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Discharge Planning – **Cardiff and Vale University Health Board**

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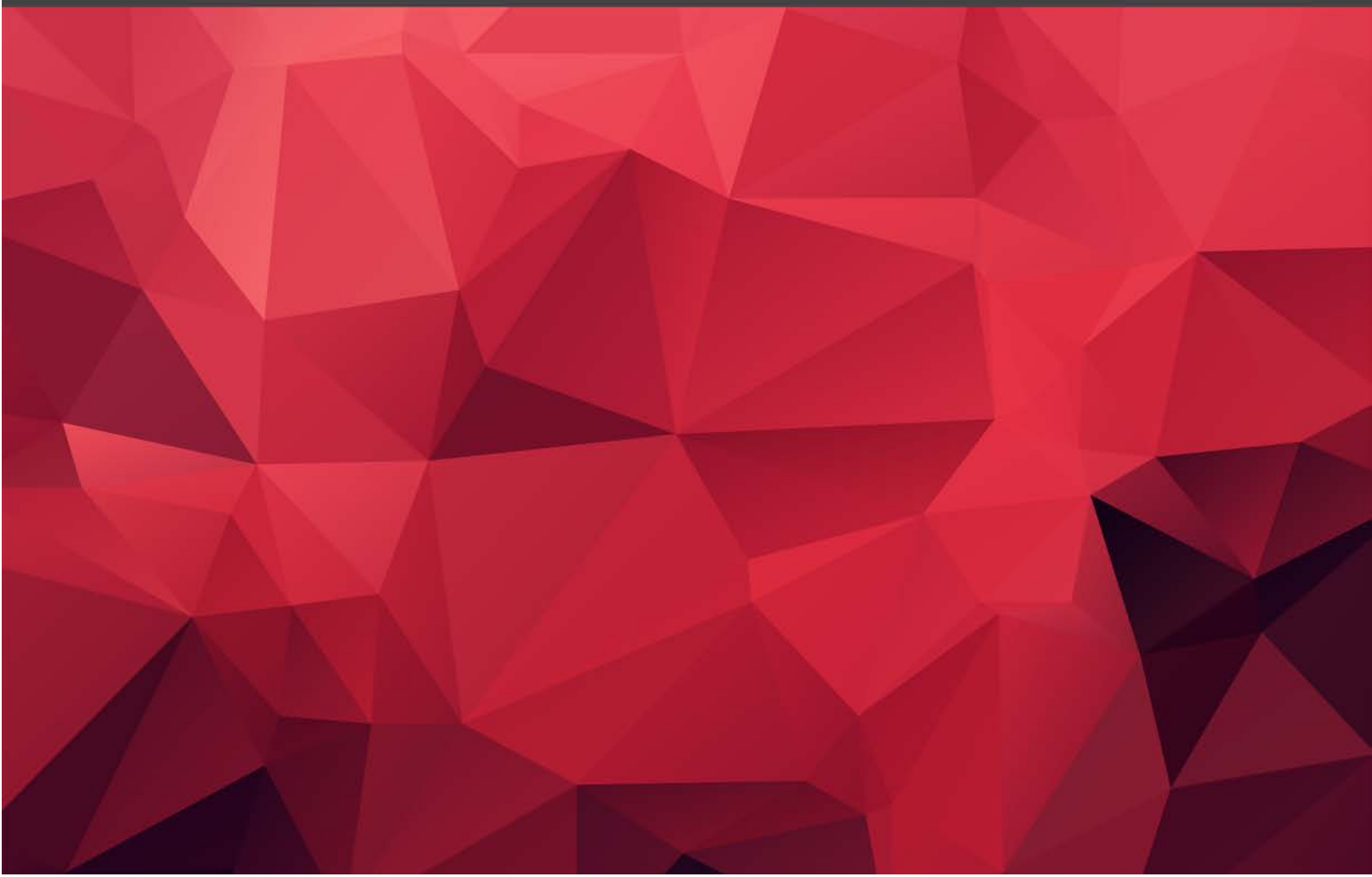

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The team who delivered the work comprised Urvisha Perez and Matthew Brushett.

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The Health Board has robust discharge improvement plans, strong performance management arrangements and performance overall is improving, but there is scope to improve ward staff training and awareness of policies and community services.

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 Cardiff and Vale 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: **The Health Board has robust discharge improvement plans, strong performance management arrangements and performance overall is improving, but there is scope to improve ward staff training and awareness of policies and community services**. 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 supported by comprehensive policies and pathways. We reached this conclusion because:

- there are clear plans for improving discharge planning, which have been developed with partners.

- the Health Board has a well-developed draft discharge policy, reviewed with partners, however patient and carers have not been involved in its review.
- the recently revised discharge pathways are comprehensive and form part of the draft discharge policy.

12 **Arrangements for supporting discharge**: Multiagency and multidisciplinary teams are available to support discharge but only during the week; staff training and awareness of policies and community services needs improvement. We reached this conclusion because:

- the Health Board has dedicated discharge resources, which are multiagency and multidisciplinary but these are available weekdays only.
- there is scope to improve staff training and raise awareness of policies, pathways and access to information about community services.

13 **Monitoring and reporting**: Overall, performance is improving; the Health Board has strong scrutiny arrangements for discharge planning and is taking positive steps to capture more meaningful information. We reached this conclusion because:

- there are clear lines of accountability and regular scrutiny of discharge planning performance, which includes partners.
- Board members generally feel informed about discharge planning performance, with action being taken to develop further the range of information available.
- performance is improving but it is too early to comment on whether this is linked to improvements in discharge processes.

Recommendations

Exhibit 1: recommendations

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

Recommendations	
R1	**Information on community health and social care services:** We found the Health Board collates a comprehensive range of information about community services but there is scope to strengthen ward staff knowledge and extend the range of data collated. The Health Board should: a. develop a system where ward staff are able to access up-to-date information about community health and social care services. b. review the range and frequency of data collated about community health and social care services. For example, waiting times for some services

Recommendations	
	and the frequency data on services available through other NHS bodies and housing options is collated.
R2	**Policy review:** We found that recently revised discharge and transfer of care and choice of accommodation policies were part of partnership action plans but we found no evidence that patients and carers were involved in the process. The Health Board should seek to involve patients and carers when the next policy revisions are due.
R3	**Staff awareness of policies and pathways:** We found that ward staff were unaware of discharge policies and pathways. Whilst these documents were under review at the time of the audit, staff should have been aware of previous iterations. The Health Board should undertake training and awareness raising once the draft discharge policy has been finalised to ensure all staff involved in discharge planning understand how to use it.
R4	**Discharge planning training:** We found that staff training on discharge planning is patchy and that the Health Board does not monitor compliance with training. Plans to improve training is included on the discharge improvement plans but staff told us that a lack of capacity on the wards is a barrier to attending training. The Health Board should: a. explore developing an e-learning course for discharge planning which ward staff may find more accessible. b. ensure that attendance at training is captured on the electronic staff record, which will help to improve compliance monitoring.

Detailed report

Part 1: the Health Board has clear plans for improving discharge planning supported by comprehensive policies and pathways

There are clear plans for improving discharge planning, which have been developed with partners

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. The Health Board area has three main plans for improving patient flow and discharge planning. These are: the Home First Plan, the Unscheduled Care Improvement Programme and the Cardiff and Vale Integrated Winter Plan. There are links between all three plans but their focus differs.

- the Home First Plan is the region's delayed transfer of care (DToC) action plan. It was developed by the Cardiff and Vale Integrated Health and Social Care (IHSC) Partnership[5] following a peak in DToCs in February 2015. This plan provides the strategic overview for work underway to improve DToCs and overall care for people needing care and support.
- the Unscheduled Care Improvement Programme aims to improve hospital inpatient processes and discharge and transfer arrangements.
- Cardiff and Vale Integrated Winter Plan details actions to enhance discharge arrangements to better manage winter pressures. The Health Board, Cardiff and Vale local authorities, third sector organisations[6] and the Welsh Ambulance Services Trust (WAST) jointly agreed the plan.

