

55 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 2000 per WTE (Exhibit 6). At Nevill Hall Hospital, one registered nurse and one healthcare assistant staff the discharge lounge. Between 1 October 2015 and 30 September 2016, 2,087 discharges were managed through the lounge meaning that each WTE member of staff manages 1,044 discharges.

[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 6: number of discharges per whole-time equivalent (WTE) staff supported through hospital discharge lounges 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, from just under 400 per WTE staff to just over 2000 per WTE staff.



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

56 The ward nurses we spoke to expressed concerns about long waits for patients in the discharge lounges, waits can be as long as seven hours, and not being able to tell patients how long their wait will be. Reasons given for the long waits were mainly to do with the capacity of non-emergency patient transport and nurses booking the right form of transport for their patients. Ward staff told us that patients can be returned to the discharge lounge if the ambulance service cannot transport them and that when booking non-emergency transport patients can end up in a queue for hours. The Urgent Care Plan states that one of the outcomes of implementing the model ward is to reduce patient handback. And as detailed in paragraph 25, patient transport paid for through ICF funding, has at times been used to supplement the WAST discharge contract, that is, a patient that could not be accommodated on the day. Staff felt it would be beneficial to establish a surgical discharge lounge.

There is no training on discharge planning and awareness of the discharge policy is poor, however staff know where to obtain information about community services

57 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. This should be supported by clear awareness of policies and pathways, access to appropriate levels of training, and a good awareness of the range of services available to support discharge.

Staff have not received training on discharge planning and awareness of the discharge policy is poor, but staff are aware of policies which support it

58 As part of our audit work, we met with a group of ward nurses to talk about a range of issues related to discharge planning. The ward nurses were clear about their role in discharge planning. When asked about their awareness of an overall discharge policy they explained that there were different policies in place for different parts of the system. For example, choice of accommodation, occupational therapy referral and mental health. Whilst this is positive, nurses should be cited of the overall discharge policy. In terms of discharge pathways, ward staff did not mention a generic discharge pathway, but spoke about different hospitals and local authority areas having separate pathways and procedures.

59 The discharge procedures and systems described by ward nurses seem to differ depending on ward and speciality. This may be because some wards have implemented or are piloting initiatives detailed in the Urgent Care Plan. In rolling out the 'model ward', senior managers explained that it is important for wards to take ownership. Provided the principles of the 'model ward' are kept, wards have been given the freedom to implement it in their own way.

60 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.

61 Exhibit 7 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, nursing staff told us that they did not receive any training on discharge planning. We found induction programmes for nursing, medical, occupational therapy and physiotherapy staff did not include training on discharge planning.

Exhibit 7: 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 induction programmes for new starters	Refresher training on discharge planning provided regularly[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 (county teams)		
• Pembrokeshire	Yes	No
• Ceredigion	No	No
• Carmarthenshire	No	No
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 6)

62 The Divisional Nurse for Community, who is responsible for the Discharge Liaison Nurse Service, said she holds monthly engagement and training sessions with her team and the Associate Director of Operations explained that ward teams go to learning and sharing sessions with ABCi[14]. Whilst this is positive, it is clear there is no formal approach to discharge planning training in place at the Health Board. All staff involved in discharge planning should receive training as part of their induction, with regular refreshers thereafter. For consistency, training should also be available for partner organisations involved in patient discharge planning.

[14] ABCi stands for Aneurin Bevan Continuous Improvement. Established in 2013, it is the Health Board's innovation and improvement centre.

The Health Board is in the process of rolling out some changes to improve discharge planning, but it is too early to comment on the impact and there is some way to go before barriers to timely discharge are fully addressed

63 In its review, the Delivery Unit found a culture of risk aversion across Wales with staff speaking openly of a 'cwtch' culture[15] and insufficient time dedicated to managing the discharge process. Ward staff highlighted a number of barriers to timely discharge, these related mainly to lengthy waits for social worker allocation, long continuing health care (CHC) process, waiting for care packages and shortage of bariatric facilities.

