Archwilio Cymru
Audit Wales

Discharge Planning Progress Update – Betsi Cadwaladr University Health Board

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Summary report

About this report

1 In 2017, the Auditor General reviewed discharge planning across all Health Boards in Wales. That work focussed on strategic planning, arrangements for monitoring and reporting on discharge planning, and action being taken to manage discharge planning and secure improvements. Our 2017 report on discharge planning for Betsi Cadwaladr University Health Board (the Health Board) found that '**the Health Board can demonstrate its intention to improve patient flow and discharge planning, but staff confidence and training remains challenging and performance remains poor'**. We made several recommendations to the Health Board as part of that report.

2 The Auditor General had originally included work in his 2021 local audit plans to examine whole system issues affecting urgent and emergency care services, including the discharge of patients from hospital. The COVID-19 pandemic resulted in this work being postponed and brought back on stream in 2023. Our work has sought to examine whether health boards and local authorities have effective arrangements in place to ensure the timely discharge of patients out of hospital. The findings from that work are set out in a separate report to the Health Board and its local authority partners in the North Wales region. The regional report will be made available on our website once considered by the appropriate Health Board and local authority committees.

3 As part of our regional review, we have sought to assess the progress made by the Health Board in addressing the recommendations set out in our 2017 discharge planning report. This report sets out the findings with respect to progress against those recommendations. The approach we adopted to deliver our work is set out in **Appendix 1**.

4 We have undertaken the follow up work and our wider regional review to help discharge the Auditor General's statutory requirement to be satisfied that NHS bodies and local authorities have proper arrangements to secure economy, efficiency, and effectiveness in their use of resources, as required by the Public Audit Wales Act 2004. In addition, to support our previous work on discharge planning, we produced 'What's the hold up? Discharging patients in Wales' which sets out important issues that board members should be sighted of when seeking assurance that patients are discharged from hospital in safe and timely ways. Many of the issues identified are still relevant and should be considered alongside the findings of this report.

Key findings

5 The most recent data from October 2023 showed that across the Health Board's main hospital sites, there were 339 patients whose discharge had been delayed beyond 48 hours. Approximately 18% of these delays related to discharge planning issues within the Health Board, including the completion of clinical assessments.

6 In overall terms, the Health Board has made limited progress in addressing the recommendations we made in 2017 to help improve discharge planning. Our 2017 report made five recommendations that set out 12 specific actions for the Health Board. Noting that the Health Board had accepted these recommendations, our follow up work found that:

- no progress has been made against four of the actions;
- work is still on-going against four of the actions; and
- four of the actions have been superseded by other developments.

7 We note that the introduction of Discharge to Recover then Assess (D2RA) has altered the Health Board's approach to discharge planning and that the Health Board is now adopting the nationally mandated D2RA pathways, but it is of concern that:

- Capacity issues are making it difficult to secure consistent application of the new pathways across the Health Board;
- Little progress has been made in providing training on discharge planning and pathways to relevant staff;
- There is limited evidence the Health Board has introduced an audit cycle of compliance with its discharge approach;
- The "golden hour programme" to encourage discharges before 11am is no longer in place and time of discharge is no longer formally reported;
- There remains a lack of understanding of services available in the community to support timely discharge; and
- Action has not been taken to strengthen performance reporting of patient flow and discharge planning to the board and its committees, despite the significant and growing pressures caused by delayed discharges.

8 The following sections of this report set out our follow up findings in more detail and **Appendix 2** summarises our assessment of progress against each of the actions identified in our 2017 report.

Recommendations

9 Our follow up work and wider regional report on patient flow have identified some fresh recommendations on discharge planning for the Health Board, and where relevant, its local authority partners. These have replaced the outstanding recommendations from our 2017 work that are shown in **Appendix 2**.

10 Recommendations arising specifically from this follow up work are set out in **Exhibit 1**. The Health Board's response to these updated recommendations is captured in **Appendix 3**. Recommendations arising through our wider regional report on patient flow which are relevant to, and have replaced, the recommendations from our 2017 work are set out in **Exhibit 2**. The Health Board should respond to these recommendations as part the finalisation of the regional report.