16 The Unscheduled Care Improvement Programme is based on recommendations from several reviews[7], including the Delivery Unit's discharge audit and good

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

[5] The partnership includes representatives from the Vale of Glamorgan Council, Cardiff Council, the Health Board and third and independent sectors. The partnership is part of the Regional Partnership Board governance structure.

[6] Glamorgan Voluntary Services (GVS) and Cardiff Third Sector Council (C3SC).

[7] The document states that the programme 'is based on the recommendations of the Welsh National Unscheduled Care programme, Welsh, Scottish and English NHS guidance/best practice and the results of the Day of Care Audits and the Delivery Unit's

practice identified by others. The programme was established in autumn 2016 and at the time of our audit was still in its infancy. Phase 1 of the programme concentrates on short to medium term (12-18 months) improvements to inpatient processes and discharge arrangements. Phase 1 initiatives are split under the themes of 'keeping people well' and 'home first'.

17 'Keeping people well' focuses on stabilising and reducing demand, for example by educating patients on how to better manage their own care, increasing out-of-hours primary care support to reduce accident and emergency referrals, and minimising admissions from care homes. In addition, the Health Board is making traditionally hospital-based services or treatments available in the community, for example intravenous (IV) antibiotics.

18 'Home first' focuses on improving patient flow once a patient is within the hospital system. For example, by admission avoidance at the accident and emergency department, improving waiting times within the accident and emergency department, reducing waiting times for beds once a decision is made to admit a patient and ensuring patients stay in hospital for an appropriate length of time. It also details specific actions to improve the management of discharges and transfers of care by relaunching the discharge support service and reviewing available community pathways[8], to support patients once discharged from hospital.

19 The second phase of the programme seeks to support a joined-up and sustainable health and social care system. Much of these discussions are already progressing through the IHSC partnership and detailed within the Home First Plan.

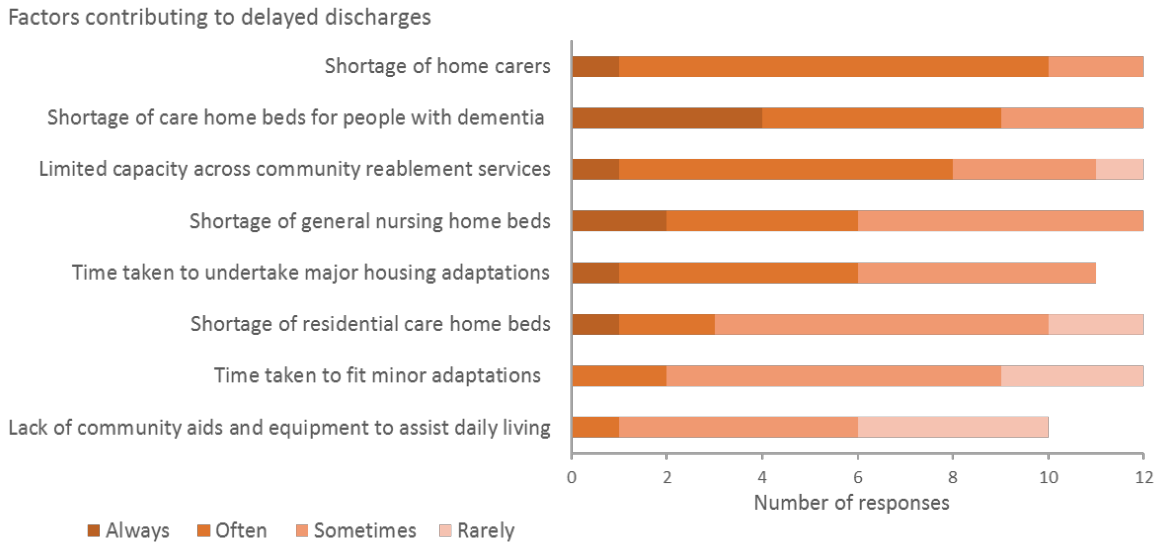
20 We asked NHS organisations what factors contribute to delayed discharges or transfers of care, to ascertain how well their plans seek to address the factors causing most problem. Exhibit 2 shows that across Wales, a shortage of home carers, a shortage of care home beds for people with dementia, and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

Discharge Audit of Care at Cardiff and Vale Health Board. The programme 'has been informed by significant evidence on what works well and the damage caused by poor patient flow'.

[8] Community pathway include services such as community resource teams, acute response teams, palliative care teams and step-up and step down intermediate care facilities.

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[9]

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

- a shortage of care home beds for people with dementia;
- the time taken to undertake major housing adaptations;
- a shortage of home carers; and
- a shortage of general nursing home beds.

22 In addition, the Health Board highlighted family issues such as disputes about choice of home or financial issues, or family (and staff) members being unavailable to take part in discharge planning meetings. Community service capacity, such as allocation of social workers, community nursing service provision, lack of suitable alternative accommodation and the integrated assessment process were cited as causing delays.

[9] 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 included within the regions Home First Plan seek to address the issues highlighted by the Health Board. The plan, as mentioned above is the regions delayed transfers of care action plan. The plan aims to develop services that speed up the progress of people using acute or long-term care services, and reduce the number of people needing these services. The actions within the Home First Plan concentrate on key stages of a patients care journey when they need additional support. The aim at each point is to return patients home or as close to home as possible. The stages are:

- first contact – when people present with a potential need;
- ongoing support – when people have an ongoing, though relatively stable set of needs;
- crisis response – when people have a crisis or short-lived exacerbation of need; and
- comprehensive assessment – when people experience a significant and permanent change to their health and wellbeing.

24 In 2016, we conducted a review in Cardiff and the Vale of Glamorgan to find out whether partners were making sustainable improvements in relation to DToCs. We concluded that partners were working well together to manage DToCs whilst realising their plans for a whole systems model[10].

25 Over the years, the Welsh Government has released funding streams that aim to foster greater collaboration between services, the most recent of which is the Integrated Care Fund (ICF). The ICF, introduced in 2014-15 is a pooled resource and in terms of patient flow, funds initiatives 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 was changed to a recurrent fund. Health Board and local authority directors in Cardiff and Vale told us that the Welsh Government has confirmed, in writing, that the fund is guaranteed for the next three years. This confirmation has given partners the confidence to plan long-term, for example, by recruiting permanent staff for some ICF funded posts, which in-turn will stabilise services. Partners, through the Regional Partnership Board governance structure, agree and evaluate ICF funded initiatives annually.

26 Long-term, the region has a strategy called Health Enterprise Alliance for Regional Transformation (HEART). This is the overarching blueprint for regional change over the next 10 years. The strategy includes plans for supporting an aging population in Cardiff and the Vale of Glamorgan, including dementia friendly initiatives and localities based service models. Currently, some of these initiatives are being piloted, with regular updates posted on the Integrated Health and Social Care Partnership website.

[10] A whole systems approach means putting the patient at the centre, by looking at what care a person needs instead of which organisation will deliver or pay for it. This way of working reduces duplication, can deliver cost savings, and ultimately ensures patients receive the right care, at the right time and by the right person.

The Health Board has a well-developed draft discharge policy, reviewed with partners, however patient and carers have not been involved in its review

27 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.

28 We reviewed the organisation's policy on discharge and transfers of care using a maturity matrix[11]. The maturity matrix assesses 17 elements of the policy, with each element assigned a score from one (less developed) to three (well developed). At the time of our audit, the Health Board was in the process of reviewing its discharge policy. We reviewed a draft version dated February 2017. Exhibit 3 shows how the Health Board's draft discharge policy scored against the maturity matrix.

