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Auditor General for Wales

Discharge Planning – **Cwm Taf University Health Board**

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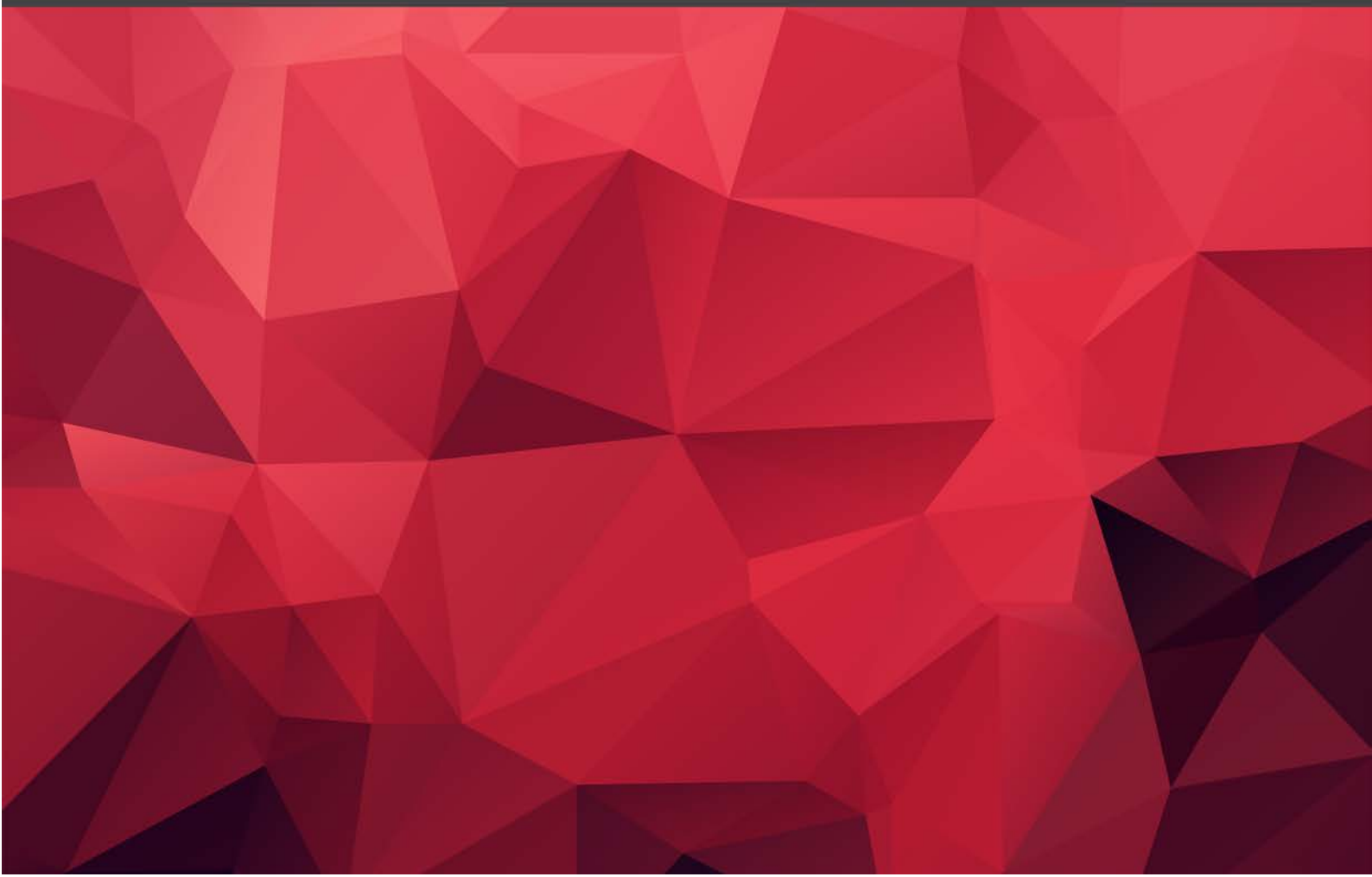


The team who delivered the work comprised Kate Febry, Delyth Lewis and Gabrielle Smith.

Contents

The Health Board has plans in place to improve patient flow and discharge planning and there is regular scrutiny of performance; however, there is scope to improve the discharge policy and pathways.

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.

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 straightforward or simple for 80% of patients leaving hospital. These patients return home with no or simple health or social care needs that do not require complex planning and delivery. For the remaining 20%, discharge planning is more complex because of ongoing health and or social care needs, which may be short or long term.

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

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

- better working with community services;
- clearer and earlier identification of the complexity of the discharge to enable better facilitation of the discharge process;
- greater clarity around discharge pathways[4]; and
- better information and communication with patients and families.

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

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

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

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

6 The Delivery Unit assessed the written evidence in case notes against specific requirements set out in **passing the Baton** (See Footnote 2). The findings for Cwm Taf University Health Board (the Health Board) show that written evidence in relation to the patient discharge process was 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 method. The work focused specifically on whether the Health Board has:

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

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

Key findings

10 Our overall conclusion is: **the Health Board has plans in place to improve patient flow and discharge planning and there is regular scrutiny of performance; however, there is scope to improve the discharge policy and pathways.** In the paragraphs below, we have set out our reasoning.

11 **Planning**: the Health Board has plans in place to improve discharge planning underpinned by policies and improvement initiatives:

- the Health Board has a number of plans in place to improve discharge planning and patient flow;
- there is scope to strengthen aspects of the Discharge Planning Policy when it is next updated; and

- the steps in the discharge pathway could be better articulated.

12 **Arrangements for supporting discharge**: dedicated resources are available to support discharge planning and ward staff are confident about what needs to be done to support timely discharge:

- a discharge liaison team is available to support complex discharges;
- the discharge lounge at Prince Charles Hospital appears well utilised; and
- ward staff are confident about what needs to be done to support timely discharge with training recently provided by the discharge liaison team.

13 **Monitoring and reporting**: there is regular scrutiny of performance related to discharge planning ensuring board members feel well informed, and while there are improvements in performance there is still more to do:

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

Recommendations

14 As a result of this work, we have made a number of recommendations on discharge planning for Cwm Taf University Health Board. The Health Board's management response detailing how it intends responding to these recommendations is included in Appendix 3.

Exhibit 1: recommendations

Recommendations	
R1	**Discharge Planning Policy:** Our assessment of the Health Board's policy indicates that it could be strengthened when it is next reviewed. The Health Board should include: • a patient discharge leaflet; • the discharge checklist; • the escalation procedures; • arrangements for patients discharged from A&E departments or medical/clinical assessment units; • electronic links to the Hospital Discharge Protocol for Patients in Housing Need, the Choice of Accommodation Protocol and the Continuing NHS Care Framework; and • a flow chart or decision tree to support decisions on whether discharges are simple or complex and the pathway to follow.
R2	**Discharge Pathway**: the steps in the discharge pathway are not clearly set out in the Discharge Planning Policy. The Health Board should: • set out each discharge pathway as a clear sequence of steps; • ensure that all pathways are available in one place – such as the Discharge Planning Policy, with links provided in other related policies/guidance; and • ensure that staff are aware how to access discharge pathways.
R3	**Patient leaflet**: Adapt the community hospital patient leaflet so it is relevant for patients staying in acute hospitals, setting out: • information about the discharge process, • how the patient and family will be kept informed of the discharge process; • arrangements that the patient may need to make (such as arrange transport); • information about follow-up care; and • the complaints process.
R4	**Monitoring performance or compliance:** although the Health Board's Discharge Planning Policy and draft Discharge Protocol include a range of both qualitative and quantitative measures to monitor compliance, these performance measures have yet to be reported systematically to the Board or its committees. The Health Board should regularly report on these measures.