64 However, staff also told us about some areas of good practice, for example a social worker from Newport visiting the wards twice a week and then liaising with other councils if necessary. This is part of a pilot on one ward, which ward nurses expect will be rolled out across the Health Board.

65 In terms of managing CHC there is a newly formed CHC Board, which meets every three months and is attended by three of the five local authorities. The aim of the board is to manage overall improvement collectively, and try to stop disagreements over funding for patients onward care. In addition the Health Board is planning on expanding the number of CHC managers so there is one for each of the five local authority areas. CHC managers' quality check CHC applications and commission packages of care.

66 The Delivery Unit found limited evidence in patient records that patients' expectations of discharge were discussed with them. The Health Board is piloting a personalised leaflet called 'your discharge ticket'. The leaflet has space to enter the patients name, expected discharge date, ward number and consultants name; it also includes a list of useful phone numbers for patients, their families and carers. Your discharge ticket includes information to help prepare for discharge, for example, it explains that patients may be transferred to an intermediate care or community setting, what to think about before being discharged or transferred and things to think about before going home. The leaflet also explains that on discharge, the Health Board expects patients to make their own way home, but in exceptional circumstances transportation can be arranged.

67 Ward staff told us that 'your discharge ticket' was being piloted in two wards and at the time of our review had been in operation for about two months. This is a positive step, as the Delivery Unit review, the Community Health Council representative and ward staff highlighted communication as an issue.

68 Following the Delivery Unit review, the Health Board reported that findings have been presented to a number of teams to identify what actions need to be taken to

[15] 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.

improve discharge planning. The Health Board is addressing the Delivery Unit's recommendations through:

- implementing the first phase of the Urgent Care Plan which concentrates on improving emergency department targets and patient experience, further detail is included in paragraph 16;
- undertaking further scoping within complex care to identify a model that facilitates earlier assessment of patients with complex needs, as complex care discharges were highlighted as an area for improvement;
- introducing 'patient flow coordinators' and 'model ward' concepts as a way of addressing communication issues;
- developing a work programme to support the recommendations following a day-of-care audit, and
- undertaking a campaign called 'Breaking the Cycle' between 29 March and 13 April 2017. The principles of 'Breaking the Cycle' is to have no tolerance for patient delays and to ensure the principle of 'right bed, right patients, first time'.

Information about community services to support discharge is regularly collated, and, whilst the Health Board does not have a community services directory, staff know where to get information when needed

69 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 8 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 8: 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/Trust'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 6)

70 At the Health Board, both health and social care informatics departments in conjunction with key patient flow leads are responsible for collating information on the availability of community services. The Health Board collates information about all of the services shown in exhibit 9, except for community services provided by other NHS services. The Health Board does not collate information about waiting times (for needs assessments or for services to commence). Most information is updated on a daily basis, apart from information on independent sector services, which is done weekly. The Health Board does not know how often housing options data is updated.

71 We asked ward nurses about their knowledge of the range of community services to support patients on discharge. The ward nurses we spoke to were not aware of a directory of community services. They did mention a few ways to obtain the information needed, for example each county borough has a liaison nurse who has up-to-date information about care homes vacancies. They can contact the Gwent Frailty Programme or Age Concern for information and contact local authorities, Torfaen County Borough Council was highlighted as being good at making information about community services available.

The Health Board has strong scrutiny arrangements, however performance fluctuates and there is scope to improve information reported to the board

Whilst partnership governance structures are under review, the Health Board has clear lines of accountability and performance is regularly scrutinised

72 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.

73 At the Health Board, responsibilities for discharge planning are set out in the discharge policy. Senior managers reported that whilst discharge planning was everybody's responsibility, ward managers and clinical teams are responsible for making sure the policy is implemented correctly. The Associate Director of Operations, who reports directly to the Chief Operating Officer, has strategic responsibility for discharge planning and patient flow, and developing and driving forward the Urgent Care Plan and integrated winter plan.