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

The table shows that the Health Board's discharge policy is generally well developed scoring highly against the elements assessed by auditors.

Elements assessed	Score	Auditor observations on the policy
Multi-agency discharge policy	2	Reviewing the policy is on the Home First Plan and its implementation is monitored at the Regional Partnership Board. However, there is no reference to patient/carer involvement in its development.
Policy reviewed within the last year	3	The policy was being reviewed at the time of our fieldwork. We reviewed a draft version dated February 2017.
Patient/carer involvement	3	The policy has a strong emphasis on involving patients and carers throughout the discharge process. For example, it mentions giving early information and advice and the importance of communicating to prevent misunderstanding.

[11] 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
Communication	3	Frequent reference to advocates throughout the policy and the choice of accommodation policy stresses the importance of communication with the individual, family and carers.
Information	3	Policy details actions to ensure patients get clear and accurate information about discharge processes. Such as: patient receiving a leaflet at an early stage detailing discharge planning process, meeting with patient/family or carer to explain restrictions on choice and the Discharge Support Officer ensuring accessibility to information.
Vulnerable groups eg patients who are homeless	3	Policy makes reference vulnerable groups such as people with learning disabilities, homeless people, people living with dementia and those who are old and frail. There are also links to protection of vulnerable adults (POVA) procedures.
Early discharge planning for elective admission	3	Policy states that 'predicted date of discharge for scheduled admissions should be set at the pre-admission clinic stage'.
Estimated discharge date set within 24 hours of admission	3	Clearly states that all patients will have a predicted date of discharge within 24 hours of admission.
Avoiding Readmission	1	There is no reference to avoiding admission.
Local Agreements and Protocols	3	Regional choice of accommodation policy forms part of the discharge policy. The policy also details process for when patients need equipment.
Assessment	3	Policy refers to integrated assessment, assessment of NHS funded nursing care and continuing health care a part of the complex needs pathway.
Discharge from A&E	1	Does not include discharge from A&E.
Discharge to care home	3	Clearly states that patients should not be directly admitted to a care home from acute hospital care.
Links to choice of accommodation policy	3	Policy makes reference to choice of accommodation policy, which is appended to the discharge policy.
Care Options	2	Policy refers to interim homes when first choice is not available.

Elements assessed	Score	Auditor observations on the policy
Escalation processes	3	Policy states that the Head of Integrated Care supports the IDS in complex discharge process. And a senior medical decision maker has to attend at all board rounds.
Accessible Discharge Protocols	3	Policy contains appendices showing different flow charts for pharmacy pathway, homeless patients and a clear discharge flowchart showing simple, complex and supported pathways.

Source: Wales Audit Office review of Cardiff and Vale University Health Board's discharge policy, 2017

29 Out of the 17 criteria we tested against, Cardiff and Vale's policy scored level 3 on 13 of the 17 elements, meaning that in general the Health Board has a well-developed discharge policy. We found some areas of the Health Board's discharge policy that were less developed. While the policy emphasises the need for prompt discharge, there is no specific reference to the risk of avoiding readmission. The policy also does not include information about discharging patients from accident and emergency.

30 The Health Board's draft policy is based on good practice and incorporates relevant elements of the Social Services and Wellbeing Act (2014). The revised policy aims to be an all-in-one reference for discharge planning. The policy includes relevant guidance material for example, discharge pathways, example discharge checklists and standard operating procedures for the clinical workstation[12]. The document also includes performance measures to monitor compliance with the policy.

31 The regional choice of accommodation policy, reviewed in October 2016, forms part of the draft discharge policy. Both policies make clear that the aim is to discharge patients to their normal place of residence. The choice of accommodation policy indicates that patients will not be discharged from an acute hospital to a permanent placement in a care home.

32 Reviewing both policies is an action within the Home First Plan, the implementation of which is overseen by the Regional Partnership Board. Whilst partners have been consulted on the revised policies, there is no evidence to suggest that patients and carers have been involved.

33 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

[12] The clinical workstation is a patient administration system. At the Health Board, it is used in conjunction with the patient record, which is a paper-based system.

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.

34 At the Health Board, we found that a section within the draft discharge policy clearly outlines the roles and responsibilities of professions and teams involved in discharge planning. This includes the Health Board's chief executive, clinical staff, discharge support staff, social workers and allied health professionals (for example, therapies staff).

The recently revised discharge pathways are comprehensive and form part of the draft discharge policy

35 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.

36 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.

37 We found that the Health Board uses three generic discharge pathways: simple, supported and complex, as well as a number of condition specific pathways that include parts of the discharge process. The supported pathway is a recent addition, which aims to differentiate between patients needing short-term assistance to reach pre-admission independence and those requiring long-term care. The Health Board's clinical workstation has been updated to include the additional pathway. The three pathways are presented in a single flow diagram within the draft discharge policy, which acts as a detailed reference guide.

38 We reviewed the three generic pathways against the criteria set out in Exhibit 4, which shows that generally, the Health Board has clear discharge pathways with most leading a patient back to their previous residence.

Exhibit 4: elements presented within the Health Board's generic discharge pathways

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

Elements	Pathway		
	Simple	Supported	Complex
Flow diagram/decision tree for identifying appropriate patients	Yes	Yes	Yes
Specific discharge destination eg usual place of residence	Yes	Yes	Yes
Clear purpose	Yes	Yes	Yes
Generic or condition specific pathway	Generic	Generic	Generic
Transport or transfer logistics clearly acknowledged	Yes	Yes	Yes
Applies across all hospital sites	Yes	Yes	Yes
Applies 24 hours a day, 365 days per year	Unclear	Unclear	Unclear
Developed with NHS partners eg neighbouring LHBs, WAST or Velindre	No	No	No
Developed with local authority partners and applies equally across partners	Yes	Yes	Yes
Supported by generic discharge documentation	Yes	Yes	Yes
Supported by generic assessment documentation	Yes	Yes	Yes
Referral processes are clear	Yes	No	Yes
Agreed standards for response times for assessing need	Yes	No	Yes
Agreed standards for response times for service delivery	Yes	No	Yes
Agreed standards for quality and safety	No	No	No
Standards for information sharing with clinical/care staff in the community eg discharge letters	Yes	Yes	Yes

Source: Wales Audit Office review of Cardiff and Vale University Health Board's discharge pathways, 2017

39 The complex discharge pathway references the fast track policy, for patients who wish to die at home, and stages of the choice of accommodation policy. Whilst this pathway leads to a care home placement, as already stated, the draft discharge policy is clear that care/nursing home placement is a last resort. The pathways flow

diagram also references discharge arrangements such as transport, take home medication, transfer of care information and sets out high-level timescales for processes.

40 The discharge pathways form part of the draft discharge policy, the review of which is part of the partnership's Home First Plan. However, there is no evidence to suggest the pathways were developed with Velindre Cancer Care Trust or neighbouring health boards. It is unclear from the discharge policy whether the discharge pathways apply 24 hours a day, 365 days per year but we are aware that some discharges are reliant on the operational hours of the discharge support services, for example community resources teams.

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

42 Welsh Government has been encouraging a 'discharge to assess' pathway or model[13] [14]. This is where patients are discharged home once they are 'medically' fit for discharge and no longer need a hospital bed. On the day of discharge, members of the appropriate community health and social care team will then assess the patients' support needs at home. This enables patients to access the right level of home care and support in real-time, and removes the need for patients to be inappropriately kept in a hospital bed while waiting for assessments and services to be put in place.