The Health Board has plans in place to improve discharge planning underpinned by policies and improvement initiatives

The Health Board has a number of plans in place to improve discharge planning and patient flow

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

16 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, a number of programmes and plans are in place to address to improve discharge planning and improve patient flow. In 2013, the Health Board established a project, the 'Focus on Flow', to identify blockages and delays in the health and social care system and to identify ways to maintain independence, avoid admission, reduce length of stay and plan effective discharge. The project continues and has led to a implementation a number of initiatives, including;

- new local escalation protocols;
- introducing a new live-bed management system;
- an increase in the number of short-stay surgery beds;
- twice-daily patient flow meeting at each hospital site;
- daily ward rounds; and
- a discharge lounge at Prince Charles Hospital.

17 The Health Board's main plans for improving patient flow and discharge planning are set out in the integrated medium-term plan (IMTP) and the unscheduled care plan. These plans set out the key initiatives for improving patient flow and include:

- measuring the impact of a range of interventions the Health Board is investing in, to support scheduled care;
- developing a bed model and plan aimed at redressing the balance between unscheduled and scheduled care across the Cwm Taf system to help create a more sustainable unscheduled care system; and
- developing proposals for community-based alternatives to hospital admission and to support earlier discharge with appropriate support.

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

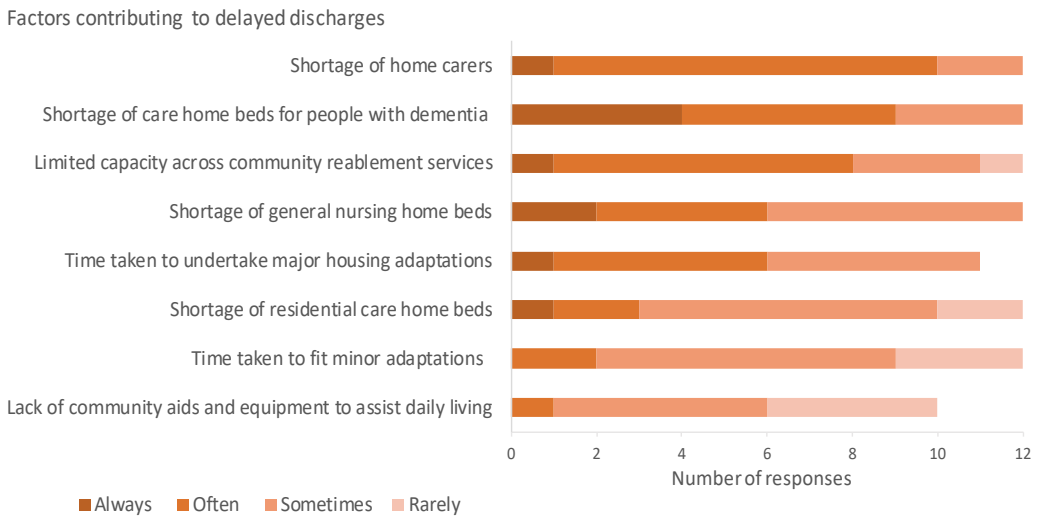
18 In 2014, the Health Board and Rhondda Cynon Taf County Borough Council (RCTCBC) and Merthyr Tydfil County Borough Council (MTCBC) issued a Statement of Intent to integrate services for the health and social care of older people in the region. The organisations set out their intention to work together to provide services for people with complex needs focussed on prevention, self-management and reablement. The Joint Commissioning Statement for Older People 2015-25 set an overarching strategy to support joint commissioning of older people services, based on shared plans and objectives.

19 In 2015, the Health Board developed a delayed transfers of care (DTOC) action plan in collaboration with local authority colleagues to maximise efficiency of transfers and as far as is reasonably practicable to eliminate delays.

20 At the time of our audit work, the Health Board was evaluating the success of its 2016-17 Winter Plan, for managing unscheduled care (including mental health) pressures between October and March. The Plan, developed in collaboration with RCTCBC, MTCBC and the Welsh Ambulance Service NHS Trust, set out responsibilities and action to cope with increased demand during winter periods to maintain patient flow through the hospital system.

21 We asked NHS organisations what factors contribute to delayed discharge or transfers of care, to ascertain how well their plans seek to address the factors causing the 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. At the Health Board, these factors were seen as rarely or sometimes contributing to delays while family disputes, homelessness and bariatric issues were more problematic. Some transfers of care delays occur as a result of patients and their families wanting to wait for a particular care home to become available (rather than be discharged to an alternative care home with available capacity). The Health Board has introduced improved monitoring of the Choice Policy, by employing a patient co-ordinator to review the discharge process to care homes and have developed an action plan to improve procedures in this area.

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]

22 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. The Health Board has used ICF to support a number of initiatives to strengthen discharge planning and admission avoidance across the Cwm Taf Regional Partnership. The funding has, for example, supported the following:

- the development and implementation of a complex discharge team with input from Discharge Liaison Nurses and Social Workers. Central to the complex discharge team was the new role of discharge co-ordinators to assist with simplifying the assessment process and to act as the link between health and social care to enable better sharing of information about patients.
- the development and implementation of an early supported discharge service for patients with mild to moderate stroke who are able to return home sooner with intensive input.

[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.

- the development and implementation of a multidisciplinary and multiagency integrated assessment and response service, Stay Well @ Home, to undertake initial assessments to prevent unnecessary admissions from A&E or clinical decision units or undertake integrated complex discharge assessments so patients are supported to return to a community setting. The Stay Well @ Home service works 12 hours a day and seven days a week. The Health Board is looking to see how the discharge liaison team will fit in with the service.

There is scope to strengthen aspects of the Discharge Planning Policy when it is next updated

23 The discharge process should be seen as part of the wider care process and not an isolated event at the end of the patient's stay. NHS organisations should have policies and procedures for discharge or transfers of care, developed ideally in collaboration with statutory partners. 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.

24 We reviewed the organisation's policy on discharge and transfers of care using a maturity matrix[7]. 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 our assessment of the Health Board's Discharge Planning Policy and draft Discharge Protocol against the maturity matrix. Our assessment found a small number of the elements were less developed, scoring only one, and could be strengthened by including:

- a patient and carer discharge leaflet;
- the discharge checklist;
- typical escalation procedures;
- arrangements for patients discharged from A&E departments or medical/clinical decision units;
- electronic links to the Hospital Discharge Protocol for Patients in Housing Need, the Choice of Accommodation Protocol and the Continuing NHS Care Framework; and
- a flow chart or decision tree to support decisions on whether discharges are simple or complex and the pathway to follow.

[7] 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.

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

Elements assessed	Score	Auditor observations on the policy
Multi-agency discharge policy	3	The policy was developed by the Health Board and refers to a multi-agency approach with the local authorities and third sector. The policy is underpinned by a draft joint hospital discharge protocol by the Health Board and its two co-terminous local authorities. It clarifies the expectations of all agencies in relation to timely assessment and safe discharge from hospital settings across the Cwm Taf area.
Policy reviewed within the last year	3	The Executive team ratified the policy in September 2016. The policy is reviewed and updated every three years with the next review scheduled for September 2019.
Patient/carer involvement	2	The importance of patients and carer needs is referred to in the policy, however, there is no evidence to indicate that patients or their representatives were engaged as part of the policy development. Furthermore, the Health Board's analysis of patient experience feedback indicates that there is a lack of involvement of carers in the care planning and discharge process.
Communication	3	The policy indicates the following communication needs are taken account of in the policy: • Accessible Communication for People with Sensory Loss • Language needs – interpreter • Any cultural or communication needs of the patient, family or carers
Information	1	There is no reference in the policy to providing information/guidance for patients and carers. Ward staff told us that they provide verbal information for patients and carers with written information provided by physiotherapists and occupational therapists. The Health Board has a patient leaflet for patients in Community Hospitals, but not for Acute Hospitals.