Exhibit 1: new recommendations arising from this follow up work

Recommendations
R1 The Health Board, to support its focus on increasing morning discharges, should: 1.1. ensure learning is captured from previous initiatives, such as the 'golden hour programme' and mitigate the creation of perverse incentives. 1.2. introduce routine reporting of the time of discharge to ensure that morning discharges are maximised where appropriate.
R2 The Health Board should ensure that all relevant staff are aware of the role of the Home First Team (Hub) and that the team operate consistently across the three acute hospital sites.
R3 The Health Board should strengthen its performance reporting by including the following measures within its routine performance report to Board and/or committees: • number and % of patients who have an estimated discharge date; • readmissions within 28 days of discharge from hospital; • % of discharges before midday; • % of unplanned discharges at night; and • % of discharges within 24 hours and 72 hours of being declared 'medically fit'.

Exhibit source: Audit Wales

Exhibit 2: recommendations included in the regional report on discharge planning replacing previous 2017 recommendations

Regional recommendations
R1 The Health Board and local authorities should develop jointly agreed guidance to provide clarity to all staff on how the discharge planning process should work across the region. This should be based on the national guidance issued in December 2023 and should set out clearly defined roles and responsibilities, and expectations, including when referrals for ongoing care should be made.
R2 The Health Board and local authorities should ensure processes are in place to communicate discharge planning guidance to all relevant health and social

Regional recommendations	
	services staff, including those working on a temporary basis, supported by an ongoing programme of refresher training and induction training for new staff.
R3	The Health Board should embed a regular cycle of audit to assess the effectiveness and consistency of the application of discharge policies and guidance, including the application of D2RA.
R5	The Health Board, working with local authorities, should ensure that all relevant staff have access to up-to-date information on services available in the community that support hospital discharge.

Detailed report

Implementation of previous audit recommendations

11 We considered the Health Board's progress in implementing our 2017 audit recommendations. These focus on:

- training on discharge planning (Recommendations 1a, b and c);
- discharge policy compliance (Recommendation 2);
- consistency and clarity of discharge pathways (Recommendations 3a and b);
- timely discharge (Recommendations 4a and b);
- single point of access (Recommendations 5a, b and c); and
- discharge reporting (Recommendation 6).

12 Overall, we found that **the Health Board has made limited progress in addressing our previous recommendations. While the introduction of Discharge to Recover then Assess altered the Health Board's approach to discharge planning, challenges remain relating to training, compliance with guidance, embedding initiatives and reporting discharge planning performance at Board and committee level.**

Training on discharge planning

13 We considered whether the Health Board has:

- broadened the availability of discharge planning as part of induction training to include new medical staff (2017 Recommendation 1a);
- provided refresher training on the discharge policy and protocol for all relevant staff (2017 Recommendation 1b); and
- provided training on the Health Board's simple and complex discharge pathways (2017 Recommendation 1c).

14 We found **no evidence that the Health Board was providing training on discharge planning or pathways to new or existing relevant staff at the time of fieldwork, though some training activity has since started.**

15 The Health Board did not offer routine and accessible training on discharge planning at the time of our work. Health Board staff we spoke to noted that they had not received training on discharge planning either as part of their induction or as part of ongoing learning and development. This is likely exacerbating the variations in discharge practices we found between the Health Board's hospital sites, as well as variations in arrangements of how sites interact with different local authorities. Variations included levels of risk tolerance; the roles of different staff including progress chasers; and how and when to refer patients between different specialties and organisations. High agency and bank staff usage in the Health Board adds to the challenge of maintaining a consistent and clear approach.

16 The Health Board did not have an up-to-date discharge policy at the time of our fieldwork; however, it is acknowledged that the Health Board has been awaiting updated national guidance before developing its own guidance. National guidance on discharge planning was issued in December 2023. Since our fieldwork we are aware the Health Board has developed training on Criteria Led Discharge with various levels of staff having completed the training at each hospital site. While this is positive, the Health Board will need to build on this work to ensure there is consistent access to training on discharge planning. Training should also be developed jointly with key partners, including local authority social services, to ensure a clear and consistent understanding of the discharge planning processes across partner organisations.