43 The Delivery Unit found the use of 'discharge to assess' pathways was limited, and recommended that NHS organisations implement them. We found that half (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. In Cardiff and Vale, the Health Board has recently introduced a residential 'discharge to assess' pathway where patients can recover away from an acute hospital bed. Using ICF monies, the partnership agreed to purchase beds (eight beds in Cardiff and six in the Vale of Glamorgan) in two residential homes to act as an intermediate care facility.

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

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

Part 2: multiagency and multidisciplinary teams are available to support discharge but only during the week; staff training and awareness of policies and community services needs improvement

The Health Board has dedicated discharge resources, which are multiagency and multidisciplinary but these are available weekdays only

The Health Board's discharge liaison team is multiagency and multidisciplinary; however like services at other health boards, it operates weekdays only

44 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.

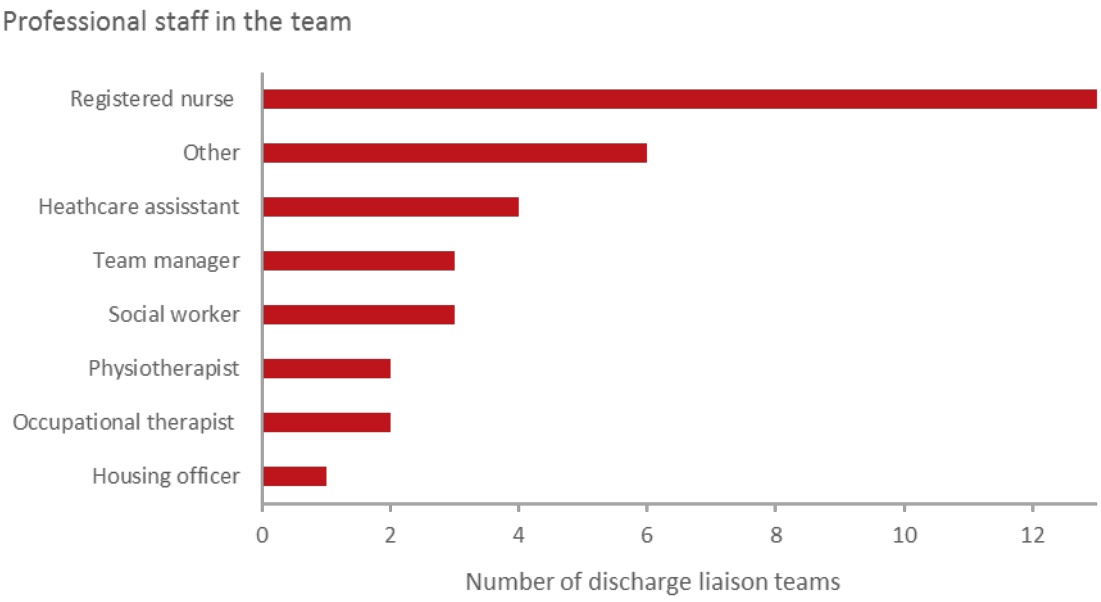
45 We sought information from every NHS organisation about whether they operate discharge liaison services and the scope of the services remit. Across Wales, we found that all NHS organisations, with the exception of Velindre NHS Trust, run one or more discharge liaison teams. All teams operate during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

46 At the Health Board, we found it operates an Integrated Discharge Service (IDS), which covers all hospital sites. The Head of Integrated Health oversees the IDS, with health and local authority managers responsible for operational management. The IDS manages both complex and simple hospital discharges.

47 Typically, discharge liaison teams are made up of nursing staff, but to better manage complex discharges ideally teams should be multidisciplinary. Exhibit 5 shows the different professions within discharge liaison teams across Wales. The data shows fewer than half the teams are multi-disciplinary with most teams being 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 was seven WTE staff.

Exhibit 5: 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.



Source: Wales Audit Office analysis of information collected on discharge liaison teams, 2017[15]

48 At the Health Board, the IDS is multi-disciplinary and multi-agency with staff from the Health Board, both local authorities and the third sector. The service includes nurses, social workers, housing officers and more recently discharge support officers. Discharge support officers are part of the IDS but employed by Age Connect. They help older patients and their families with discharge planning, for example by providing advice about available community services as well as offering emotional support. Staff we spoke to felt this was an invaluable service because discharge support officers can offer objective impartial advice, and can challenge clinical staff on behalf of the patient and family.

49 The combined cost of 13 of the 15 discharge liaison teams totalled £2.9 million between 1 October 2015 and 30 September 2016 with individual team costs ranging from £43,000 to £692,000. The average cost per discharge liaison team

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

was £244,000. At the Health Board, the cost of the discharge liaison team was £521,000.

50 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 15 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. Please note that 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 number of discharges managed by the team.

51 The Health Board has not evaluated the IDS since its implementation in 2013. However, there have been recent changes to the service, which form part of wider plans to improve patient flow. These include working with particular wards, expanding the team to include more social workers and a nurse to support education and development.

52 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 IDS always validate DToC data and provide training and development for clinical staff to effect timely discharge. The team also often undertakes the following activities, and this is broadly in line with other discharge liaison teams:

- participate in ward rounds and/or multi-disciplinary meetings;
- support staff to identify vulnerable patients whose discharge could be delayed;
- ensure individual discharge plans are in place for patients with complex discharge needs;
- liaise with other public bodies to facilitate successful hospital discharge and minimise readmission;
- provide a central point of contact for health and social care practitioners during discharge planning process; and
- provide housing options advice and support to patients and their families.

53 However, the IDS rarely update bed managers with information on hospital discharges, unlike 87% of other discharge liaison teams who always or often undertake this activity. However, the Health Board has a system in place to track patient flow (see paragraph 77) so the IDS does not need to undertake this activity. 60% of discharge liaison teams said they signpost patients and their families to advice and support for maintaining independence at home, the IDS sometimes does this. And just under half (47%) of discharge liaison teams work with

operational managers to develop performance measures on hospital discharge, whereas the IDS sometimes undertakes this activity.

Location and environment of discharge lounges were raised as concerns, but improving the lounges, which operate weekdays only, is part of the Health Board's improvement plan

54 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.

55 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 awaiting discharge; the average capacity per discharge lounge was 11. 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 toilet facilities available for patients.

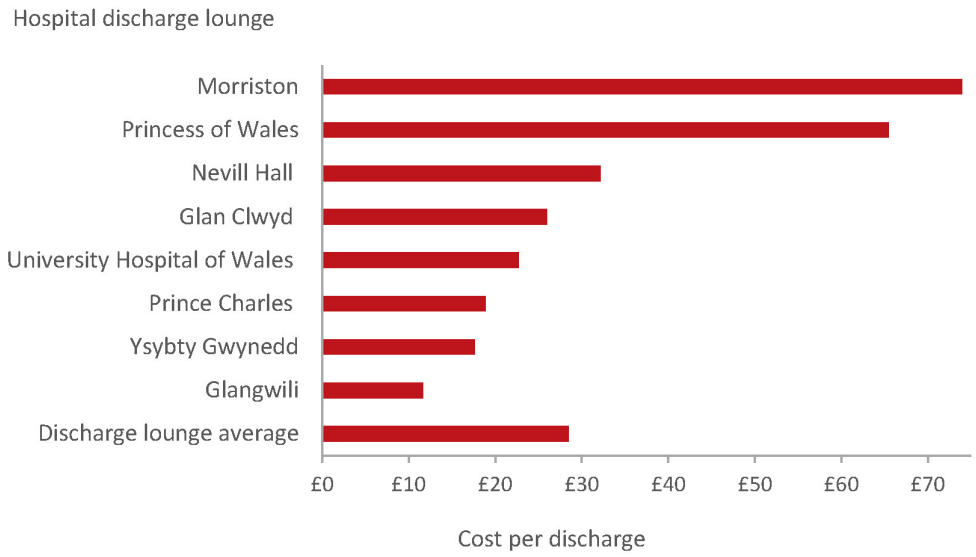
56 The Health Board runs discharge lounges at University Hospital of Wales (UHW) and University Hospital Llandough (UHL) during weekdays. Both lounges have capacity for 15 patients, and operate between 7am and 7.30pm at UHW and 8.30am and 5.30pm at UHL. Between October 2015 and September 2016, 5,337 patients were managed through the discharge lounge at UHW, the figure for UHL is unknown.