Elements assessed	Score	Auditor observations on the policy
Vulnerable groups, eg patients who are homeless	3	Specific guidance is given in the policy for patients who have housing needs with the discharge process managed in accordance with the Discharge Protocol for Patients in Housing Need. Note that one of the IMTP priorities for 2017-18 is to implement the Cwm Taf Hospital Discharge Protocol for Patients in Housing Need for both MTCBC and RCTCBC.
Early discharge planning for elective admission	2	The policy states that the discharge pathway should begin before admission wherever possible.
Estimated discharge date set within 24 hours of admission	3	An anticipated date of discharge (ADD) will be set as soon as possible within the first 24 hours of admission to a district general hospital and entered on the Myrddin system (patient administration system) and the discharge planning tool (hospital to home ADD discharge tool). Community hospitals must undertake an initial assessment and agree anticipated discharge date within four days.
Avoiding Readmission	1	Only refers to the role that the third sector can play in providing support to prevent readmission.
Local Agreements and Protocols	3	The policy refers to local procedures, such as the joint hospital discharge protocol, the Hospital Discharge Protocol for Patients in Housing Need, the Choice of Accommodation Protocol and the Continuing NHS Care Framework.
Assessment	3	The policy indicates that the integrated assessment process should be followed for complex discharges to determine whether the patient will be discharged home supported by a package of care, transferred to an intermediate, residential, specialist care or nursing home facility. Those patients assessed as requiring continuing NHS-funded nursing care will follow the Continuing NHS Care framework. There is no reference to the possible need for a mental capacity assessment.

Elements assessed	Score	Auditor observations on the policy
Discharge from A&E	1	The policy applies to inpatient admissions only. There is no reference to the process for managing discharges from A&E or medical/clinical decision units.
Links to choice of accommodation policy	3	Where difficulties are experienced in discharging from a NHS care facility to the patient's first choice of care home, the hospital, social services and community staff should work with the patient and his or her family to find a suitable alternative. This should be done in accordance with the Choice of Accommodation Protocol.
Discharge directly from hospital to permanent care home	1	The policy does not make specific reference to the default position of not transferring patients directly from hospital to a permanent care home although the Choice of Accommodation Protocol does.
Care Options	1	Other than the possible outcomes from an integrated assessment (see 'assessment' above), the policy does not set out specific care options.
Escalation processes	2	The policy refers to the Head of Nursing/ Directorate Managers having responsibility to develop escalation procedures that clearly identify triggers for additional support and actions when delays occur.
Accessible Discharge Protocols	2	The draft discharge protocol underpinning the policy provides an example of a simple and complex discharges. Although there is a flow diagram, it is about the referrals for social care assessment and therapy assessment.

Source: Wales Audit Office review of Cwm Taf University Health Board's discharge policy, 2017

25 The Discharge Planning Policy does not set a time after which patients would or should not be discharged or transferred from inpatient wards. We asked staff what was the latest time at which patients would be discharged. Staff told us that provided a patient was well both physically and mentally they could be discharged late in the day although one ward manager reported that it was not usual practice to discharge elderly patients late in the day. Ward staff also told us that discharge takes place seven days a week, unless it is more appropriate to keep the patient in hospital, for instance if the community service required is available weekdays only.

26 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. The Health Board's 'Discharge Planning Policy' sets out guiding principles and clearly outlines roles, responsibilities and accountability for discharge across the organisation and the local authorities and third sector organisations from whom they commission services.

The steps in the discharge pathway could be better articulated

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

28 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.

29 The Discharge Planning Policy refers to a discharge pathway and a complex discharge pathway but these are not set out as a sequence of steps. Instead, the policy and draft Joint Discharge Policy sets out a broad range of actions, such as setting the anticipated date of discharge. The expectation is that patients will be discharged home with no support or discharged home supported by a package of care, transferred to an intermediate, residential, specialist care or nursing home facility. The Joint Discharge Protocol sets out a flow diagram for the purpose of referring patients for social care or therapy assessment.

30 We reviewed the policy and draft protocol against the elements set out in Exhibit 4. Both documents cover many elements that we would expect to see in a discharge pathway but the sequence of steps could be better articulated. Although the Discharge Planning Policy refers to discharge pathways, ward managers appeared more ambivalent about their existence. One ward manager told us that discharge pathways were used in the past. Instead, ward managers frequently referred to using the anticipated date of discharge and discharge checklist as the basis for planning and deciding on what steps to take.

Exhibit 4: elements assessed in relation to the sequence of steps expected in a discharge pathway

Elements assessed	Covered	Comment
Flow diagram/decision tree for identifying appropriate patients	No	The flow diagram is for referral for therapeutic input from a physio or occupational therapist or to the local authority for assessment for eligibility for social care input.
Referral processes are clear	Yes	As above. If a patient received domiciliary care before admission, they have been in hospital less than four weeks, and there is no change in their condition or needs, the care package should be re-started within 48 hours following ward staff confirming the date of hospital discharge with the relevant care agency. In these circumstances there is no need to make referrals to the single point of access (SPA).
Specific discharge destination, eg usual place of residence	No	The policy sets the expectation that the patient will be discharged home supported by a package of care, transferred to an intermediate, residential, specialist care or nursing home facility.
Clear purpose of the pathway	No	
Generic or condition specific pathway	Generic	Process applies to all discharges.
Transport or transfer logistics clearly acknowledged	Yes	Policy sets out expectation that patients will make their own arrangements wherever possible.
Applies across all hospital sites	Yes	Ward staff, including medical staff, at district general hospitals use professional judgement to refer patients to other professionals, while in community hospitals referral decisions, made by the multidisciplinary team or patient flow meetings.
Applies 24 hours a day, 365 days a year	Yes	Policy sets out expectation that discharge takes place seven days a week.
Developed with local authority partners and applies equally across partners	Yes	The draft discharge protocol was developed with local authority partners.
Developed with NHS partners, eg neighbouring local health boards, the Welsh Ambulance Services NHS Trust or Velindre	No	
Supported by generic discharge documentation	Yes	Discharge checklist.
Supported by generic assessment documentation	Yes	Expectation that integrated assessment will be completed.

Elements assessed	Covered	Comment
Agreed standards for response times for assessing need	Yes	Response is expected within 24 hours in working week for referrals to therapies. Referrals received by the local authority SPA should be triaged within one day. Once triaged by the SPA, if the referral is for intermediate care or reablement, the referral is passed to service for action within two working days. Where a discharge is more complex and the patient is referred to social workers for assessment, the response time is within a maximum of two working days of the case being allocated while initial assessments should be completed within five working days of being allocated the case.
Agreed standards for response times for service delivery	Partially	If a simple discharge but patient assessed for intermediate care or reablement, the service is usually planned for within one day if received before 3pm.
Agreed standards for quality and safety	No	Although the draft discharge protocol sets out the process for recording and investigating discharges considered to be unsafe.
Standards for information sharing with clinical/care staff in the community, eg discharge letters	No	

Source: Wales Audit Office review of Cwm Taf University Health Board's Discharge Planning Policy and Joint Discharge Protocol

31 There is no reference to discharge letters and the standards expected. The Health Board had reported previously that the highest number of reported incidents from GP practices related to the quality and timeliness of the documentation shared between primary, community and secondary care, particularly the quality of discharge letters. However, the Health Board has taken a number of actions to address the issue, including rolling out the electronic discharge advice letter. In August 2017, the electronic discharge advice letter was live in all acute and community wards with the exception of maternity, mental health and day surgery. There have been a number of reported improvements, including improved legibility, documented medication changes, fewer prescribing errors and time savings. The system itself, however, has not had an impact on patient flow, with no change in the time patients leave the hospital. We did not assess the quality and timeliness of the discharge information, which is the subject of HIW's review.

