Discharge Planning

Final Internal Audit Report

2024/25

Swansea Bay University Health Board

Reasonable Assurance

Contents

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Executive Sign Off	13 January 2025
Audit Committee	23 January 2025
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Executive Summary

Purpose

To review the arrangements in place within the health board for the timely and safe discharge of patients and whether established processes are being adhered to, including progress in implementing the actions agreed with management to address the issues identified in the previous internal audit report (SBU-1920-025). This review has been limited to the arrangements and mechanisms within the health board to facilitate the discharge of patients.

Overview

Since our previous review, the health board has embedded the use of SIGNAL, its in-house patient flow system, and incorporated SAFER (Seen, Aim, Flow, Early Discharge, Recovery) principles within ward rounds, to support the discharge planning process. Through recent externally facilitated discharge planning and patient flow reviews, the health board has identified a number of process and system issues, including external constraints within social care, which are preventing the operation of Discharge to Recover and Assess (D2RA) model in its intended form, with extended length of stay providing further challenges in identifying and agreeing the level of support patients require. Our review of patient records and SIGNAL noted similar issues impacting the timely discharge of patients, alongside areas for improvement for the health board to comply with national discharge/patient flow guidance, and where detail and documentation could be improved.

The Urgent and Emergency Care Summit, held by Management Board in October 2024, set out the actions, and preliminary timescales, required to address the gaps identified from the above referenced external reviews. The operational management and delivery of actions by partners or third parties was excluded from the scope of this audit, however we noted the health board's recent development of an Integrated Discharge Strategy and the phased roll out of the Integrated Discharge Hub (IDH) demonstrates alignment with partners within this area. Whilst IDH operation is yet to be embedded at all acute sites, performance data shared at the UEC Programme Board in November 2024 indicated the initial impact has been positive.

We have concluded **reasonable** assurance on this area reflecting the arrangements for planning, monitoring and reporting of patient discharges. It will take time for recently agreed actions to be embedded and improvements to be realised; and at time of audit fieldwork concluding, performance and outcomes remain a significant challenge as is the case for all NHS organisations in Wales.

The matters requiring management attention include:

- Welsh Government hospital discharge guidance has been adopted by the health board, but this does not offer standards for completion, quality or ongoing audit requirements. The development of a discharge toolkit or policy could strengthen this area.
- Criteria Led Discharge protocol has been adopted by Morriston; however, it has not been formally approved, and would benefit from greater engagement and promotion.
- The health board does not undertake formal discharge planning training or quality improvement programmes to support all sites.
- Review of records identified occasions where expected discharge dates had not been assigned in line with guidance, and the need to improve documentation.
- Action plans from recent discharge planning/patient flow reviews have been developed, however some initial timescales have not been met and, noting the cross over between these, there is opportunity to combine within one improvement plan to assist in monitoring and oversight.
- Reporting against UEC Programme 3 ('Acute Hospital Flow and Discharge') is limited to updates for the Morriston site only, and the narrative does not reflect current action status.

Full details of matters arising are detailed within the Findings & Agreed Action Plan. Review of progress in implementing the recommendations raised (see Appendix A) within the previous internal audit report has identified five actions which can be closed within the audit tracker; and for those which remain outstanding we have indicated where these are superseded by recommendations raised within this review.

Scope & Assurance Summary

	Objectives	Related Findings	Assurance
1	Guidance is available for staff on discharge processes and responsibilities are clearly outlined.	1,2,3	**Reasonable**
2	Discharge processes are complied with to support the timely and safe discharge of patients.	4,5	**Reasonable**
3	There are robust governance and reporting arrangements established in relation to the discharge of patients.	6,7	**Reasonable**

Management Actions

0 High Priority

7 Medium Priority

Themes

Risk Types

Quality or Safety Issues

Choose an item.

Choose an item.

Choose an item.