57 We also requested information on staffing, costs and activity for discharge lounges. This information was more complete. The number of staff deployed across hospital discharge lounges ranges from less than one WTE staff to five WTE staff; the average was three WTE staff. The combined cost for 12 of the 14 discharge lounges totalled £1 million with individual service costs ranging from £25,000 to £139,000. The average cost per discharge lounge was £86,600. We examined the cost per discharge supported through the discharge lounge. At Cardiff and Vale, the discharge lounge service cost £171,500. The cost per discharge for University Hospital Wales was £23 compared with the discharge lounge average of £28 (Exhibit 6).

58 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 whole-time equivalent staff varied between 1 October 2015 and 30 September 2016 from just under 400 per WTE staff to just over 2000 per WTE. At the University Hospital of Wales, the number of discharges per WTE staff was 1,067, which compares favourably with the discharge lounge average (1,000 discharges per WTE) (Exhibit 7).

Exhibit 6: 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.

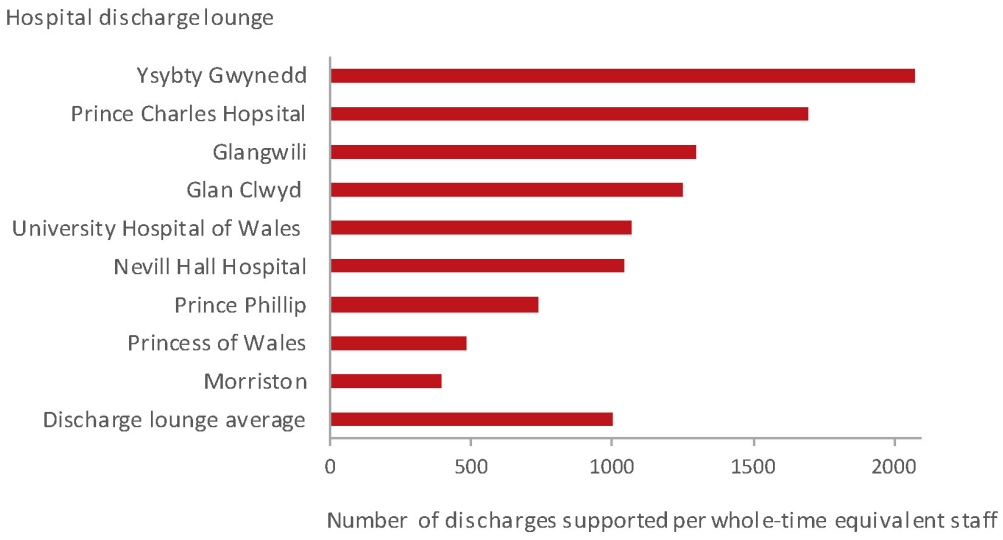


Source: Wales Audit Office analysis of information collected on hospital discharge lounges, 2017[16]

[16] 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 7: 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 16)

59 As part of this review, we met with a Community Health Council representative (CHC), who expressed concerns about the discharge lounges being uninviting, not located in visible places and a lack of things to do while waiting for transport. However, reviewing the discharge lounges at both hospitals is an action on the Unscheduled Care Improvement Programme. It is unclear if there is a set of standards for the discharge lounges, but the draft discharge policy refers to potentially appending the set criteria for discharge lounge patient access.

There is scope to improve staff training and raise awareness of policies, pathways and access to information about community services

60 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.

Training on discharge planning is patchy and ward staff capacity can prevent attendance while staff awareness of discharge policies and pathways is poor

61 As part of our audit work, we met with a mixed group of ward staff[17] to talk about a range of issues related to discharge planning. The staff that we met were clear about their role in discharge planning; however, they were not aware of the discharge policy or any written procedures for discharge planning. Each staff member worked to professional standards, but the different professional standards are not integrated. Whilst we accept that the discharge policy is currently under review, ward staff should be aware of and be working to the policy. We would also expect ward staff to know the policy is under review. The ward staff that we met were also unaware of any written discharge pathways but assumed they existed. The IDS staff were aware of the pathways as the team specialises in discharge.

62 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.

63 Exhibit 8 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, ward staff told us that training on discharge planning was patchy. We found induction programmes for nursing and medical staff did not include training on discharge planning, while it did for occupational therapists and physiotherapists.

[17] Participants included a senior nurse, ward sister, physiotherapist, occupational therapist, social worker, integrated discharge service manager, discharge support officer and a consultant.

Exhibit 8: 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 (hospitals)		
• 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 9)

64 Ward staff interviewed felt training on discharge planning should be mandatory. Staff highlighted a lack of time and ward capacity as barriers to accessing training. Also, part of the IDS's role is to offer training and advice, but with the team taking on more discharge cases (simple and complex), there is less time for the team to perform this role. Staff suggested delivering training through an e-learning course, as a lot of training at the Health Board is already delivered this way. The Health Board does not monitor compliance with discharge planning training, but developing an e-learning course would allow easier compliance monitoring.

65 The Health Board recognises the lack of training on discharge planning with actions for staff training set out in the Home First Plan and Unscheduled Care Improvement Programme. The Home First Plan has an action to 'establish partner-wide training programme for discharge planning across the organisations'. The Health Board has appointed a nurse to support and develop an education and

training programme. The February 2017 update on the Home First Plan states that weekly advice and information session are held at both UHW and UHL but staff attendance is inconsistent.

There is a greater focus on discharge planning and some positive changes have been made, but there is some way to go before processes are efficient to allow timely discharge, patients receiving information and ward staff fully confident in handling more complex discharges

66 In its review, the Delivery Unit found a culture of risk aversion across Wales with staff speaking openly of a 'cwtch' culture[18] and insufficient time dedicated to managing the discharge process. Some nursing staff at the Health Board explained that they do not feel confident handling complex discharges because the majority of the time the discharges they manage are simple and routine. This chimes with the views of the IDS who feel that ward staff are becoming de-skilled and less confident in managing patient discharges. Staff told us that they feel that some patients could be discharged sooner but the risk averse culture within the organisation prevents it.

67 Ward staff also highlighted a number of barriers to timely discharge. Barriers were related either to processes or behaviour. Process barriers included:

- a lack of equipment in the joint equipment store;
- referral forms for occupational therapists being faxed instead of emailed;
- occupational therapists receiving referrals for assessment late, sometimes on the day of discharge;
- last minute visits by consultants who raise issues that have already been considered and addressed; and
- late medical assessments, which impacts on bed turnaround times.

68 Whilst procedural issues can be relatively simple to rectify, changing behaviour or perceptions can take longer. Ward staff spoke about families not respecting a patient's choice. For example, if a patient wants to go home and can with some support, family members may still insist on a nursing or care home placement. This was perceived to be the case when a doctor mentions admission to a residential care or nursing home as an option. We were told that in these cases, a social worker will spend considerable time with the family to talk through alternative support options that would help the patient to return home.

69 The Delivery Unit found limited evidence in patient records that patients' expectations of discharge were discussed with them. The Health Board has a 'Planning Your Discharge' leaflet (the version we reviewed was dated 2013), but

[18] 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.

not everyone we met was aware of it. The CHC representative expressed concerns that the patients and their families or carers receive little information about their discharge and that discharge information is not displayed on wards. Issues highlighted include:

- planned discharge dates are not always set or visible on the ward whiteboard;
- patients and their families or carers are not told when they can expect to be discharged;
- responsibility for organising transport is not always made clear; and
- contradictory views of different medical teams on whether a patient is ready for discharge.