32 The Health Board has a patient leaflet for patients staying in the Health Board's community hospitals. There is no equivalent for patients staying in acute hospitals.

33 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.

34 The Welsh Government has been encouraging a 'discharge to assess' pathway or model[8] [9]. 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.

35 The Delivery Unit found the use of 'discharge to assess' pathways was limited, and recommended that NHS organisations implement them. We found that half (four out of eight) of NHS organisations had implemented a 'discharge to assess' model, although in some organisations, the model had been implemented only at specific hospital sites.

36 The Health Board's draft Discharge Protocol makes it clear that instead of waiting to be assessed when medically fit, patients should be assessed when they are deemed well enough to participate in the assessment. We were told by staff that when patients are medically fit for discharge they are included on a transfer list. Senior community nursing staff can access this transfer list to help ensure discharge arrangements can be made for some patients. It also provides a list of patients potentially waiting for transfer to the community hospitals.

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

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

Dedicated resources are available to support discharge planning and ward staff are confident about what needs to be done to support timely discharge

A discharge liaison team is available to support complex discharges

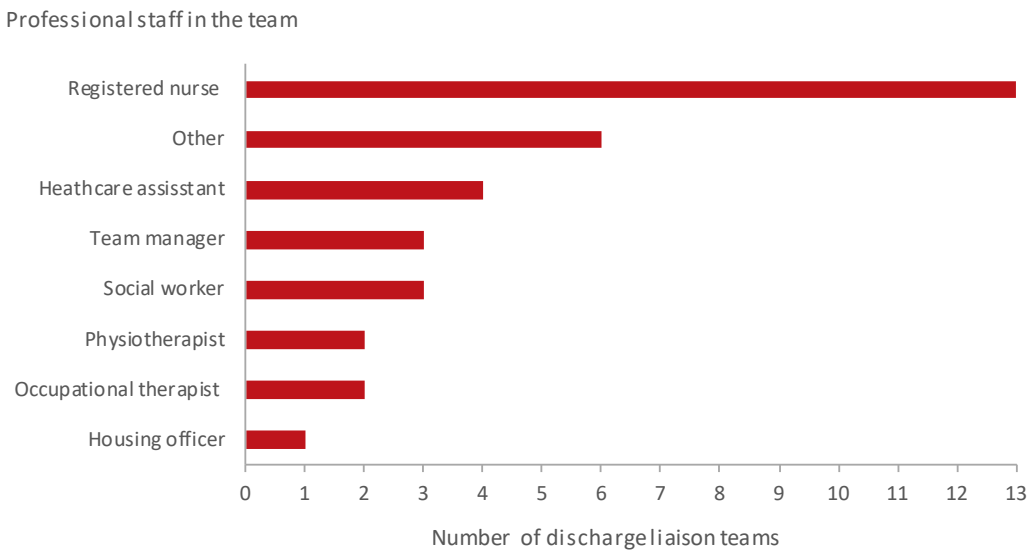
37 A discharge liaison team is a specialist team aimed at supporting the safe and seamless discharge or transfer of care of patients moving from hospital to community service provision. These teams can provide valuable support and knowledge to ward staff and offer help to facilitate complex discharges.

38 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.

39 At the Health Board, there is one team comprised of five whole-time equivalent (WTE) registered nurses who manage all complex discharges across all hospitals. The team members rotate across all hospitals with a team member available at each site every day. Operationally, the team is part of the Health Board's locality management structure with lines of accountability to the lead nurse for continuing healthcare and NHS nursing funded care. The team work weekdays between 9am or 5 pm each weekday. At weekends, ward staff are expected to expedite discharge plans already agreed while continuing to plan discharges to avoid unnecessary stays in hospital and improve patient flow.

40 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 professional staff that make up the discharge liaison teams across Wales. Only four teams across Wales are multidisciplinary with the remaining teams comprised of nursing staff. Discharge liaison teams across Wales range in size from two 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 5: different professional staff deployed across discharge liaison teams in Wales at 30 September 2016



Source: Wales Audit Office analysis of information collected on discharge liaison teams, 2017[10]

41 The Health Board's discharge team is supported by input from social and discharge co-ordinators providing a link between the local authority staff and Health Board staff to facilitate better information sharing about patients' care information.

42 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 between October 2015 and September 2016 was £237,000 compared with the average for Wales (£244,000).

43 Gaps in information on staffing, activity and service costs make it difficult to establish the relative value for money of the discharge liaison teams between or within NHS organisations. Only four of the fifteen discharge liaison teams across Wales provided the information that we requested. Based on the information provided by these four teams, we compared the number of discharges 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 to comment on numbers of discharges per WTE.

[10] 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. Other staff include, for example, administrative staff and pharmacists.

44 We asked discharge liaison teams to describe how frequently they carried out a range of activities to support discharge planning. Appendix 4 shows the extent to which, from always to never, a range of activities is carried out by discharge liaison teams across Wales. Exhibit 6 shows the frequency with which the Health Board's discharge liaison team undertakes the range of activities. Although the team manages all complex discharges, the team only sometimes ensures individual discharge plans are in place for patients with complex needs. Across Wales, 87% of discharge liaison teams always or often undertook this activity compared with 13% who undertook it sometimes. The Health Board's team was the only team to rarely participate in ward rounds or multi-disciplinary meetings to identify the most appropriate discharge pathway for patients. Across Wales, 73% of discharge liaison teams always or often undertook this activity.

Exhibit 6: the frequency with which a range of activities is undertaken by the Health Board's discharge liaison team

Frequency with which the discharge liaison team undertakes a range of activities
Always carries out the following activities
• 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 the discharge planning process.
• Work with operational managers to develop performance measures on hospital discharge.
• Validate data on delayed transfers of care.
• Provide training and development for clinical staff to effect timely hospital discharge.
• Update bed managers with information on hospital discharges.
Often carries out the following activities
• Support staff to identify vulnerable patients whose discharge could be delayed.
• Provide housing options advice and support to patients and their families.
• Signpost patients and their families to advice and support for maintaining independence at home.
Sometimes carries out the following activities
• Ensure individual discharge plans are in place for patients with complex discharge needs.
Rarely carries out the following activities
• Participate in ward rounds and or multi-disciplinary meetings to identify the most appropriate discharge pathway for patients.

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

The discharge lounge at Prince Charles Hospital appears well utilised

45 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.

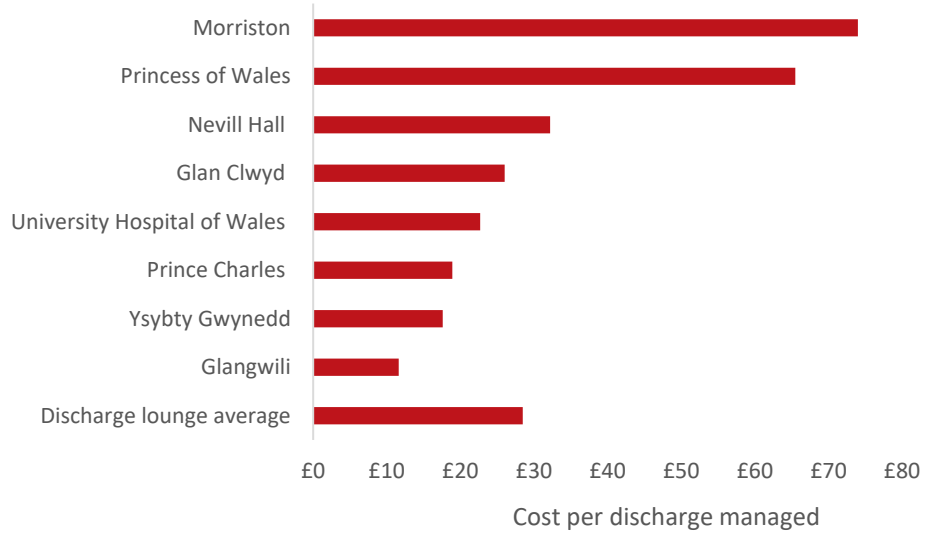
46 We asked NHS organisations about their discharge lounge facilities. Across Wales, we found that all health boards, except Powys, operate discharge lounges in their acute hospitals. At the time of our audit work, discharge lounges had capacity to support 192 patients awaiting discharge; the average capacity per discharge lounge was 11. Across Wales, discharge lounges operate for between eight 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.