17 We therefore consider there is **ongoing action to address recommendations 1a and 1b (replaced with 2024 Recommendation 1 and 2)**.

18 Since 2020 the Health Board has been implementing the nationally mandated NHS Wales Discharge to Recover then Assess (D2RA) pathways[1] which replaced its previous simple and complex discharge pathways with four pathways:

- Pathway 0 – no additional support required for discharge
- Pathway 1 – Supported, Home First
- Pathway 2 – Short-Term Supported Facility
- Pathway 3 – Complex Support

19 We therefore consider **recommendation 1c to be superseded.**

Discharge policy compliance

20 We considered whether the Health Board has:

- introduced a regular cycle of audit to ensure compliance with its discharge policy and protocol (2017 Recommendation 2).

21 We found **limited evidence the Health Board had introduced an audit cycle of compliance with its discharge approach.**

22 The Health Board stated that, rather than regular audits, it applied methods such as escalation identification and regular meetings to monitor compliance with its discharge approach. However, the efficacy of these monitoring and escalation arrangements is questionable given our wider regional review of patient flow review highlighted:

- weaknesses in discharge documentation;
- examples of staff adding patients to multiple waiting lists to try and expedite their discharge, such as for reablement, home care packages and residential

[1] Discharge to Recover then Assess (D2RA) is designed to support people to recover at home before being assessed for any ongoing need, thereby reducing length of stay in hospital.

care, to facilitate a timelier discharge regardless of patients' specific needs; and

- information relating to discharge planning in patient case notes was of variable quality and completeness with gaps in several important areas including What Matters to Me[2] conversation forms.

23 Acknowledging that the Health Board was waiting for national guidance to update its discharge policy, it is important that it knows whether its discharge arrangements are working as intended. We therefore consider that there is **ongoing action on recommendation 2 (replaced with 2024 Recommendation 3)**.

Consistency and clarity of discharge pathways

24 We considered whether the Health Board has:

- ensured consistent application of its discharge pathways across its three hospital sites (2017 Recommendation 3a); and
- further developed its simple and complex discharge pathways (2017 Recommendation 3b) by including:
  - agreed standards for response times;
  - quality and safety information;
  - processes for sharing information; and
  - signposting for patients with end-of-life care needs.

25 We found **the Health Board is now adopting the nationally mandated Discharge to Recover then Assess pathways, although there remain difficulties in consistent application due to capacity issues.**

26 During our review of discharge planning in 2017 the Health Board had two pathways in place: simple discharge and complex discharge. Since that time, the Health Board has been implementing the D2RA pathways as mentioned in paragraph 19. Each admitted patient is placed on one of the four D2RA pathways and, depending on the acute hospital site, there will be teams in place to facilitate more complex discharges (i.e. discharges that are not Pathway 0), such as the Home First Hub. We therefore consider **recommendation 3a and recommendation 3b to be superseded.**

27 However, whilst the Health Board has been implementing D2RA pathways, we observed that there were difficulties in ensuring their consistent delivery due to the lack of capacity. For example, the ability of the Health Board to apply pathway 2, which states the patient would be transferred to a non-acute bed until able to return home, was limited by the lack of availability of step-down beds. Ensuring a regular

[2] What Matters to me refers to conversations' hospital staff are expected to undertake with patients. The conversations are structured around what the patient can do for themselves and what they will require ongoing support with.

cycle of audit is in place to monitor compliance with discharge policies and guidance, would help the Health Board gain a comprehensive understanding on the challenges preventing it from implementing the pathways consistently (see **Recommendation 3**).

Timely discharge

28 We considered whether the Health Board has:

- taken steps to report more in-depth data on patients discharged between 12am and 7am, and those discharged between 7am and 11am (2017 Recommendation 4a); and
- introduced additional measures that will allow it to understand whether patient discharges under the 'golden hour programme' are appropriate, or whether patients are being delayed overnight unnecessarily to comply with the 11am target (2017 Recommendation 4b).