74 In June 2016, the Delivery Unit undertook an assurance review at the Health Board. The review highlighted a lack of robust programme management to deliver the Health Board's unscheduled care change programme. In response, the Health Board has put in place a governance structure to deliver the Urgent Care Plan, which is being delivered through the Urgent Care Collaborative. The collaborative is responsible for monitoring and updating the Urgent Care Board, which has oversight and strategic responsibility for identifying priority improvement areas. The Health Board's divisions and directorates, with the support of ABCi, are responsible for delivering the improvement plans.

75 At a higher level, board members receive an IMTP progress update, which includes performance against Welsh Government targets and progress on service change programmes, including urgent and emergency care. A similar report is scrutinised by the Finance and Performance Committee as part of their performance review. Quality and Safety Committee review updates on winter pressures and the Public Partnership and Wellbeing Committee receives updates on partnership initiatives such as ICF progress and older peoples' integrated pathway.

76 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 9 out of 11 of the board members (82%) who responded

agreed or strongly agreed that the Board and its committees regularly scrutinises the effectiveness of discharge planning. This compares to 56% across Wales.

77 As good discharge planning relies on partner organisations working together, as well as internal challenge, joint scrutiny arrangements should also be in place. The Gwent Regional Partnership Board was established in April 2016, as part of the requirements of the Social Services and Well Being Act. A regional leadership group formed of senior officers from health, social care and the third sector supports the board. The regional partnership board has three main priorities, two of which are the older people's pathway and carers, both of which are relevant to discharge planning.

78 The Gwent region has a number of partnership boards for example the Gwent Frailty Joint Committee, Gwent Wide Integrated Community Equipment Board and the Urgent Care Board. At the time of our review, the regional governance structure was under review. The purpose of the review is to have a clearer governance structure, avoid duplication and ensure appropriate oversight for areas of joint working. We reviewed a briefing paper, which set out five options for the regional partnership board to consider at its September 2016 meeting. The option taken forward was to reduce the number of integration bodies and align them to the areas identified in part 9 of the Social Services and Well-Being Act.

The Health Board collates comprehensive performance data, and whilst board members feel informed they would benefit from more patient flow data

79 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.

80 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.

81 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 9 sets out the performance indicators and updates reported to the Board at Aneurin Bevan.

Exhibit 9: range of performance information reported to the Board during 2016-17

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

Discharge planning	Patient flow
• Delayed Transfers of Care measures • Updates on the10 service change plans detailed within the IMTP including urgent care plan initiatives, such as: – model ward programme; – transformation of the ambulatory care pathway; – recruiting discharge coordinators; – recruiting operational flow managers; and – work with Clinical Directors and Deputy Medical Director to improve and speed up assessment and discharge times.	• % of patients waiting less than 4 hours in all A&E facilities until transfer, admission or discharge. • % of emergency ambulance response times to category red calls up to and including 8 minutes. • Number of ambulance handovers over one hour. • Number of patients waiting 12 hours or more in all A&E facilities until transfer, admission or discharge.

Source: Wales Audit Office review of papers presented to the Board at Aneurin Bevan University Health Board.

82 As detailed in paragraph 75, the Board's committees also receive process reports related to patient flow and integrated working. As well as high-level information, the Health Board produces hourly, daily and weekly operational reports, which help with demand and capacity planning and identifying areas for improvement. The reports are used to inform Executive Leads, operational teams and bed management meetings (site meetings).

83 In response to our board member survey:

- 7 out of 11 board members (64%) 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 11 board members (91%) 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%.

84 Further information that would prove helpful to understand discharge planning performance in particular but not currently reported to the Board in Aneurin Bevan would include:

- number and % of patients who have an estimated discharge date;
- readmission within 28 days of discharge from hospital;
- % of discharges before midday;

- % of unplanned discharges at night; and
- % of discharges within 24 hours and 72 hours of being medically fit.