47 The Health Board operates a discharge lounge at Prince Charles Hospital on weekdays from 9am until 5pm. The discharge lounge can accommodate six patients, including one patient who may need a bed while waiting for discharge. Between October 2015 and September 2016, just under 3,400 discharges were managed through the discharge lounge, which equates to roughly 13 patients per day. There is no formal discharge lounge at the Royal Glamorgan Hospital. When staff are available, an informal discharge lounge may operate on the side of one ward.

48 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 between 1 October 2015 and 30 September 2016 with individual service costs ranging from £25,000 to £139,000. At the Health Board, the discharge lounge service cost less than the Wales average (£64,000 and £86,600 respectively).

49 Exhibit 7 shows the variation in the cost per discharge supported by discharge lounges, which ranged from £12 to £74 per discharge. At Prince Charles Hospital, the cost per discharge was £18.90 compared with the discharge lounge average of £28.50.

Exhibit 7: comparison of the cost per discharge managed by individual discharge lounges between 1 October 2015 and 30 September 2016



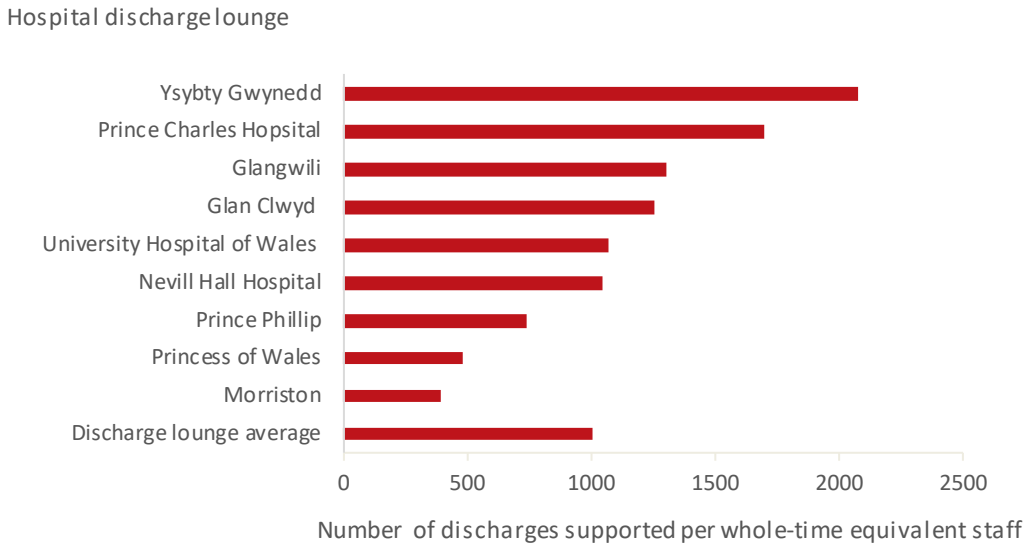
Source: Wales Audit Office analysis of information collected on hospital discharge lounges, 2017[11]

50 Again, we compared the number of discharges supported through the discharge lounge with the WTE number of staff. Based on the information provided by nine of the 14 discharge lounges, the number of discharges per WTE staff varied between 1 October 2015 and 30 September 2016 from just under 400 per WTE staff to just over 2,000 per WTE (Exhibit 8). At Prince Charles Hospital, the discharge lounge supported 1,694 discharges per WTE staff compared with the Wales average of 1,000 discharges per WTE staff.

51 The Health Board operates an informal discharge lounge at Royal Glamorgan Hospital. There are no dedicated staff for the service, as it is a side room of a ward, and can only be used when staffing levels in the ward are adequate.

[11] 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 8: number of discharges per whole-time equivalent (WTE) staff supported through hospital discharge lounges between 1 October 2015 and 30 September 2016



Source: Wales Audit Office analysis of information collected on hospital discharge lounges, 2017 (See Footnote 11)

Ward staff are confident about what needs to be done to support timely discharge with training recently provided by the discharge liaison team

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

Historically, training on discharge planning has been infrequent but the discharge liaison team is rolling out training

53 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 multi-professional basis to ensure discharge planning is everyone's business.

54 Exhibit 9 shows that across Wales, only half of NHS organisations include discharge planning in nurse induction programmes and offer regular refresher training. At the Health Board, discharge planning is not part of the induction programmes for new starters, and refresher training is undertaken at least biennially. At the time of our audit work, ward managers told us that they were releasing staff to attend training on discharge planning being provided by the discharge liaison teams. Ward managers told us that physiotherapists and occupational therapists provide ad hoc training in relation to discharge planning.

Exhibit 9: availability of training on discharge planning for nursing staff

NHS organisation	Training on discharge planning included in induction programmes for new starters	Refresher training on discharge planning provided
Abertawe Bro Morgannwg	No	Yes
Aneurin Bevan	No	No
Betsi Cadwaladr (hospitals)		
• Ysbyty Gwynedd	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	Yes
Powys	No	No
Velindre	Yes	Yes

Source: Wales Audit Office analysis of information on discharge planning returned by NHS bodies in 2017 (See Footnote 6)

Ward staff are confident about what needs to be done to support timely hospital discharge

55 In its review, the Delivery Unit found a culture of risk aversion across Wales with staff speaking openly of a 'cwtch' culture[12] and insufficient time dedicated to managing the discharge process. As part of our audit work, we met with ward managers and heads of nursing to talk about issues related to discharge planning at a ward level.

56 Ward managers that we met were clear about their role and that of their team in discharge planning but one of the biggest barriers to timely discharge was the amount of elapsed time needed to plan patient discharges. Other challenges cited included:

- the delay in restarting packages of care for those patients already receiving them, that is within 48 hours of discharge;
- not knowing who to speak to in other agencies (NHS and local authority) for patients who live outside the Cwm Taf area;
- the time taken to allocate a social worker;
- social workers unwilling to assess patients until medically fit;
- families and patients changing their minds about what support is required on discharge or disputes about the support offered;
- family and patient perceptions that hospital is the best place until fully well;
- difficulties getting advice or support at weekends for patients with housing needs; and
- a lack of short or long-term placements for relatively young patients.

57 Following the Delivery Unit's review of discharge planning, a number of actions were taken to support more timely discharge including:

- weekly site meetings about patients with long lengths of stay;
- deep dives by senior nurses with ward staff to discuss every patient on the ward to ensure anticipated dates of discharge have been agreed and to understand the reasons for any likely delays to discharge;
- the Stay Well @ Home service was established (see paragraph 22);
- the electronic discharge advice letter was rolled out;
- the introduction of a single point of access for referrals to social care; and
- a social service administrator from RCTCBC reviews all the social care referrals to ensure the appropriate information is included before

[12] 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 the patients' best interest.

submission, as well as finding out what packages of care might already be in place.