29 We found that **the Health Board no longer uses the 'golden hour programme' to encourage discharges before 11am, nor does it report the time of discharge although it states it is working to encourage morning discharges.**

30 During our fieldwork we found no evidence of in-depth reporting of the number of patients discharged between different time intervals. We also found that the 'golden hour programme'[3] that was in place during our original review was no longer being used. Observations of ward rounds showed that staff were generally focussed on discharging the patient in a timely way but without reference to any specific time-based target. The Health Board stated it was in discussions to explore and expedite actions to increase morning discharges at the time of our review. Driving a focus on discharging patients as early in the day as appropriately possible can be an effective tool in mitigating risks from increasing admissions throughout the day, but it can also lead to adverse incentives to hold on to patients overnight to comply with targets. We therefore consider that **no action has been taken on recommendation 4a (replaced with 2024 Recommendation 4),** and that **recommendation 4b has been superseded**.

Single point of access

31 We considered whether the Health Board has:

- worked with its local authority partners to ensure consistency and quality of information held on each single point of access (2017 Recommendation 5a).

[3] The golden hour programme was an initiative which encouraged staff to discharge patients before 11am to ensure there would be available beds for new patients later in the day.

- ensured that staff across each of its hospital sites received adequate training on the range of services available through the three single point of access models (2017 Recommendation 5b); and
- ensured that information on the new single point of access models is easily accessible to staff (2017 Recommendation 5c).

32 We found that **there remains a lack of understanding of services available in the community**.

33 The Health Board told us that it operates services to facilitate discharge into the community, including a Bed Bureau and Home First Teams. However, our regional fieldwork once again found that the understanding of the landscape of services outside of hospital was patchy, meaning opportunities to discharge earlier with support from services beyond social care were missed. Ward staff, including progress chasers, felt they knew little about the community services available, particularly within different local authorities, and that they found it hard to keep up to date with regular changes in provision and availability of services. We found that access to information on community and voluntary services was often variable and there was an absence of training to provide information to relevant staff. In addition, our case note review found very few records of single point of access referrals taking place in cases where they would be expected. The Home First Teams are not yet fully embedded and consistently used. We therefore consider that **no action has been taken on recommendation 5a and 5b (replaced with Recommendation 5)** and that there is **ongoing action to address recommendation 5c (replaced with Recommendation 6).**

Discharge reporting

34 We considered whether the Health Board has:

- strengthened its performance reporting (2017 Recommendation 6) by including the following measures within its routine performance report:
  - number and % of patients who have an estimated discharge date;
  - readmissions within 28 days of discharge from hospital;
  - % of discharges before midday;
  - % of unplanned discharges at night; and
  - % of discharges within 24 hours and 72 hours of being declared ‘medically fit’.

35 We found that al**though there is monitoring at an operational level, performance reporting to the board and its committees on discharge planning and patient flow out of hospital had not been strengthened, despite the significant and ongoing pressure on the Health Board caused by poor patient flow.**

36 The Health Board monitors various urgent and emergency care and patient flow indicators through its Integrated Performance Report to the Board and the

Performance, Finance, and Information Governance Committee. These indicators include ambulance response times and the time spent in emergency units until admission, transfer, or discharge. Discharge planning data, specifically delayed discharges, has been nationally tracked since April 2023 but is not contained within performance reports. The Health Board does monitor discharge planning data internally, including length of stay and readmission data, but does not report this to the Performance, Finance, and Information Governance Committee or the Board. Given the significant and ongoing pressure caused by poor patient flow, it is important that the Board receives stronger reporting about performance and mitigating actions to improve patient flow. We therefore consider that **no action has been taken on recommendation 6 (replaced with 2024 Recommendation 7)**.

Appendix 1

Audit methods

Exhibit 3 sets out the methods we used to deliver this work. The methods formed part of the audit methods used to deliver our wider regional review.

