Archwilio Cymru
Audit Wales

Discharge Planning Progress Update – Cardiff and Vale 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 for Cardiff and Vale University Health Board (the Health Board) found that: '**The Health Board has robust discharge improvement plans, strong performance management arrangements and performance overall is improving, but there is scope to improve ward staff training and awareness of policies and community services**.' We made several recommendations for the Health Board to address, which are set out in **Appendix 1**.

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 Cardiff and Vale 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 the 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 Data from February 2024 showed that across the Health Board's main hospital sites, there were 238 patients whose discharge had been delayed beyond 48

hours. Approximately 6% 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 reasonable progress in addressing our previous recommendations, but there remains more to do, including ensuring the discharge policy is up to date and that training and awareness raising activities are resulting in improved understanding of the landscape of community health and social care services**. Our 2017 report made four recommendations that set out six 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 one action;
- work is still ongoing against two of the actions; and
- three of the actions have been implemented.

7 Specifically, we found that:

- the Health Board has introduced mechanisms to monitor the use of community health and social care services and has taken action to improve staff understanding of the landscape of services, although it is not clear whether these actions are having the intended impact;
- while the discharge policy was revised in 2020 it is unclear what impact the involvement of patients and carers had on changes, noting also that the policy is overdue for further review and there is a need to ensure the most recent version of the policy is on the Health Board's public website; and
- while the Health Board provides regular training related to discharge planning, we found limited evidence that it monitors completion rates for training.

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
Staff understanding of landscape of community services R1 The Health Board should assess whether recent activities to signpost and streamline access to information on community health and social care have resulted in better awareness of the landscape of services outside of hospital across various staff groups.
Policy review R2 The Health Board should ensure the revised discharge policy is updated on the Health Board's website. R3 The Health Board should explore developing an e-learning course for discharge planning which ward staff may find more accessible. R4 The Health Board should ensure that attendance at training is captured on the electronic staff record, to help monitor attendance levels and ensure all relevant staff are receiving training.

Source: Audit Wales

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

Regional recommendations
R3 The Health Board, working with local authorities, should update its discharge policy 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, set out clearly defined roles and responsibilities, and expectations, and reflect the Discharge to Recover then Assess model. The process for updating the policy should include patients and carers. R4 The Health Board should embed a regular cycle of audit to assess the effectiveness and consistency of the application of the discharge policy and associated training programmes.

Source: Audit Wales

Detailed report

Implementation of previous audit recommendations

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

- information on community health and social care services (Recommendations 1a and b);
- policy review (Recommendation 2);
- staff awareness of policies and pathways (Recommendation 3); and
- discharge planning training (Recommendations 4a and b).

12 Overall, we found that **the Health Board has made reasonable progress in addressing our previous recommendations, but there remains more to do, including ensuring the discharge policy is up to date and that training and awareness raising activities are resulting in improved understanding of the landscape of community health and social care services**.

Information on community health and social care services

13 We considered whether the Health Board has:

- developed a system to enable staff to access information about community health and social care services (2017 Recommendation 1a).
- reviewed the range and frequency of data collated about community health and social care services. For example, waiting times for some services and the frequency data on services available through other NHS bodies and housing options are collated (2017 Recommendation 1b).

14 We found that **the Health Board has introduced mechanisms to monitor the use of community health and social care services and has taken action to improve staff understanding of the landscape of services, although it is not clear whether these actions are having the intended impact**.

15 The Health Board states that it provides staff with up-to-date information relating to community health and social care systems via its intranet. It has first point of contact officers who provide information to ward staff, individuals and their families. A single point of access for referrals has been established through the Integrated Discharge Hub for referrals to services in the Cardiff local authority area and Contact OneVale (C1V) for referral to service in the Vale of Glamorgan local authority area. The Health Board also incorporates information about community services as part of ongoing training to hospital and community staff. We therefore consider **Recommendation 1a implemented**.