85 We asked NHS organisations what information could be captured on their patient administration systems. Exhibit 10 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 10: 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 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 6)

86 The Health Board can record all of the data presented in Exhibit 10, using a combination of electronic and papers based systems. Ward nurses told us that they have to complete patient care records. The first page of the record is for personal information, the second section is the patient's medical history and activities of daily living and the last section is for discharge. However, the last section was seldom used. The Health Board introduced discharge planning (white) boards on all wards. On the board a patients name, borough, age, consultant, referral and daily activities is recorded. However, ward nurses had mixed feeling about the boards, some liked them whilst other thought they were impractical. The Health Board is trailing an electronic system, where each bed has a tablet computer displaying patient information. The Health Board is looking to roll this system out by the end of this year.

Data shows fluctuating performance and whilst discharge processes are being improved it may be too early to see the benefits

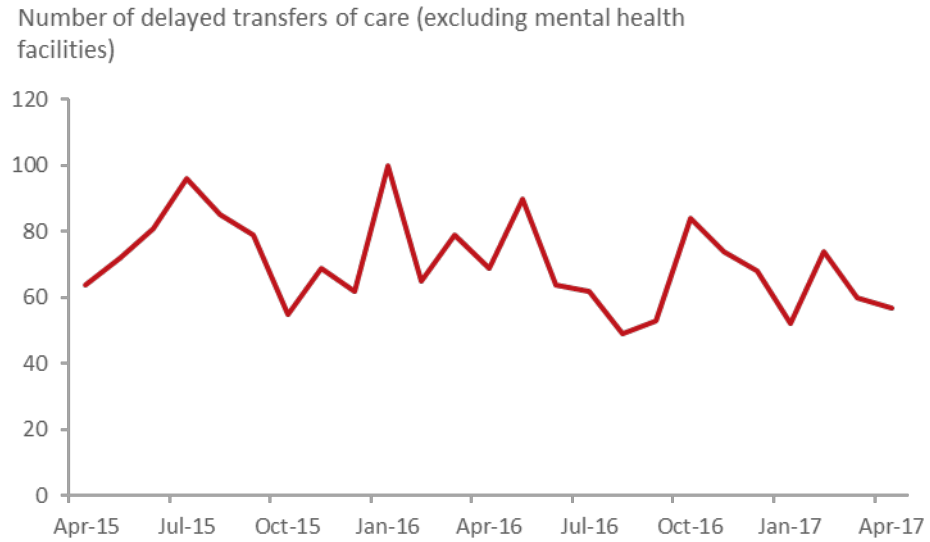
87 The Delivery Unit undertook their review of discharge planning at the Health Board in June 2016. Since then the Health Board has developed their Urgent Care Plan, as detailed in paragraph 16, the plan aims to improve performance against emergency department targets and patient experience. Whilst the Health Board has made some positive improvements, it is early days for the Urgent Care Plan and it is too soon to comment on the overall impact on discharge planning.

88 Exhibit 11 shows a variable number of DToCs each month between April 2015 and April 2017, whist performance for some months is better than others the trend shows no sustained improvement since the Delivery Unit's review of discharge planning in June 2016. The largest proportion of DToCs are attributed to reasons related to selecting a care home or waiting for care home placement, the proportion attributed to these reasons has increased from 25% in 2015-16 to 31% in 2016-17. During the same time period, the proportion of delays attributed to Healthcare reasons reduced from 34% in 2015-16 to 26% in 2016-17. The proportion of delays attributed to community care reasons remained consistent at 23% in 2015-16 and 22% in 2016-17.

89 The total number of DToCs (excluding those in mental health facilities) reduced by 12% from 907 in 2015-16 to 799 in 2016-17 and the number of patients delayed 13 weeks or more is reducing, but the number of patients delayed between 4 and 12 weeks is rising (Exhibit 12).