Findings & Agreed Action Plan

Objective 1: Guidance is available for staff on discharge processes and responsibilities are clearly outlined.	**Reasonable**

The health board applies the Welsh Government's Hospital Discharge Guidance (issued December 2023). Noting its coverage, including standards, tasks and responsibilities, the health board decided not to review its SAFER Flow Policy which was previously used. The National Six Goals Programme has also provided operational guidance through the Optimal Hospital Patient Flow Framework ('the Framework') which refines and collates the ward-based principles to support effective discharge planning. A recent externally facilitated review of all patients with a length of stay in excess of 21 days **(see audit objective two)**, identified instances where roles and responsibilities between health board teams, staffing groups, and partner organisations could be further clarified (see **Key Finding 1**). Noting also the recent implementation of the Integrated Discharge Hub (IDH), there could be consideration of including key documents, in support of regional working, within the centralisation of discharge planning resources. (see **Key Finding 1**).

A local protocol is in use within both Morriston and Singleton Hospitals to support the adoption of Criteria Led Discharge (CLD), however we note that the protocol has not been formally approved and take-up could be improved through greater engagement. (see **Key Finding 2**).

A structured roll out of SAFER principles at the Morriston site in 2023 was accompanied by a programme of ward training and follow up/quarterly reviews. Due to the reduction in the team's capacity this has since been discontinued (Q2/2023), and there is now focus on supporting Medicine wards with clinically optimised patients (COPs) through daily deep dives. Whilst wards on other sites have received support in adopting SAFER principles, we could not identify similar programmes, or a health board wide quality improvement approach to discharge planning. (See **Key Finding 3**)

Resources and services to support discharge planning have been collated to inform staff planning, and within Morriston the SAFER champion role is to be introduced; but currently, there is not a standard approach to discharge planning training to promote SAFER and other productive ward initiatives. We also identified limited uptake of the national Discharge to Recover and Assess (D2RA) training. (See **Key Finding 3**).

Key Findings		Risk & Impact	Agreed Management Action
1	**Discharge Planning Toolkit** National discharge guidance is available to support health board staff, which establishes responsibilities across ward, management and integrated care teams, but does not include reference to documentary, quality or audit requirements to ensure consistency of application. Additionally, external reviews have highlighted where further health board guidance or protocols are required which could be incorporated into the health boards resources once developed and approved: • health board wide internal professional standards, • clinical criteria to reside, • escalation frameworks (both internal and those agreed with partners) • Trusted Assessor standards/responsibilities, and • revised Patient Choice policy.	Lack of clarity, consistency, and staff awareness.	**Agreed Action:** The health board recognises there is a need to develop a local policy to ensure consistency across acute sites whilst retaining alignment with national guidance. The revised policy will include supporting documents outlined, and these will be available through the health board SharePoint for staff awareness and use. As part of the UEC programme of work the Health Board is commissioning a piece of work to develop its D2RA pathways against the national standard commencing in January 2025. The health board will be holding its 3rd UEC summit in March 2025 which will be completely focussed on discharge processes and policy. **Expected Evidence of Implementation:** *Development of a health board discharge policy, and approval at an appropriate forum.*

Key Findings		Risk & Impact	Agreed Management Action
			Policy and supporting guidance/documents communicated to staff and uploaded to the health board SharePoint.
		Medium Priority	**Officer:** Emily Warren (Associate Service Group Director of Primary, Community and Therapies) in conjunction with Alison Gallagher (Associate Director, Urgent and Emergency Care) **Date:** 30th June 2025
	Theme: Policies & Procedures	Control Design	
2	**Criteria Led Discharge Protocol** A Criteria Led Discharge (CLD) Protocol has been introduced within both Morriston and Singleton Hospitals. This allows a designated member of a multidisciplinary team to accept discharge responsibility for a patient, based upon a criteria agreed by the consultant responsible for the patients care. The protocol does not have an approver/authoriser indicated and is not available within the health board's clinical library. Whilst a positive tool, we note that there are a limited number of patients in receipt of a CLD and wider MDT engagement could support its wider use.	Opportunities to expedite discharge may be lost, resulting in increased length of stay.	**Agreed Action:** Approval of Criteria Led Discharge protocol at an appropriate forum, inclusion within the health board discharge policy, and identification of leads to promote its use across sites.
			Expected Evidence of Implementation: *Approval of the Criteria Led Discharge protocol.* *Inclusion within the health board policy* *Confirmation of CLD leads for each site.*
		Medium Priority	**Officer:** Alison Gallagher (Associate Director, Urgent and Emergency Care) in conjunction with Sharon Price (Group Nurse Director, Neath Port Talbot and Singleton Service Group) **Date:** 31st March 2025
	Theme: Policies & Procedures	Control Operation	
3	**Discharge Planning Training & Quality Improvement** Resources are available to assist in the planning of discharges, however since the conclusion of the SAFER roll out in Morriston Hospital, there has been no formal health board training available to support the embedding of discharge planning principles and procedures. We are informed that the NHS Executive is developing resources aligned to the Optimal Patient Flow Framework which may assist in this area, although the	Lack of staff training may result in inconsistent or ineffective planning processes.	**Agreed Action:** Following receipt of national training resources, there should be circulation to wards and uptake of training monitored. The principles established within the SAFER roll out programme will be adopted across other sites. SAFER principles and Criteria to Reside will form a major part of the D2RA implementation referenced within Key Finding 1.