16 However, our fieldwork found variable levels of knowledge on the breadth of out-of-hospital services amongst staff. Staff who worked out in the community, such as community occupational therapists and hospital staff, felt reasonably well informed about community health and social services. Yet hospital staff we spoke to as part

of our fieldwork said they were not confident they had good knowledge of the landscape of services available outside of hospital. The Health Board advised us during our fieldwork that it had plans to strengthen these arrangements, such as by appointing an administration manager to manage the Integrated Discharge Service website and a discharge pathway manager. We were unable to assess the impact of these actions at the time of our work, and therefore recommend that the Health Board undertake activity to assess whether these activities have resulted in better levels of awareness of community services (**2024 Recommendation 1**).

17 To monitor information on demand and access to community health and social care services, the Health Board informed us that it holds regular multiagency meetings. During these meetings the Health Board can review capacity and waiting times for community support services, in particular Community Resource Teams in Cardiff and the Vale of Glamorgan Community Resource Services. As we reported in our regional report, the region has some of the lowest waiting lists for domiciliary care and reablement packages in Wales. We therefore consider **Recommendation 1b implemented**.

Policy review

18 We considered whether the Health Board has:

- involved patients and carers in the process to develop and revise the Health Board's policy in relation to discharge planning (2017 Recommendation 2)

19 We found that **while the discharge policy was revised in 2020, it is unclear what impact the involvement of patients and carers had on changes, and the policy is overdue for further review with a need for the Health Board's website to be updated to include the most recent version**.

20 At the time of our 2017 review, the Health Board was planning to refresh its discharge policy. The Health Board's discharge policy was subsequently revised in September 2020 although we note that that Health Board's website still contains the 2017 version. This should be updated (**2024 Recommendation 2**). The Health Board informed us that during the revision process, the patient experience team sent copies to the Carers and Young Carers groups for consultation and an Equality Health Impact Assessment was completed. However, there is no record of any changes made because of this consultation. There are very few differences between the 2017 and 2020 discharge policy, and although the 2020 version includes a small section on carers and young carers, it is not clear if this was informed by its consultation activities. We found no evidence to suggest that the choice of accommodation policy, which supports the discharge policy, has been revised since 2017.

21 The policy was due for further review in 2023 which has yet to be completed. Given that there have been several changes to discharge planning since 2020, including the introduction of the Discharge to Recover than Assess (D2RA) model by the Welsh Government, the Health Board should prioritise updating its policy. This is particularly important given the Welsh Government issued national guidance on

discharge planning in December 2023. We recommend that, during the next revision to the policy, the Health Board ensures it undertakes meaningful collaboration with patients and carers and records the impact of that work. We therefore consider that there is **ongoing action to address recommendation 2 (replaced with 2024 Regional Recommendation 3)**.

Discharge planning training

22 We considered whether the Health Board has:

- undertaken training and awareness raising following the finalisation of the revised discharge policy to ensure all staff involved in discharge planning understand how to use it (2017 Recommendation 3);
- explored developing an e-learning course for discharge planning which ward staff may find more accessible (2017 Recommendation 4a); and
- ensured that attendance at training is captured on the electronic staff record, which will help to improve compliance monitoring (2017 Recommendation 4b).

23 We found that **while the Health Board provides regular training related to discharge planning, we found limited evidence that it monitors completion rates for training**.

24 The Health Board informed us that it provides regular training to staff, including for new starters and ongoing SNAP[1] training on the ward. These training programmes include information for staff on how to access relevant pages on the intranet which include policies and information on pathways and services. The Health Board's Integrated Discharge Services staff also provide demonstrations on how to access the policies on the intranet via the clinical workstation.

25 Outside of its own hospitals, the Health Board says that it has offered training sessions to care home staff, although it is unclear how many of these sessions have been provided or how many staff have attended. The Health Board's has also run workshops on its 'Get Me Home' programme which have included sessions for social services staff, care home managers and the voluntary sector. The Health Board does monitor how many discharge training sessions have been delivered for new starters. However, it is not clear how many staff have completed this training. In addition, an e-learning course for discharge planning has not been made available. We therefore consider **recommendation 3 implemented, no action has been taken on recommendation 4a (replaced with 2024 Recommendation 3), and ongoing action is needed to address recommendation 4b (replaced with 2024 Recommendation 4)**.