Exhibit 11: trend in delayed transfers of care (excluding mental health facilities) between April 2015 and April 2017

The chart shows a fluctuating number of delayed transfers of care from Aneurin Bevan University Health Board; whilst performance is better some months, the overall trend does not show a sustained improvement in numbers.



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

Exhibit 12: 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 Aneurin Bevan University Health Board with numbers of patients delayed between 4 and 12 weeks rising.

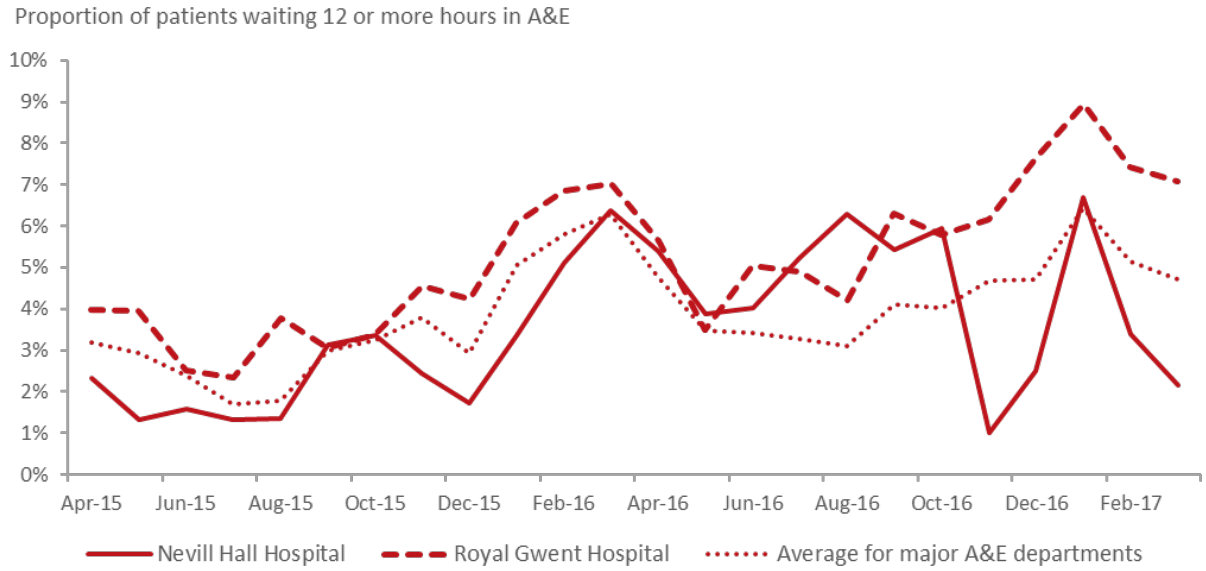
Length of delay	Number of delayed transfers of care (DToC)		Percentage change in number of DToCs (%)
	2015-16	2016-17	
0-3 weeks	565	425	-25%
4-6 weeks	188	207	10%
7-12 weeks	97	121	25%
13-26 weeks	52	45	-13%
26+ weeks	5	1	-80%
Total DToCs	**907**	**799**	**-12%**

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

90 During the same period, Exhibit 13 indicates that the proportion of patients waiting over 12 hours in accident and emergency has increased at the Royal Gwent Hospital and performance is worse than the Wales average. Compared to the Royal Gwent Hospital there are less 12-hour breaches at Nevill Hall Hospital, and performance fluctuates above and below the Wales average.

Exhibit 13: proportion of Health Board patients waiting more than 12 hours in accident and emergency compared to all Wales average between April 2015 and March 2017

The chart shows, compared to the Wales average, in general, there is a higher proportion of patients waiting 12 hours or more at Aneurin Bevan University Health Board's emergency departments at Royal Gwent and Nevill Hall hospitals.