70 In recognition of these issues, the draft discharge policy has a strong emphasis on communication and patient/carer involvement and the Health Board reported that the discharge leaflet is being updated.

71 Following the Delivery Unit review, the Health Board held a series of staff workshops to feedback the findings and to discuss how best to address them. The Health Board reported that the workshops were well attended. There was consensus amongst staff at both strategic and operational levels that recently there has been a greater focus on discharge planning and that a number of changes have been implemented. These changes included:

- staff appointed to support patient flow, with patient flow co-ordinators now in place in general surgery;
- better communication about discharge constraints, for example Clinical Boards implementing a regime of board rounds to identify constraints and weekly meetings held to review all patients who are medically fit but still in hospital;
- revised policies and procedures, including the introduction of a supported discharge pathway, and the inclusion of a ticket home and discharge checklist within the discharge policy; and
- improved data collection and monitoring systems with clinical workstation updates, measures to monitor policy compliance in development and a case review process established to learn from very complex cases.

Information about community services to support discharge is regularly collated but ward staff are unclear how to access it

72 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 9 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 9: 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 9)

73 At the Health Board, the Primary, Community and Intermediate Care (PCIC) Clinical Board compiles information on independent, community and third sector services on a daily or weekly basis. The Integrated Discharge Service (IDS) also has available data on social work activity and housing provision[19], however housing options data are not formally collated. Whilst the Health Board collates information about community services provided by other NHS bodies, they were unsure how often this was undertaken.

74 We asked ward staff about their knowledge of the range of community services to support patients on discharge. Staff at the Health Board were unclear how to

[19] Housing Support Officers are part of the Integrated Discharge Service so have access to housing provision data.

access up-to-date information on community services, for example through a directory of community services. Some mentioned the 'Dewis Cymru'[20] website but the website is still in its infancy. Nursing staff were confident that they could get information if needed from therapy staff and the IDS, who both have up to date information about community services. However, therapy staff are not readily available on all wards and the IDS capacity is limited.

75 Ward staff should know how to access up-to-date information on community services to support patients on discharge. The Health Board has identified this issue, which is being addressed through the Unscheduled Care Improvement Programme. The plan details actions to map the range of available services and improve staff knowledge of available community resources.

Part 3: overall, performance is improving; the Health Board has strong scrutiny arrangements for discharge planning and is taking positive steps to capture more meaningful information

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

76 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.

77 At the Health Board, operational responsibilities for discharge planning are clearly set out in the draft discharge policy. Day to day accountability for discharge planning lies with each of the eight Clinical Boards, which are subject to quarterly performance review meetings with Health Board executives. All Clinical Boards report directly to the Chief Operating Office.

78 In 2016, Cardiff and Vale Councils and the Health Board jointly appointed the Head of Integrated Care (October 2016) who reports jointly to the relevant Directors in each of the organisations, allowing strategic oversight across the region. The aim of the role is to improve patient flow and reduce levels of delayed transfers of care, and to lead the Home First Plan.

79 At the time of this review, the governance structure for the Unscheduled Care Improvement Programme was in development. However, the programme is supported by a weekly in-hospital working group, which at the time of our review was chaired by the Executive Lead for Unscheduled Care and attended by relevant

[20] 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.

heads of service, directors of nursing and heads of operational service for Cardiff and Vale local authorities. This group reviews performance but also monitors progress being made against actions in response to previous external reviews, including the Delivery Unit. At the time of our audit, the Chief Operating Officer and then Executive Lead for Unscheduled Care received daily updates on measures related to the status of hospital capacity.

80 Following previous concerns from the Delivery Unit in relation to how the Health Board manages its bed capacity, the Health Board introduced site meetings. These have now been in place for approximately 18 months and there is a strong performance management element to them. The meeting which is led by a band 7 nurse is attended by representatives from each of the Clinical Boards, WAST and emergency unit controller. The meetings take place four times per day (8.30am, noon, 3pm and 6pm) and at its centre is a detailed spreadsheet that captures:

- bed demand and capacity split by medical, surgery and specialist wards;
- patients waiting for a bed, prioritised by clinical concern;
- patients admitted to temporary wards, known as outliers;
- ward closures because of infection control and building issues; and
- action points for named staff which are reviewed at the next meeting.

81 The Health Board report that they have received positive feedback about site meetings from the Delivery Unit and is sharing their approach with other health boards.

82 At a higher level, board members receive an overall performance report as part of their board papers, which include some patient flow indicators (mainly tier one targets) and other updates as requested. The People, Planning and Performance committee also requests updates on particular areas of performance, for example updates on the Unscheduled Care Improvement Programme.

83 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 9 of the board members (67%) 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.

84 As good discharge planning relies on partner organisations working together, as well as internal challenge, joint scrutiny arrangements should also be in place. Cardiff and Vale's Regional Partnership Board oversees the work of the IHSC partnership and one of their priorities is improving patient flow. Delivery against regional priorities is reported at the quarterly Regional Partnership Board meetings and the monthly IHSC Strategic Leadership Group meetings. The IHSC Strategic Leadership Group has a particular focus on performance and discusses patient flow, DToCs, ICF funded projects, winter planning and the Health Boards big improvement goals (BIG). The relevant directors from each of the partner organisations attend these meetings. In addition, a scrutiny task group made up of

the Health Board's Chair and the two local authority cabinet leads for adult services meet on a quarterly basis to oversee progress against the Home First Plan. The Health Board's Chief Operating Officer holds responsibility for patient flow on behalf of the IHSC partnership, with delegated responsibility to the Head of Integrated Care.

Board members generally feel informed about discharge planning performance, with action being taken to develop further the range of information available

85 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.

86 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.

87 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 10 sets out the performance indicators and updates reported to the Board at Cardiff and Vale:

Exhibit 10: 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 Cardiff and Vale University Health Board

Discharge planning	Patient flow
• patient experience performance; • numbers of complaints and incidents, of which some are related to discharge planning with evidence of lessons learned and changes to practice; • percentage of people over 65 who are discharged from hospital and referred to a nursing or residential home (new address); • delayed transfer of care measures;	• percentage of patients who had procedures postponed on more than one occasion for non-clinical reasons with less than 8 days' notice and are subsequently carried out within 14 calendar days or at patient's earliest convenience; • percentage of patients waiting 4 hours or less in accident and emergency; • percentage of patients waiting less than 1 hour for ambulance handover;

Discharge planning	Patient flow
• bed days lost for all patients still in hospital beyond date declared medically fit for discharge; • updates about how older peoples independences is supported and maintained; and • updates on how health care and support are delivered close to home.	• percentage patients waiting less than 26 weeks for elective treatment; and • timeliness of referrals for assessment.

Source: Wales Audit Office review of papers presented to the Board at Cardiff and Vale University Health Board

88 In response to our board member survey:

- 7 out of 9 board members (78%) 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
- 7 out of 9 board members (78%) 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%.

89 Further information that would prove helpful to understand discharge planning performance in particular but not currently reported to the Board in Cardiff and Vale would include:

- 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;
- percentage of discharges within 24 hours and 72 hours of being declared 'medically fit'.

90 We asked NHS organisations what information could be captured on their patient administration systems. Exhibit 11 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 11: 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 9)

91 The Health Board's clinical workstation can record all of the data presented in Exhibit 11. The Health Board is improving its clinical workstation both by making better use of it to monitor discharges (across multi-agencies) and system updates. One such improvement is to capture reasons for lengthened length of stay and delays to discharge. An algorithm has been developed, which calculates a patient's predicted length of stay and discharge date based on the clinical condition entered on the system. If staff change the predicted date of discharge or a medically fit patient is still occupying a bed, the system makes it mandatory for staff to log a reason. The stroke unit is piloting the system update. If rolled out to all wards the Health Board will have strong evidence on issues causing delays.