26 In addition, our regional review found weaknesses in the way the discharge process is applied, including incomplete discharge documentation and a lack of

[1] Support Needs Approach for Patients

understanding of various roles involved in discharge planning, suggesting there is a potential to measure the success of training and consider whether changes or additional activity are necessary **(2024 Regional Recommendation 4)**.

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 • Updates on the six goals programme and urgent and emergency care to committees • Discharge procedure
Interviews	We interviewed the following: • Senior Nurse Integrated Discharge; • Managing Director Acute Services; • Head of Operations Patient Flow and Site Services; • Head of Integrated Care; • Chief Operating Officer; • Director of Operations; • Deputy Director of Nursing; • Executive Lead of Strategic Planning; and • Programme Manager for Six Goals.
Observations	We observed a bed meeting at the University Hospital of Wales We also observed the following individual: • Discharge Coordinator
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 20 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.

Source: Audit Wales

Appendix 2

Summary of progress against our 2017 recommendations

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

Recommendations	Progress
Information on community health and social care services	
R1a Develop a system where ward staff are able to access up-to-date information about community health and social care services.	**Implemented** – see paragraph 15
R1b Review the range and frequency of data collated about community health and social care services. For example, waiting times for some services and the frequency data on services available through other NHS bodies and housing options is collated.	**Implemented** – see paragraph 17
Policy review	
R2 The Health Board should seek to involve patients and carers when the next policy revisions are due.	**Ongoing** – see paragraph 21 (replaced with 2024 Regional Recommendation 2)
Staff awareness of policies and pathways	
R3 The Health Board should undertake training and awareness raising once the draft discharge policy has been finalised to ensure all staff involved in discharge planning understand how to use it.	**Implemented** – see paragraphs 24 to 25

Recommendations	Progress
Discharge planning training	
R4a Explore developing an e-learning course for discharge planning which ward staff may find more accessible.	**No action** – see paragraphs 24 to 25 (replaced with 2024 Recommendation 3)
R4b Ensure that attendance at training is captured on the electronic staff record, which will help to improve compliance monitoring.	**Ongoing** – see paragraphs 24 to 25 (replaced with 2024 Recommendation 4)

Source: Audit Wales

Appendix 3

Management response to audit recommendations

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

Ref	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 should assess whether recent activities to signpost and streamline access to information on community health and social care have resulted in better awareness of the landscape of services outside of hospital across various staff groups.	i. The rolling ward-team education sessions continually evaluate the knowledge and skills of staff to inform training. There are a number of key mechanisms for training, including: • Cardiff First Point of Contact Officers working with ward teams • Rolling programme of discharge planning education • Increasing the profile of discharge services ii. The Integrated Discharge Hub provides a fully centralised source of expertise on the range of out-of-hospital resources to support people to return home from hospital.	Already in place	Head of Integrated Discharge

Ref	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)
R2	The Health Board should ensure the revised discharge policy is updated on the Health Board's website.	We have a plan in place to ensure the policy is updated by April 2025 when we will then add to Health Board website.	June 2025	Head of Integrated Discharge
R3	The Health Board should explore developing an e-learning course for discharge planning which ward staff may find more accessible.	i. The Health Board discharge learning lead will explore the feasibility and opportunity of an e-learning course. This was previously considered prior to COVID-19 but this was not taken forward. ii. Face-to-face practice-based learning is already in place (see R1)	June 2025	Head of Integrated Discharge
R4	The Health Board should ensure that attendance at training is captured on the electronic staff record, to help monitor attendance levels and ensure all relevant staff are receiving training.	The Integrated Discharge Service has a training database for staff who have attended any session that has been delivered regarding the discharge process. In addition, all-day training (once a month) is also put onto ESR. There are no plans to increase recording of training, as current record keeping has been assessed as sufficient for the Health Board's requirements.	Already in place	Head of Integrated Discharge

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