Key Findings	Risk & Impact	Agreed Management Action
timescale for release had not been confirmed at time of fieldwork closing. Similarly, we identified that ad-hoc support was available to support wards to refresh awareness of SAFER principles, however this was not consistent across the health board.		**Expected Evidence of Implementation:** *Evidence to confirm uptake of training.* *Evidence of SAFER audits undertaken across all sites.*
	Medium Priority	**Officer:** Alison Gallagher (Associate Director, Urgent and Emergency Care) in conjunction with Emily Warren (Associate Service Group Director of Primary, Community and Therapies) **Date:** 31st July 2025
Theme: Training & Development	Control Operation	

Objective 2: Discharge processes are complied with to support the timely and safe discharge of patients.	**Reasonable**

The Optimal Hospital Patient Flow Framework ('the Framework'), and its key principles, have been embedded into the patient discharge process across all health board sites through regular ward rounds. Attendance by a Multi-Disciplinary Team was noted, although capacity constraints for some staff groups (district liaison nurses, pharmacists) and social workers limit this being fully adopted. A recent externally facilitated discharge event at Morriston Hospital provided positive feedback relating to Board rounds, however we noted the use of Red2Green[1] varied across sites. Discussion with management confirmed that there is intention to focus instead on the *Clinical Criteria to Reside* to identify the reason why a patient requires acute treatment, and its use to identify systemic issues impacting the discharging of patients. Noting this differs from the adopted national guidance there is an opportunity to develop further guidance to clarify the requirements on a health board wide basis. (see **Key Finding 1**)

We reviewed and compared information within SIGNAL (the health board's patient flow system) and the Welsh Nursing Care Record (WNCR) to evidence compliance with discharge planning principles. This demonstrated there has been significant progress in embedding the use of SIGNAL since our previous internal audit. Our testing confirmed the majority of patients had been assigned to a D2RA pathway. The setting of expected discharge dates (EDD) varied against the Framework target of 24 hours (see **Key Finding 4**), however, we did note frequent revision of EDD indicating pro-active review. We also noted that some WNCR entries held limited detail of patient and carer communication relating to discharge planning. (See **Key Finding 4**) Similar Audit and Assurance reviews elsewhere across Wales have highlighted similar challenges, including the need to ensure a consistent approach to discharge planning, and to improve the completeness of patient records.

Each health board site has established arrangements for regular review of COP patients, including daily deep dives for Medicine wards at Morriston Hospital. Observation of the COP meetings noted a check and challenge approach which scrutinised the accuracy of the information captured within SIGNAL, and considered a range of actions to support patient discharge. Constraints to discharge processes were noted through the lack of social worker availability and assessment capacity, the complexity and frailty of patients (where further risk of deconditioning can result in increased care requirements); and patient/family reluctance to agree discharge.

In October 2024, an externally facilitated review of all patients with a length of stay in excess of 21 days was undertaken across the health board. This identified that 220 (69.6%) of the 316 patients reviewed were deemed 'not to require a hospital bed'. The length of stay audit followed three prior discharge/patient flow reviews, where similar themes regarding internal professional standards, the need for agreement for criteria to reside (to ensure treatment plans reflect care that can be provided in an acute setting only); and agreement of rehabilitation pathway standards (to assist in setting definitive treatment periods) were identified. An Urgent and Emergency Care (UEC) Summit held by the Management Board in October 2024 included additional actions to centralise discharge resources in support of expansion of the Integrated Discharge Hub. We noted that the timescales included for some of the actions were not defined; with others unlikely to be achieved (as per the discussions held at the second UEC summit in December 2024) (see **Key Finding 5**).