Exhibit 3: audit methods

Element of audit methods	Description
Documents	We reviewed a range of documents, including: • Board and committee papers • Operational and strategic plans relating to urgent and emergency care • Standard Operating Procedure for discharge planning
Interviews	We interviewed the following: • Hospital Directors, East and Central • Interim, Director of Regional Delivery • Programme Director for Unscheduled Care • Clinical Lead for Unscheduled Care • Deputy Executive Medical Director • Business Planning and Improvement Manager • Health Board lead for Ysbyty Glan Clwyd improvement work.
Observations	We observed the Health Board Performance, Finance, and Information Governance Committee. We also observed the following individual(s): • Head of Nursing and Site Manager, Ysbyty Gwynedd • Progress Chaser and Home Hub Officer, Ysbyty Maelor • Site Manager and Home First Officer, Ysbyty Glan Clwyd
Data analysis	We analysed the monthly delayed discharges dataset submitted to the NHS Executive. We also analysed data provided by the Health Board relating to all emergency medicine patients discharged in October 2022 with a length of stay greater than 21 days (excluding those who died).

Element of audit methods	Description
Case note review	We reviewed a sample of 32 case notes relating to emergency medicine patients discharged in October 2022 with a length of stay greater than 21 days (excluding those who died).
Self-assessment	We asked the Health Board to complete and submit a self-assessment, setting out its view of progress against our 2017 recommendations.

Appendix 2

A summary of progress against our 2017 recommendations

Exhibit 4 sets out the recommendations we made in 2017 and our summary of progress

Recommendations	Progress
Training on discharge planning R1 We found that despite plans to organise multi-agency and multi-disciplinary training on discharge planning policy and protocol, training is not consistently available. The Health Board should: a) broaden the availability of discharge planning as part of induction training to include new medical staff; b) provide refresher training on the discharge policy and protocol for all relevant staff; and c) provide training on the Health Board's simple and complex discharge pathways.	**Ongoing** – see paragraphs 15 -16 (replaced with Regional Recommendation 1) **Ongoing** – see paragraphs 15-16 (replaced with Regional Recommendations 1 and 2) **Superseded** – see paragraph 18
Discharge policy compliance R2 Although the discharge policy and protocol include the use of clinical audit to monitor compliance, we found that there has been no recent audit undertaken. The Health Board should introduce a regular cycle of audit to ensure compliance with its discharge policy and protocol.	**Ongoing** – see paragraphs 22-23 (Replaced with Regional Recommendation 3)

Recommendations	Progress
Discharge pathways R3 The Health Board uses two generic discharge pathways: simple and complex, however there is inconsistency in application across the three hospital sites and some aspects of good practice are not included. To improve its use of pathways, the Health Board should: a) ensure consistent application of its discharge pathways across its three hospital sites; and b) further develop its simple and complex discharge pathways by including: – agreed standards for response times; – quality and safety information; – processes for sharing information; and – signposting for patients with end-of-life care needs.	**Superseded** – see paragraphs 26 **Superseded –** see paragraphs 26
Timely discharge R4 We found that staff are encouraged to discharge patients by 11am (referred to as the 'golden hour programme'), but this may result in patients who are potentially safe to be discharged the previous afternoon or evening having their discharge delayed to the following day to meet the 11am target. Information reported to the Finance and Performance Committee on discharges by time of day did not differentiate between appropriate and inappropriate discharges as all discharges between midnight, and 11am are included in a single category. While we found no current evidence that perverse behaviour is occurring, the Health Board should take steps to mitigate this risk, by: a) reporting more in-depth data on patients discharged between 12am and 7am, and those that discharged between 7am and 11am; and b) introducing additional measures that will allow it to understand whether patient discharges under the 'golden hour programme' are appropriate, or whether patients are being delayed overnight unnecessarily to comply with this target.	**No action** – see paragraph 29 (Replaced with 2024 Recommendation 1) **Superseded** – see paragraph 30