92 Since the Delivery Unit's review, the Health Board has also established a case review process to learn from very complex cases. Each week a patient's case is reviewed against the 'Passing the Baton' guidance. The case review form includes space for the patient's story and the potential number of bed days saved. At each stage of the discharge process, the form asks reviewers:

- What happened?
- What was the impact for the patient/family?
- What could have been done to make a difference?

Performance is improving but it is too early to comment on whether this is linked to improvements in discharge processes

93 The Delivery Unit undertook their review of discharge planning at the Health Board in January 2016. Since then the Health Board has developed robust plans and made a number of positive improvements. However, it is still early days for the Unscheduled Care Improvement Plan and the recently implemented changes (see paragraph 68) so it is too soon to comment on the overall impact on discharge planning.

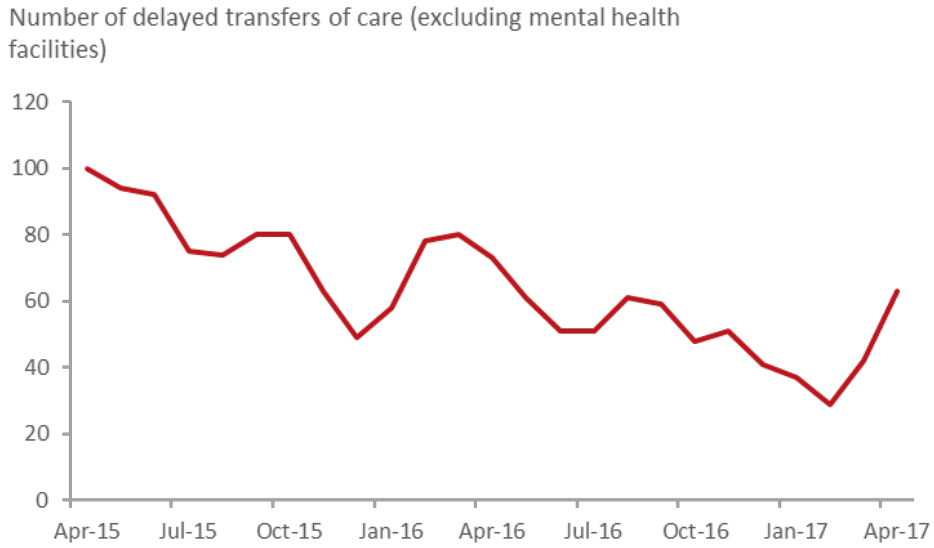
94 Nevertheless, some performance indicators are showing signs of improvement. Exhibit 12 shows a general downward trend in the numbers of DToCs reported each month between April 2015 (one year before the Delivery Unit's review of discharge planning) and April 2017 (one year later) with small fluctuations that could be attributed to seasonal pressures. The high number of DToCs in February 2015 (155 DToCs), led partners to take action and develop a DToC action plan (see paragraph 15).

95 The largest proportion of DToCs are attributed to Healthcare reasons and the proportion of delays attributed to these reasons has remained largely consistent at 38% in 2015-16 and 2016-17. However, the proportion of delays attributed to reasons related to selecting a care home or waiting for care home placement rose from 23% in 2015-16 to 28% in 2016-17. Positively, during the same time period, there was a 10% reduction in the proportion of delays attributed to community care reasons, from 27% in 2015-16 to 17% in 2016-17.

96 Although the total number of DToCs (excluding those in mental health facilities) reduced by 35% from 923 in 2015-16 to 604 in 2016-17, the number of patients delayed 13 or more weeks is rising (Exhibit 13).

Exhibit 12: trend in delayed transfers of care (excluding mental health facilities) between April 2015 and April 2017

The chart shows the general downward trend in delayed transfers of care from Cardiff and Vale University Health Board although there has been a small increase over the last two months.



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

Exhibit 13: 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 general downward trend in the number of delayed transfers of care (DToC) by length of delay at Cardiff and Vale University Health Board but an increasing proportion of patients delayed by more than three weeks.

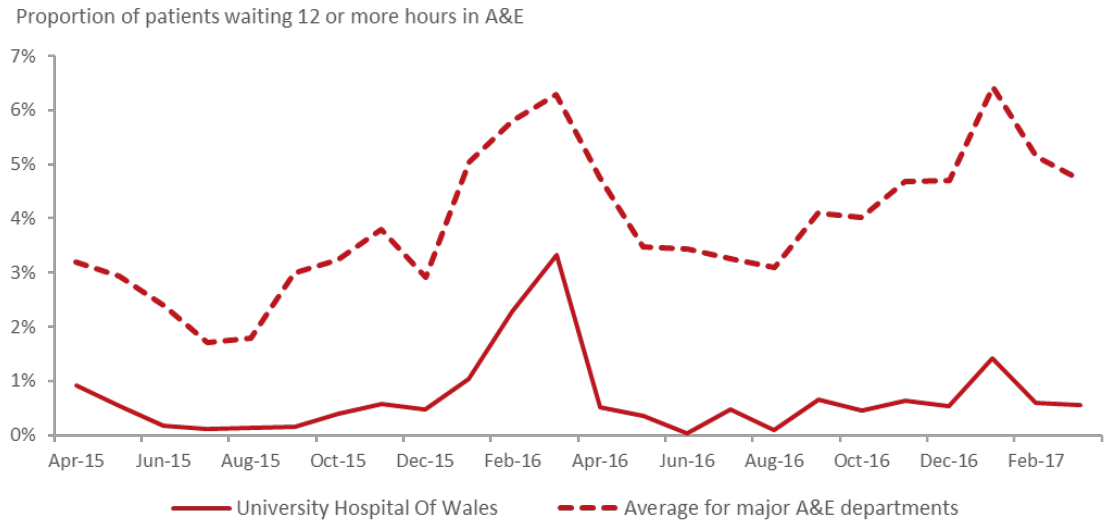
Length of delay	Percentage of delayed transfers of care (DToC)	
	2015-16	2016-17
0-3 weeks	35%	25%
4-6 weeks	25%	19%
7-12 weeks	26%	28%
13-26 weeks	11%	22%
26+ weeks	2%	6%
Total DToCs	923	604

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

97 During the same period, Exhibit 14 indicates that the proportion of patients waiting over 12 hours in accident and emergency has reduced and the number of breaches is low. The Health Board's performance is better than the Wales average. However, the percentage of 12 hour breaches increased over the winter months mirroring the all Wales trend.

Exhibit 14: 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 the proportion of patient waiting 12 hours or more at Cardiff and Vale University Health Board's accident and emergency department is reducing. Whilst the Health Board's performance is better than the Wales average, the percentage of 12-hour breaches generally increased over the winter months mirroring the all Wales trend.