58 Ward managers reported that the increased focus on discharge planning is helping to change the culture around discharge planning with ward staff fully aware of their responsibilities for improving the timeliness of hospital discharges. During meetings with ward managers, there were frequent references to the Discharge Planning Policy. Ward managers told us that nursing staff are confident that patients are discharged when they are ready and that staff are empowered to challenge decisions made by other professionals who want to keep the patient in hospital.

59 The Health Board promotes the discharge of patients prior to 12 noon with patients ready for discharge transferred to the discharge lounge (where available) in line with the local operational protocols. Interviews with some ward managers indicate that some wards aim to discharge patients by 2pm. Some ward managers told us about piloting criteria-led discharge at the weekends to ensure patients once medically fit could be discharged in a timely fashion.

60 Staff that we met were confident that patients with end of life care needs could be fast tracked on a daily basis if necessary. Meanwhile, 50 local authority home care workers have been trained to support rapid discharge.

Information about social care and the independent sector to support patient discharge is regularly collated

61 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 about the types of information they collated on community services. Exhibit 10 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 10: number of health bodies who reported collating a range of information on community services

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

Source: Wales Audit Office analysis of information on discharge planning returned by NHS bodies in 2017 (See Footnote 6)

62 Based on the Health Board's response to our survey, it has very good knowledge about the range and availability of services provided by social care and the independent sector, as well as its own community services. Information is collated electronically and manually on a daily and weekly basis for social services and the independent sector respectively.

63 We asked ward staff about their knowledge of the range of community services to support patients on discharge. We were told by the ward managers they have an understanding of the range of services available, and where they are uncertain, they ask the Discharge Liaison team for help. The Discharge Liaison team are well sighted of the services available.

There is regular scrutiny of performance related to discharge planning ensuring board members feel well informed and while there are improvements in performance there is still more to do

There are clear lines of accountability for discharge planning with regular scrutiny of performance both strategically and operationally to identify and address reasons for delays

64 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.

65 At the Health Board, strategic responsibility for discharge planning is delegated to both the Chief Operating Officer/Executive Director for Therapies and Health Sciences and the Executive Nurse Director with these responsibilities clearly set out in the Discharge Planning Policy. The Unscheduled Care Delivery Group is a senior management forum that reports to the Chief Operating Officer/Executive Director for Therapies and Health Scientists. The group is chaired by the Assistant Director of Operations and includes representation from both local authorities and the third sector. The Unscheduled Care Delivery Group meets monthly to oversee development and implementation of winter planning arrangements, developing the unscheduled care plan, considering cross-cutting themes for unscheduled care and unscheduled care actions set out in the integrated medium-term plan.

66 Within each hospital site, there are a number of arrangements in place for scrutinising performance in relation to discharge planning and patient flow. These include twice daily bed meetings held on both sites to bring together all aspects of patient flow including assessing demand and capacity. The meetings are supported by the senior nurses at each acute site, as well as other key staff who can take appropriate action. Escalation from these meetings and the daily conference call which occur across the sites is directed to the appropriate level within the organisation as determined in the escalation policy. Site-based escalation is reported on a visible dashboard on the intranet to advise as many staff as possible of the level of organisational pressure. The bed management teams at both acute hospitals support the day-to-day running and management of inpatient beds.

67 The Health Board holds weekly discharge meetings, attended by senior nurses, occupational therapists and physiotherapy staff. Every patient with a length of stay of more than nine days is discussed to identify whether there are any appropriate actions that can be undertaken to ensure timely discharge. The Health Board told

us that appropriate local authority staff attend when there are local authority services causing a blockage in the system. Staff told us that there are good working relationships with senior social service staff if matters need escalating.

68 The Health Board and local authority representatives meet on a monthly basis to discuss the most complex delayed transfers of care. At these meetings, decisions are made on what action is needed to facilitate discharge.

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

69 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.

70 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.

71 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 11 sets out the performance indicators and updates reported to the Cwm Taf Board and Finance, Performance and Workforce Committee through the integrated performance dashboard.

Exhibit 11: range of performance information reported to the Board during 2016-17

Discharge planning	Patient flow
a. Numbers of delayed transfers of care for both mental and non-mental health facilities. b. Number of delayed transfers of care per 10,000 head of local authority population for mental health (all ages). c. Number of delayed transfers of care per 10,000 head of local authority population for non-mental health (age 75+).	a. Percentage of patients who had procedures postponed on more than one occasion for non-clinical reasons with less than eight days' notice and are subsequently carried out within 14 calendar days or at patient's earliest convenience. b. Percentage of patients waiting four hours or less in A&E. c. Number of patients waiting 12 hours or more in A&E. d. Number of ambulance handovers within 15 minutes. e. Number of ambulance hand overs over one hour. f. Number of ambulance handovers within 15 minutes. g. Percentage patients waiting less than 26 weeks for elective treatment. h. Percentage of patients waiting less than 26 weeks for treatment. i. Number of patients waiting more than 36 weeks for treatment. j. Average lengths of stay for emergency medical admissions. k. Delayed transfers of care from critical care. l. Emergency hospital admission rate for basket of eight chronic conditions per 100,000 of the health board population. m. Emergency hospital multiple admissions rate (within a year) for basket of eight chronic conditions per 100,000 of the health board population.

Source: Wales Audit Office review of papers presented to the Board at Cwm Taf University Health Board

72 The Health Board's Integrated Performance Report provides:

- a good understanding of the reasons and challenges affecting patient flow across hospital sites;
- the trends in performance and the reasons for variation in performance; and
- the action being taken to improve discharge planning and patient flow performance.

73 However, other than complaints and concerns, we did not find information about patients' experience of the discharge process reported to the Board or its committees, although ward managers told us that they do ask patients for feedback. Concerns raised about discharge planning through complaints or incidents are not systematically reported or included as a key indicator.

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

- half agreed or strongly agreed that the Board and its committees regularly scrutinise the effectiveness of discharge planning, compared to the all-Wales average of 56%;
- all agreed or strongly agreed that they received sufficient information to understand the factors affecting patient flow, compared to the all-Wales average of 75%; and
- all agreed or strongly agreed that they understood the reasons for delays in discharging patients from hospitals within my organisation, compared to the all-Wales average of 82%.

75 We asked NHS organisations what information could be captured on their patient administration systems. Exhibit 12 shows that most organisations' 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. At the Health Board, all data fields are captured with the exception of whether the discharge is simple or complex. Performance information is available on the dashboard by hospital site, but was not available at ward level at the time of our review. The Health Board is using 'Red and Green Bed Days'[13], a visual management system to assist in the identification of wasted time in a patient's journey.

[13] Days where the patient receives no diagnostic tests or treatment are coloured red, whereas days where the patient receives a service only a hospital can provide are coloured green.

Exhibit 12: data fields on NHS organisations' patient administration systems related to the discharge process

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)

76 The Discharge Planning Policy and draft Discharge Protocol include a range of both qualitative and quantitative measures to monitor compliance, to ensure standards for timeliness and quality are met and to ensure patients are receiving appropriate care. These measures include: patients' and carers' experience of hospital discharge; time of day and number of patients discharged per day, the proportion of anticipated discharge dates recorded on the Myrddin system, the quality of information for referrals to therapists, and social care and response times following referral. However, these performance measures have yet to be reported systematically to the Board or its committees.

Performance related to discharge planning and patient flow is improving but there is still more to do to reduce delayed transfers of care, lengths of stay and A&E waits

77 The Delivery Unit undertook their review of discharge planning at the Health Board in May 2016. Since then, there have been signs of improvement across a small number of performance measures related to discharge and patient flow but there is still more to do.