Recommendations	Progress
Single point of access (SPoA) R5 When reviewing staff's awareness of community services to support discharge, we found inconsistency. The Health Board must ensure that each of the local SPoA models established during 2016- 17 are implemented effectively. The Health Board should: a) work with its local authority partners to ensure the consistency and quality of information held on each SPoA; b) ensure that staff across each of its hospital sites receive adequate training on the range of services available through the three SPoA models; and c) ensure information on the new SPoA models is easily accessible to staff	**No action** – see paragraph 33 (replaced with Regional Recommendation 5) **No action** – see paragraph 33 (replaced with Regional Recommendation 5) **Ongoing** – see paragraph 33 (replaced with 2024 Recommendation 2)
Discharge reporting R6 We found that the Board, Executive Team and the Finance and Performance Committee receives regular information relating to delayed transfers of care but receives limited information specific to discharge planning that would support a better understanding of the reasons behind the Health Board's performance. The Health Board should strengthen its performance reporting by including the following measures within its routine performance report: • number and % of patients who have an estimated discharge date; • readmissions within 28 days of discharge from hospital; • % of discharges before midday; • % of unplanned discharges at night; and • % of discharges within 24 hours and 72 hours of being declared 'medically fit'.	**No action** – see paragraph 36 (replaced with 2024 Recommendation 3)

Exhibit source: Audit Wales

Appendix 3

Organisational response to audit recommendations

Exhibit 5 sets out the Health Board's response to our audit recommendations.

Exhibit 5: organisational response

Recommendation	Organisational response Please set out here relevant commentary on the planned actions in response to the recommendations	Completion date Please set out by when the planned actions will be complete	Responsible officer (title)
R1 The Health Board, to support its focus on increasing morning discharges, should: 1.1. ensure learning is captured from previous initiatives, such as the 'golden hour programme' and mitigate the creation of perverse incentives. 1.2. introduce reporting of the time of discharge to ensure that morning discharges are maximised where appropriate.	Identify areas of good practice and areas of learning / improvement from poor compliance demonstrated through monthly performance reporting Produce monthly reports for IHCs on time of discharge for review and monitoring at IHC UEC meetings and scrutiny at the 6 Goals programme board	**Q1** **Q1**	Goal 6 Lead - Acting Assistant Director Care Homes and Continuing Health Care Commissioning Programme Manager for Urgent & Emergency Care

Recommendation	Organisational response Please set out here relevant commentary on the planned actions in response to the recommendations	Completion date Please set out by when the planned actions will be complete	Responsible officer (title)
			IHCs
R2 The Health Board should ensure that all relevant staff are aware of the role of the Home First Team (Hub) and that the team operate consistently across the three acute hospital sites.	Feedback on process mapping of Home First Bureau processes Develop Comms and engagement plan, refocus and raise awareness to increase focus & awareness on D2RA pathways, STREAM, including raising awareness of the Home First Teams	**Q1** **Q2**	Goal 6 Lead - Acting Assistant Director Care Homes and Continuing Health Care Commissioning Programme Manager for Urgent & Emergency Care IHCs
R3 The Health Board should strengthen its performance reporting by including the following measures within its routine performance report to Board and/or committees:		**Q1**	Goal 6 Lead - Acting Assistant Director Care Homes and Continuing Health Care Commissioning Programme Manager for

Appendix 3

Recommendation	Organisational response Please set out here relevant commentary on the planned actions in response to the recommendations	Completion date Please set out by when the planned actions will be complete	Responsible officer (title)
• number and % of patients who have an estimated discharge date;	Identify baseline position and agree trajectory for improvement	**Q3**	Urgent & Emergency Care IHCs
• readmissions within 28 days of discharge from hospital;	This is one of the revised D2RA Measures which are in pilot phase until September 2024	**Q1**	
• % of discharges before midday;	Identify baseline position and agree trajectory for improvement. Priority area will be discharges to Care Homes. Review the time of discharge number / % of patients discharged before midday by D2RA Pathway	**Q3**	
• % of unplanned discharges at night; and	Identify baseline position and agree trajectory for improvement	**Q1**	
• % of discharges within 24 hours and 72 hours of being declared 'medically fit'.	STREAM development group established and a key priority will be to support increasing the compliance of recording when patient is Clinically optimised in line with D2RA reporting	**Q3**	

Recommendation	Organisational response Please set out here relevant commentary on the planned actions in response to the recommendations	Completion date Please set out by when the planned actions will be complete	Responsible officer (title)
	Monthly reporting will be re-established in May and will be reported as part of the D2RA Measures (Pilot phase until September)		

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