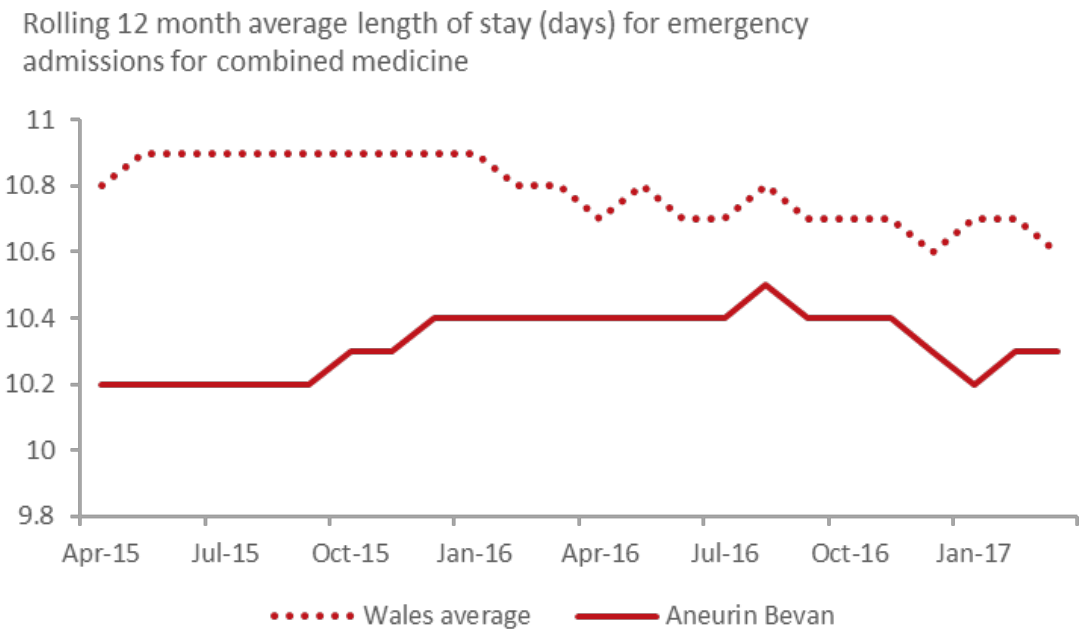


Source: Wales Audit Office analysis of the Time Spent in NHS Wales Accident and Emergency Departments: Monthly Management Information, NHS Wales Informatics Services, March 2017

91 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 14 shows little change in the rolling average length of stay for emergency medical admission over the last two years, with lengths of stay consistently below the Wales average.

Exhibit 14: 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 chart shows little change in the rolling average length of stay for emergency medical admissions over the last two years, with lengths of stay consistently 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

Appendix 1

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

Exhibit 15: the RAG status[16] of the Delivery Unit's assessment of written evidence in the case notes against specific requirements set out in Passing the Baton[17]

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

Discharge process	Expected practice	Royal Gwent Hospital (RGH)	Neville Hall Hospital (NHH)
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.		

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

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

Discharge process	Expected practice	Royal Gwent Hospital (RGH)	Neville Hall Hospital (NHH)
	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.		
	The EDD can be flexed according to an individual's response to treatment, in order to provide a realistic date for discharge.	Evidence this occurred but only 35% (RGH) and 16% (NHH) of case notes reviewed found evidence that the EDD had been recorded	
	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 (eg 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)		

Discharge process	Expected practice	Royal Gwent Hospital (RGH)	Neville Hall Hospital (NHH)
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 Aneurin Bevan University Health Board, June 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 16: 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 the completed data collection form in April 2017.
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 submitted two forms, one for the Royal Gwent Hospital and one for Nevill Hall 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 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 Discharge Liaison Nurse service; the service covers both community and acute hospital sites.