78 Exhibit 13 shows that the total number of DTOCs[14] (excluding those in mental health facilities) reduced by 2% from 343 in 2015-16 to 336 in 2016-17. Based on the DTOC figures for the first half of 2017-18, numbers of DTOC are likely to be much the same as last year. The number of patients whose discharge or transfer was delayed by more than three weeks also reduced (22%) but data for the first half of 2017-18 suggests that the number experiencing long delays is increasing.

Exhibit 13: trend in the number of delayed transfers of care (excluding mental health facilities) by length of delay between 2015-16 and 2017-18

Length of delay	Number of delayed transfers of care (DTOC)		
	2015-16 (April – March)	2016-17 (April – March)	2017-18 (April – September)
0-3 weeks	206	219	83
4-6 weeks	71	61	33
7-12 weeks	35	32	27
13-26 weeks	19	20	19
26+ weeks	12	4	3
Total number of DTOCs	343	336	165

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

79 The risk of delayed discharges from acute hospitals is recorded on the organisational risk register. The Health Board has set a target of no more than 12 DTOCs per month from the acute hospitals. Information presented to the Quality, Safety and Risk Committee and the Finance, Performance and Workforce Committee shows that the Health Board has achieved and maintained this target for more than a year. The number of DTOCs is greatest in the community hospitals.

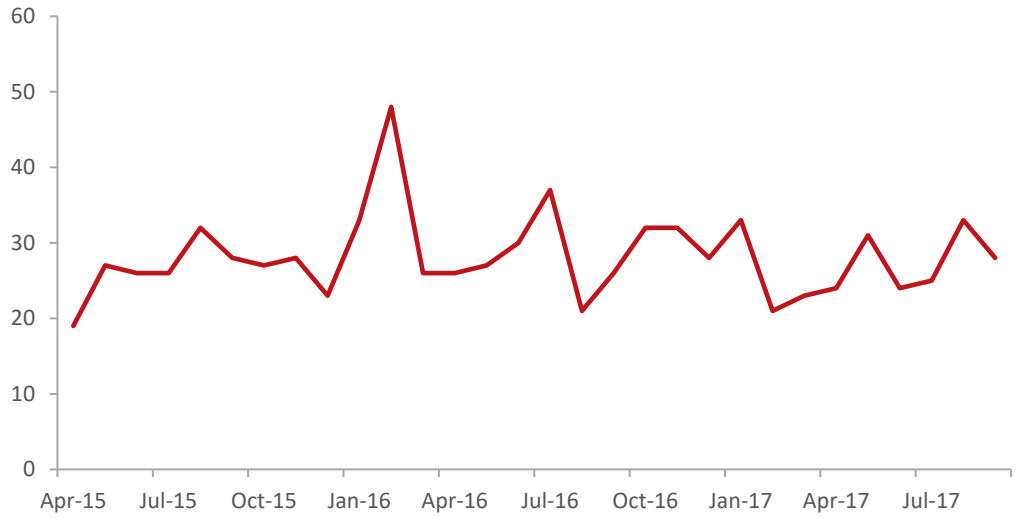
80 Exhibit 14 shows the trend in the number of DTOCs (excluding those in mental health facilities) since April 2015 with small fluctuations each month and no repeat of the spike in numbers recorded in February 2016. The DTOC trend for the first half of 2017-18 broadly matches that for 2015-16.

81 Community care reasons accounted for a third (33%) of the delays at the Health Board in 2015-16 while a fifth (20%) were attributed to healthcare reasons. In 2016-17, the proportion of delays attributed to community and healthcare reasons had increased, 39% and 25% respectively. Delays attributed to community and

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

healthcare reasons in the first half of 2017-18 have reduced. However, the number and proportion of delays attributed to waiting availability of care home of choice are increasing along with delays attributed to the protection of vulnerable adults or the inability to discharge to a safe place, and other reasons, such as patients refusing to leave.

Exhibit 14: trend in delayed transfers of care (excluding mental health facilities) between April 2015 and September 2017

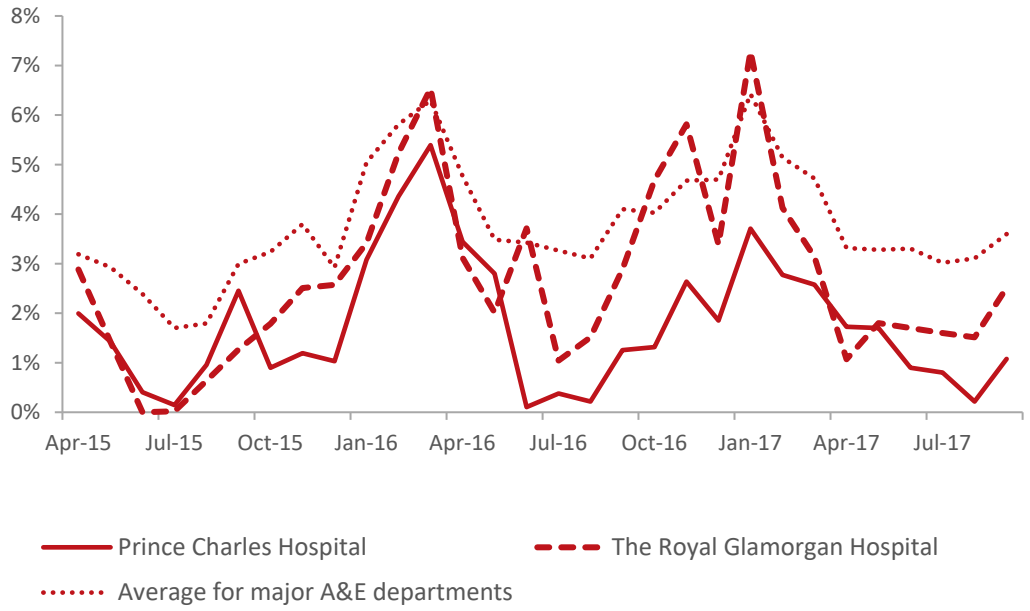


Source: Wales Audit Office analysis of the NHS Wales delayed transfers of care database, October 2017

82 No patients should wait more than 12 hours in accident and emergency (A&E) departments to be admitted, transferred or discharged. Recent feedback in the Health Board's Quality Report (September 2017) indicates that the patients are unhappy with the long waiting times in A&E. Patients waiting 12 or more hours in A&E is often indicative of problems with patient flow. At the Health Board's major A&E departments, the number of patients waiting 12 hours or more increased by 28% between 2015-16 and 2016-17 compared with 23% across Wales. There was a very small (0.2%) reduction in A&E attendances during this period, while across Wales, attendances increased by less than 1%. It is too early to assess the impact that the Stay Well @ Home team is having on reducing waiting times in A&E, by helping to avoid admissions and enabling direct discharge from A&E to other more appropriate services. However, the Health Board will be able to evaluate the service and the impacts it has had over the coming few months.

83 Exhibit 15 compares the proportion of patients waiting 12 hours or more at the Health Board's A&E departments with the Wales average. Performance has been improving and is generally better than the Wales average with the Prince Charles A&E department regularly achieving the target in the summer.