	Key Findings	Risk & Impact	Agreed Management Action
4	**Compliance with discharge planning guidance** Of the 30 patients sampled: • 17 had not had an initial EDD set within 24 hours in line with Welsh Government guidance. • 3 had no D2RA pathway assigned. • 2 held no evidence of discharge planning discussions within WNCR.	Inaccurate or incomplete information retain impacting on the safe and timely discharge of patients.	**Agreed Action:** The development of a health board policy will include direction on the completeness of records, including in relation to setting of expected discharge dates, and communication with patients and carers. This will also include arrangements for periodic review of records to support quality improvement, and identification of outliers in respect of records completeness.

[1] Red2Green is a system to capture nonvalue adding day (such as a planned intervention not taking place, or where the care provided could be provided in a non-acute setting) as a red day, whereas, a green day signifies progress is being made towards the patient's discharge. Through inclusion within daily review, it can identify internal or external delays.

Key Findings		Risk & Impact	Agreed Management Action
	• 9 held limited reference to discharge planning discussions. • 13 had no detail within the patient recorded under 'What Matters to Me' which should inform the development of discharge plans. Changes to EDD are recorded within SIGNAL but this does not capture reasons for change, although it can be cross referenced with WNCR by date, we did not see changes to EDD referenced directly. These points highlight that there are opportunities to address non-compliance and improve the detail recorded within clinical records.	**Medium Priority**	**Expected Evidence of Implementation:** *Approved policy with associated guidance.* *Evidence to support regular review of the accuracy and completeness of patient records.* **Officer:** Callum Allen Ridge (Head of Patient Flow and Site Services, Morriston Service Group) in conjunction with Emma Mitchell (Head of Nursing, Medicine Division, Morriston Service Group). **Date:** 31st March 2025
	Theme: Information, Data Quality & Data Accuracy	Control Operation	
5	**Actions to strengthen discharge processes** Several externally facilitated diagnostic reviews have examined the health boards discharge planning and patient flow pathways. These have highlighted where further health board guidance or protocols are required, including: • health board wide Internal Professional Standards; • Clinical criteria to reside; and • A revised Patient Choice policy. Action plans to address the above diagnostic reviews have been received at the UEC Programme Board. There have also been	Failure to address identified weaknesses could extend the cycle	**Agreed Action:** The health board will incorporate outstanding actions from recent diagnostic reviews and those identified as relating to discharge planning from within the UEC Summit, and collate these into one discharge/patient flow improvement plan with agreed timescales and action leads. Progress against the plan will be shared with the UEC Programme Board and Quality and Safety Committee. **Expected Evidence of Implementation:** *Development and approval of the improvement plan, evidence of progress being reported within appropriate forums.*

Key Findings		Risk & Impact	Agreed Management Action
	actions developed based upon the Management Board UEC Summit held in October 2024. While there is good crossover between both of the above, we noted the action plan from the Multi Agency Discharge event (MADE) lacked specific timescales. We were also informed that whilst progress has been made against the UEC Summit actions, some timescales in relation to the areas above would not be achieved. The above action plans have yet to be shared with the Quality and Safety Committee.	**Medium Priority**	**Officer:** Emily Warren (Associate Service Group Director of Primary, Community and Therapies) in conjunction with Alison Gallagher (Associate Director, Urgent and Emergency Care) **Date:** 30th June 2025
	Theme: Planning, Delivery & Deadline Management	Control Design	

Objective 3: There are robust governance and reporting arrangements established in relation to the discharge of patients	**Reasonable**

We reviewed the arrangements in place for oversight of patient discharge performance at a health board level and did not include review of reporting arrangements within individual Service Groups.

The health board has an established Urgent and Emergency Care Programme Board (UECPB), which meets monthly and is chaired by the Chief Operating Officer. Review of minutes (August 2023 – July 2024) noted regular attendance from Service Group senior management and assigned UEC programme leads.

UEC Programme 3 '*Acute Hospital Flow and Discharge*' submit monthly highlight reports to the UECPB, providing a RAG rating (amber as at the date of audit fieldwork) and narrative updates on the status of discharge initiatives such as SAFER, Red2Green, and D2RA. Review of the content identified opportunities to enhance completeness (see **Key Finding 6**), and include more detail related to ward-based metrics (see **Key Finding 7**) to align with national patient flow guidance. UEC Programme 3 remains within the health board's draft Annual Plan priorities for 2025/26, with revised monitoring arrangements recently discussed to take place within the wider UEC Redesign structure - although we note that this had yet to be implemented at date of fieldwork conclusion.