Method	Detail
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 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 the 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: • Associate Director of Operations • Associate Director Of Efficiency & Effectiveness • Executive Director of Therapies & Sciences • Divisional Nurse (Community) • Independent Board Member (Social Services) • Community Health Council representative We also met with a group of ward-based nursing staff responsible for discharge planning.
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 17: management response

The table 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	Develop supporting tools for the main discharge pathways in an appropriate format, for example flowchart or table. The documents should be developed with partner organisations and appended to the revised discharge policy.	All staff involved in discharge planning have knowledge of and consistently apply discharge pathways.	Yes	Yes	Actions identified: The current documents and pathways have been developed with partners but we accept an update needs to occur and more clarity for operational teams is required. For example, on our inpatients wards there is a flowchart of how to engage with community teams in health and care for each borough. Through our current joint partnership arrangements we will update the information we provide with the objective that it is clear and functional for teams to use. The group will also consider how the launch of this communication is delivered to ensure it makes the required impact.	February 2018	Divisional Nurse Primary & Community

Ref	Recommendation	Intended outcome/benefit	High priority (yes/no)	Accepted (yes/no)	Management response	Completion date	Responsible officer
R2a	Develop clear transport booking guidance for nurses.	Right type of transport is booked for patients, which in turn will reduce the length of time patients wait in discharge lounges.	No	Yes	Agree with the recommendation, whilst recognising that there is a process to book transport on each site, as this occurs for our patients every day through our confirmed process. The work as a health board we need to do reflects better communication to all ward teams that they understand how to book transport for their patients. We will be taking this forward through divisional nurses, senior nurses and ward managers.	December 2017	Divisional Nurses
R2b	Foster better communication with non-emergency ambulance service so nurses can communicate predicted waiting times to patients.	Discharge lounge staff can better communicate transport waiting times to patients.	Yes	Yes	Our discharge lounge and non-emergency patient transport liaison are able to give target times for patients leaving the hospital. The Health Board will ensure that at a ward level those looking after patients ask for their transport time range so that patients can be informed.	December 2017	Divisional Nurses
R3a	Include discharge planning on induction programmes for staff that will be involved in discharge planning.	New staff have the right skills and knowledge to effectively plan discharge. Discharge polices and procedure are consistently applied.	Yes	Yes	As part of the work on recommendation 1, the Health Board will ensure a training and delivery programme on discharge pathways is provided to relevant members of staff.	January 2018	Divisional Nurse Primary & Community

Ref	Recommendation	Intended outcome/benefit	High priority (yes/no)	Accepted (yes/no)	Management response	Completion date	Responsible officer
R3b	Offer staff involved in discharge planning regular refresher training.	Staff have up to date knowledge of discharge processes and procedures.	No	Yes	Accepting that professional development is ongoing, the Health Board will ensure that discharge refresher training events are provided going forward.	February 2018	Associate Director of Operations
R3c	For consistency, consider offering training to staff from partner organisations, who are involved in discharge planning.	Staff from all organisations involved in discharge planning will have knowledge of discharge processes and procedures.	No	Yes	We will include partner organisations in our training events as outlined in recommendation 3b.	February 2018	Associate Director of Operations

Ref	Recommendation	Intended outcome/benefit	High priority (yes/no)	Accepted (yes/no)	Management response	Completion date	Responsible officer
R4	The Health Board should consider including information about waiting times for needs assessments and for services to commence.	Wider knowledge on waiting times for community health and social care services will allow for more efficient discharge planning.	Yes	Yes	The Health Board accepts that communication of waiting times in delays for discharges needs to improve. However, the Health Board does capture and presents the information through its business intelligence system on a daily basis. This is used by operational teams from the complex list database. Therefore the action will be including this in more detail in our patient flow report and ensuring that this information is utilised at urgent care board. The Health Board will also ensure that this is reported through hospital clinical management groups as there are well established meetings for the discussion in a community level including a robust continuing health care process which reviews delays.	December 2017	Associate Director of Operations

Appendix 4

Activities undertaken by discharge liaison teams

As part of this review, we asked health boards to what extent their discharge liaison teams undertake a range of discharge planning activities, from always to never. Exhibit 18 shows the reported frequency with which the 15 discharge liaison teams across Wales undertake these activities.

Exhibit 18: 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.

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 delayed transfers of care.	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 6)

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