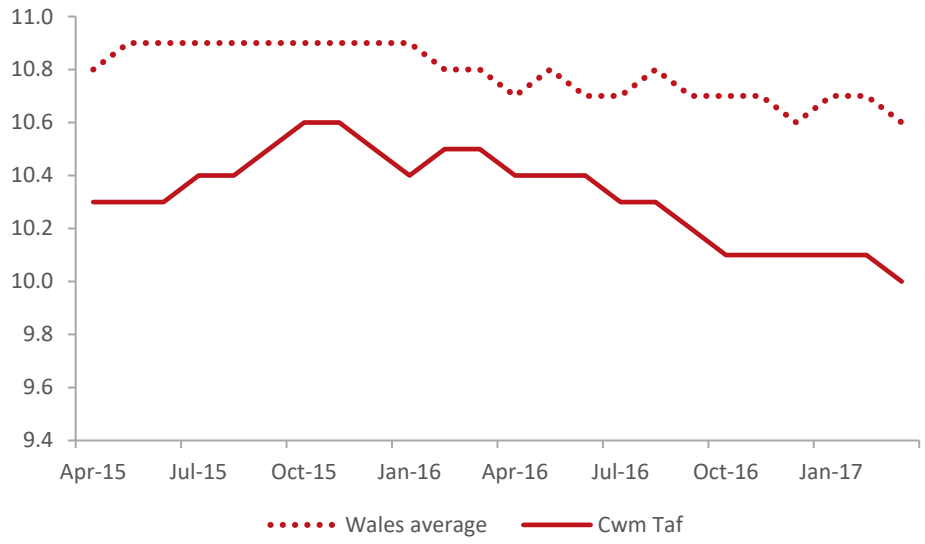
Exhibit 15: proportion of patients waiting more than 12 hours in the accident and emergency department between April 2015 and September 2017 compared with the average for major accident and emergency departments in Wales



Source: Wales Audit Office analysis of the **Performance against 12 hour waiting time target by hospital**, NHS Wales Informatics Services, October 2017

84 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 16 shows monthly improvements in the rolling average length of stay for emergency medical admissions during the latter part of 2016 with average lengths of stay well below the Wales average.

Exhibit 16: trend in the 12 month rolling average length of stay (days) for emergency admissions for combined medical wards between April 2015 and March 2017



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

Discharge process	Expected practice	Royal Glamorgan Hospital	Prince Charles Hospital
Stage 1 All discharges, within 24 hours of admission	Simple/complex discharge is identified on, or shortly after, admission to hospital.		
	A conversation will be had with the patient to establish how they were managing before admission, so that any discharge requirements can be identified, and planned for, from the admission date.		
	A conversation will be had with the patient's main carer (where appropriate) to establish any discharge requirements early in the hospital admission.		
	Long-term conditions will be identified on admission, and the patient's perception of their current status established.		
	Existing care co-ordination and support in the community are 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 are given the contact details of the named professional who will act as their care co-ordinator.		
	In complex discharges, a multi-disciplinary team (MDT) case conference is arranged to consider assessments and agree a discharge plan with the patient/carer.		
	An estimated date of discharge (EDD) is set.		

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

[16] See Footnote 2.

Discharge process	Expected practice	Royal Glamorgan Hospital	Prince Charles Hospital
Stage 3 All discharges	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 a fifth 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.	Not applicable	
	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	
	Information on care homes in the area.	Not applicable	
	Information on the Choice Policy.	Not applicable	
	Information on where they can access help in looking for a suitable home if they require it (eg third sector).	Not applicable	
Stage 5 All discharges	A checklist is completed to ensure that the practicalities of discharge are addressed.		

Source: NHS Wales Delivery Unit, Discharge Audit at Cwm Taf University Health Board, June 2016

Appendix 2

Audit methodology

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

Exhibit 18: audit methodology

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.
Data Collection Form – Discharge Lounge	We asked NHS organisations that operated a discharge lounge service 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 one form for Prince Charles 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; the service covers multiple 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 Integrated Care Fund was used and its impact in 2015-16.
Interviews	We interviewed a number of staff at both the Royal Glamorgan and Prince Charles Hospitals including: • ward managers; • heads of nursing; • lead nurse for continuing healthcare; • Chief Operating Officer; • Deputy Chief Operating Officer; • Head of Occupational Therapy; • Chief Officer for Cwm Taf Community Heath Council; and • Group Director, Community and Children's Services, RCTCBC.
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.

Source: Wales Audit Office

Appendix 3

The Health Board's management response to the recommendations

Exhibit 19: 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
R1	Discharge Planning Policy: Our assessment of the Health Board's policy indicates that it could be strengthened when it is next reviewed. The Health Board should include: • a patient discharge leaflet; • the discharge checklist; • the escalation procedures; • arrangements for patients discharged from A&E departments or medical/clinical assessment units;	Related policies and supporting documents become integral and located in one place. There is clarity about requirements for discharging patients from A&E and assessment units. There is consistent information for patients about the discharge process and procedures.	No	Yes	The Discharge Planning Policy is due for review in September 2019, however, we will complete an early review and revise the document in order to reflect upon the audit recommendations.	September 2018	Chief Operating Officer/Director of Nursing Midwifery & Patient Care

Ref	Recommendation	Intended outcome/benefit	High priority (yes/no)	Accepted (yes/no)	Management response	Completion date	Responsible officer
	• electronic links to the Hospital Discharge Protocol for Patients in Housing Need, the Choice of Accommodation Protocol and the Continuing NHS Care Framework; and • a flow chart or decision tree to support decisions on whether discharges are simple or complex and the pathway to follow.						
R2	Discharge Pathway: The steps in the discharge pathway are not clearly set out in the Discharge Planning Policy. The Health Board should: • set out each discharge pathway as a clear sequence of steps;	The steps in the discharge pathway are clearly articulated and easy to follow by staff. Expectations for action/response times by multidisciplinary staff are clear.	No	Yes	The Discharge Planning Policy is due for review in September 2019, however, we will review and revise the document early in order to reflect upon the audit recommendations.	September 2018	Chief Operating Officer/Director of Nursing Midwifery & Patient Care

Ref	Recommendation	Intended outcome/benefit	High priority (yes/no)	Accepted (yes/no)	Management response	Completion date	Responsible officer
	• ensure that all pathways are available in one place – such as the Discharge Policy, with links provided in other related policies/guidance; and • ensure that staff are aware how to access discharge pathways.						
R3	Patient leaflet: Adapt the community hospital patient leaflet so it is relevant for patients staying in acute hospitals, setting out: • information about the discharge process, • how the patient and family will be kept informed of the discharge process; • arrangements that the patient may need	Patients and carers are informed of discharge process and follow-up care and what is expected of them.	No	Partial	A patient information leaflet is already in place and used on the community hospital sites. The UHB will now consider the development of an acute hospital information leaflet.	September 2018	Chief Operating Officer

Ref	Recommendation	Intended outcome/benefit	High priority (yes/no)	Accepted (yes/no)	Management response	Completion date	Responsible officer
	to make (such as arrange transport); • information about follow-up care; and • the complaints process.						
R4	Monitoring performance or compliance: Although, the Health Board's Discharge Planning Policy and draft Discharge Protocol include a range of both qualitative and quantitative measures to monitor compliance, these performance measures have yet to be reported systematically to the Board or its committees. The Health Board should regularly report on these measures.	There is an understanding of the extent of compliance with policies and procedures for discharge planning. Reasons for poor compliance can be investigated and the effect on overall patient flow assessed.	Yes	Yes	The draft discharge protocol needs to be finalised and signed off by the UHB and its local authority partners as a priority action early in 2018.	September 2018	Chief Operating Officer

Appendix 4

Activities undertaken by discharge liaison teams

As part of this review, we asked health boards to what extent, from always to never, their discharge liaison teams undertake a range of discharge planning activities. Exhibit 20 shows the reported frequency with which the 15 discharge liaison teams across Wales undertake the activities listed.

Exhibit 20: the frequency with which discharge liaison teams across Wales reported undertaking 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%
Validate data on delayed transfers of care	87%	7%	0%	0%	7%

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

Source: Wales Audit Office analysis of information on discharge planning returned by NHS bodies in 2017 (See Footnote 10)

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