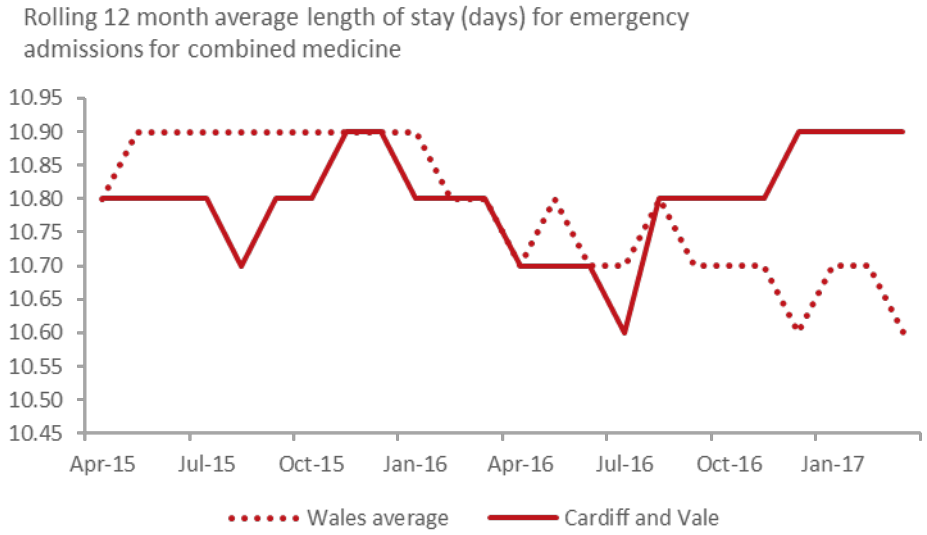
Source: Wales Audit Office analysis of the Time Spent in NHS Wales Accident and Emergency Departments: Monthly Management Information, NHS Wales Informatics Services, March 2017

98 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 15 shows little change in the rolling average length of stay[21] for emergency medical admissions over the last two years with average lengths of stay starting to rise above the Wales average.

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

Exhibit 15: 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 starting to rise above 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 16: the RAG status[22] of the Delivery Unit's assessment of written evidence in case notes against specific requirements set out in Passing the Baton[23]

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

Discharge process	Expected practice	University Hospital of Wales	University Hospital Llandough
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.		
	In complex discharges, and MDT case conference is arranged to consider assessments and agree a discharge plan with the patient/carer.		

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

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

Discharge process	Expected practice	University Hospital of Wales	University Hospital Llandough
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 22% to 24% 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.		Not applicable as none of the cases reviewed required a new care home placement.
	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 Cardiff and Vale University Health Board, February 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 17: 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/Trust 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 March 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 University Hospital of Wales and one for University Hospital Llandough.
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 Integrated Discharge Service; 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: • Interim Chief Operating Officer • Executive Programme Director Unscheduled Care • Head of Integrated Care • Intermediate Care Liaison Manager • Head of Access Management (Patient Flow) • Independent Board Member (social services) • Community Health Council representative We also met with a group of mixed ward staff, the group included a: • Senior Nurse • Ward Sister • Ward Nurse • Intermediate Care Liaison Manager • Social Worker (Cardiff Council, part of IDS) • Occupational Therapist • Physiotherapist • Discharge Support Officer (Age Connects, part of IDS) • Consultant
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 18: management response

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

Ref	Recommendation	Intended outcome/benefit	High priority (yes/no)	Accepted (yes/no)	Management response	Completion date	Responsible officer
R1a	Develop a system where ward staff are able to access up-to-date information about community health and social care services.	Wider and up to date information on community services to help patients on discharge.	Yes	Yes	The Integrated Discharge Service is the first point of contact within the Health Board and provide a signposting service for all UHB staff in relation to any queries they may have in relation to community service provision. An Intranet Website is available currently and information on how to access the content is included within training programmes. Website address for DEWIS is also available. First Point of Contact and Single Point of Access, both ICF funded projects, are assisting with the provision of information and advice to patients, their families and to staff as part of the overarching compliance with the Social Services and Wellbeing Act 2014.		Chief Operating Officer/ Head of Integrated Care

Ref	Recommendation	Intended outcome/benefit	High priority (yes/no)	Accepted (yes/no)	Management response	Completion date	Responsible officer
					Additional Discharge Support Officers and IDS team are in place to offer advice and to act as a point of contact. A review of the web site is planned to ensure that information is current and accessible to all UHB staff. Reinforcement of available information sources will continue to be included in ongoing training programmes.	Ongoing December 2017 Ongoing	
R1b	Review the range and frequency of data collated about community health and social care services. For example waiting times for some services and the frequency data on services available through other NHS bodies and housing options is collated.	Ward staff are better informed and know where to find information about community services.	No	Yes	Information relating to how to access community services is available on the UHB intranet site. The UHB is participating in the All Wales development of an integrated Community and Social Care information system which when developed will provide a platform for sharing of information and data. How staff can access the current information on the UHB website and its content will be reinforced during training programmes.	Ongoing	Chief Operating Officer/ Head of Integrated Care

Ref	Recommendation	Intended outcome/benefit	High priority (yes/no)	Accepted (yes/no)	Management response	Completion date	Responsible officer
R2	The Health Board should seek to involve patients and carers when the next policy revisions are due.	Patients and carers have a say in policy reviews and development meaning they are equal partners in the process.	Yes	Yes	The draft Choice Protocol and Discharge Policy are currently out for consultation. The current draft Discharge Policy and Choice protocol has been provided to South East Wales Carers Trust, Engagement Project for comment.	End October 2017	Chief Operating Officer/ Head of Integrated Care
R3	The Health Board should undertake training and awareness raising once the draft discharge policy has been finalised to ensure all staff involved in discharge planning understand how to use it.	Staff are well informed, leading to a consistent application of the discharge policy and pathways across the Health Board.	Yes	Yes	There is now a well-developed training and development plan in place. **Short-term Plan** **Discharge Planning** Weekly training sessions of 1-1 ½ hrs on both UHW and Llandough Topics: Discharge Policy Choice Protocol simple/supported complex. Integrated discharge Service; Care Homes; CRT; CWS and its use purpose. (20 session completed to date 64 staff attended) **“Get me Home”** 3 monthly workshops have been held which focus on the Home First principles. The HB has also embarked on an organisation wide De-conditioning	Ongoing	Chief Operating Officer/ Head of Integrated Care

Ref	Recommendation	Intended outcome/benefit	High priority (yes/no)	Accepted (yes/no)	Management response	Completion date	Responsible officer
					campaign which aims to maintain Patient independence in order to reduce avoidable harm, improve the Patient experience and expedite discharge (two workshops held to dates with two further dates agreed – 120 staff attended). **SNAP Training** Daily for 2 weeks – 30min sessions, ward-based Topics: Discharge Policy Choice Protocol simple/supported complex; Integrated discharge Service; Care Homes; CRT; CWS and its use purpose; Fast Track CHC. (160 session delivered to date 280 staff attended) **Longer-term Plan** Work ongoing with Learning and Development department to facilitate Discharge Planning within undergraduate Therapy and Nurse training programmes. Work is progressing with LED colleagues to formalise the monthly multidisciplinary training programme.	Campaign Launch October 2017 Ongoing November 2017	

Ref	Recommendation	Intended outcome/benefit	High priority (yes/no)	Accepted (yes/no)	Management response	Completion date	Responsible officer
					Work is ongoing to include discharge planning in Induction programmes for all professional staff. Arrangements are in place to include specific discharge planning in the foundation course for newly qualified nurses. Collaborative work is ongoing with Cardiff University to support the inclusion of discharge planning as part of the academic curriculum for undergraduates.	November 2017 October2017 December 2017	
R4a	Explore developing an e-learning course for discharge planning which ward staff may find more accessible.	Training delivery method, which is convenient for ward staff with limited time.	No	Yes	Work is ongoing with LED colleagues to develop a discharge planning focused e-learning resource.	TBC	Chief Operating Officer/ Head of Integrated Care
R4b	Ensure that attendance at training is captured on the electronic staff record, which will help to improve compliance monitoring.	Better discharge planning because staff are well trained, offered regular refresher courses and the Health Board has a record of training compliance.	Yes	Yes	Each Staff member now has the ability to register their own academic achievement and course attendance on ESR, whilst the IDS team are now maintaining a record of all those attending training. Formal workshops are also recorded on the ESR system.	Ongoing	Chief Operating Officer/ Head of Integrated Care/ Clinical Boards

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 19 shows the reported frequency with which the 15 discharge liaison teams across Wales undertake these activities.

Exhibit 19: 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 9)

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