The high number of COP admitted to health board sites has been regularly reported to the Quality and Safety Committee (QSC), alongside detail of internal and external actions and initiatives underway to try and address the number of delayed discharges. Reports have been consistent in highlighting that despite the range of work undertaken (through a focus on admissions avoidance, expansion of same day emergency care services, and expansion of virtual wards) the impact on overall number of COP has been minimal. This was shared, by QSC, with the Board in May 2024.

In July 2024, the QSC received the newly developed Integrated Discharge Strategy, setting out the health board's alignment with partners including the establishment of the Integrated Discharge Hub (IDH) at Morriston Hospital. In October 2024, initial IDH performance measures were shared indicating improvements in the allocation to discharge pathways (both in accuracy of pathway allocated and receipt by community services) and timescales (including referral times from IDH to community service; and between referral and discharge). The expanded roll out of the IDH to other acute sites was taking place in December 2024, as audit fieldwork concluded.

The health board routinely submits monthly pathway of care delays figures to Welsh Government.

Key Findings		Risk & Impact	Agreed Management Action
6	**UEC Programme 3 Reporting coverage** UEC Programme 3 highlight reports have provided regular updates against the roll out of productive ward initiatives within Morriston Service Group. However, there has not been similar detail related to other health board sites.	Lack of oversight relating to discharge processes across the wider health board.	**Agreed Action:** Future reporting to the UEC Programme Board on UEC Programme 3 will include updates for all sites. **Expected Evidence of Implementation:** *Amended UEC Programme highlight reports.*
		Medium Priority	**Officer:** Neil Cooper (Assistant Director of Operations, Urgent and Emergency Care) in conjunction with Lee Elwell (UEC Programme Manager) **Date:** 29th February 2025
	Theme: Reporting	Control Design	

Key Findings		Risk & Impact	Agreed Management Action
7	**UEC Programme 3 Performance metrics** UEC Programme 3 highlight reports contain UEC programme metrics, but there are no measures or indicators reported through Programme 3 itself. The National Six Goals Programme Optimising Patient Flow guidance includes 12 suggested measures to assess pathways of care and patient flow, six of these feature within current health board dashboards. There could also be benefit in development of reporting indicators linked to the use of SIGNAL which could identify any variation in use at ward level. Following the agreement of Internal Professional Standards, there is a need to establish monitoring arrangements to ensure they are embedded - this could also support the measurement of productive wards	Lack of ward focussed metrics could prevent identification of areas of poor performance.	**Agreed Action:** Metrics to support monitoring of discharge planning performance will be developed for inclusion in UEC Programme 3 reporting. **Expected Evidence of Implementation:** *Amended UEC Programme highlight reports.*
		Medium Priority	**Officer:** Neil Cooper (Assistant Director of Operations, Urgent and Emergency Care) in conjunction with Lee Elwell (UEC Programme Manager) **Date:** 29th February 2025
	Theme: Performance Monitoring	Control Design	

Appendix A: Status of Prior Year Recommendations

Ref	Key Findings	Agreed Management Response	2024/25 Status	2024/25 outcome
1	All patients we reviewed had some form of clinical plan in place promptly following admission, but the detail of plans varied from ward to ward, and the clear documentation of clinical management plans with content as expected by section 7.9 of the SAFER Policy was not common.	The policy is being reviewed and revised to provide greater clarity on expectations regarding the documentation of clinical management plans and include actions to provide assurance regarding implementation. Anticipated first draft for consultation end of February 2021.	Welsh Government Hospital Discharge Guidance is being followed, although this includes roles and responsibilities across services it does not set out the documentary requirements for discharge planning. Our sample testing identified variation in the level of detail held within records.	Recommendation superseded See Key Findings 1 & 4
2	The methods used across wards for setting EDDs was inconsistent - on some wards, EDDs were set by Ward Managers, and some by Ward clerks, but there was little evidence within patient notes of medical input in determining the EDD.	The policy is being reviewed and revised to provide greater clarity on expectations regarding the documentation of expected date of discharge within clinical management plans, and on signal. Requirement to audit and improve recording of EDD will be included within the corporate audit tool.	EDD is set through MDT review during board rounds. We note variation in achieving the target set within Welsh Government guidance (24 hours), however we found that detail of EDD amendments were often not directly referenced within patient notes. We could not identify a health board wide audit or quality improvement approach to discharge planning.	Recommendation superseded See Key Finding 1 & Key Finding 3
3	Testing at Ward E, Neath Port Talbot Hospital, showed that EDDs are not always set within 24 hours having identified 9 patients that did not have an EDD after being admitted between 2 to 14 days earlier.	The policy is being reviewed and revised to provide greater clarity on expectations regarding the documentation of expected date of discharge within clinical management plans, and on signal. Requirement to audit and improve recording of EDD will be included within the corporate audit tool.	A sample of patients reviewed for Ward E, NPT confirmed EDD had been set appropriately. Whilst this is the case on a wider basis we found the setting of EDD varied against both national and local targets.	Recommendation superseded See Key Finding 4
4	Several observations identified divergence from policy requirements across wards: • Records did not demonstrate senior medical review occurring on a daily basis. Discussion with the Senior Corporate Matron has identified that a senior review might not always be	The policy is being reviewed and revised to provide greater clarity on expectations regarding the frequency, timing and recording of senior medical review, and include actions to provide assurance regarding implementation.	Ward rounds within NPTH and Gorseinon include daily medical review, but not all included daily consultant review. No update to policy has been made, we were informed there would be differences between acute vs non acute wards. At present the differences in	Recommendation superseded See Key Finding 1

Ref	Key Findings	Agreed Management Response	2024/25 Status	2024/25 outcome
	required for some patients on some wards. • Patients at Gorseinon and Neath Port Talbot Hospitals did not receive a daily consultant review and there were also gaps between reviews by junior doctors too, but it was considered that patients on the wards visited here did not require daily medical input. The Policy does not indicate where variation from the daily requirement would be acceptable. • Often, the times of patient reviews recorded in notes fell after midday. • Reviews undertaken at weekends were very inconsistent across all wards with the majority of patients not receiving a senior or junior review.		arrangements are not formally set out.	
5	Ward 8 at Singleton used a Weekend Handover Sheet which outlined the criteria for patient discharge over the weekend to enable nurse-led discharge.	The standard for handover will be reflected within the revised policy version.	The development of Criteria Led Discharge provides the scope to increase nurse and wider MDT led discharge, however we found outside of Morriston use was limited.	Recommendation superseded See Key Finding 2
6	There was non-compliance with policy in that the reason for changing the EDD was not always recorded within the Clinical Portal (or SIGNAL) which meant that it was not always possible to establish if all of the changes to the EDD were appropriate. Additionally, we noted differences between EDD dates recorded in the portal and those within SIGNAL (with one ward inputting only to SIGNAL). SIGNAL being a relatively new development is not currently covered by policy.	The policy is being reviewed and revised to provide greater clarity on expectations regarding adjustments to EDDs, appropriate reasons for them and how these will be documented. The policy will include actions to provide assurance regarding implementation	SIGNAL functionality captures the revision of EDD dates, including the date/time of revisions for each patient but not the reason. Information within WNCR contained changes in patient status, but did not directly reference EDD in doing so.	Recommendation superseded See Key Finding 4

Ref	Key Findings	Agreed Management Response	2024/25 Status	2024/25 outcome
7	Of the 55 patients tested there were ten patients where the EDD was updated beyond a patient being medically fit for discharge with the reason being related to Social Worker, Continuing Healthcare/Funded Nursing Care applications or repatriation. These do not fall under clinical reasons for change of EDD and therefore the EDD should not have been changed. Five patients at Singleton Hospital were identified as being medically fit for discharge within patient notes but this was not recorded as such within the Clinical Portal or Signal and so the EDD continued to be updated.	The policy is being reviewed and revised to provide greater clarity on expectations regarding adjustments to EDDs, appropriate reasons for them and how these will be documented. The policy will include actions to provide assurance regarding implementation.	The setting of EDD has been standardised, guidance from NHS Delivery Unit was provided to support this. SIGNAL provides detail of EDD, COP, and recently introduced, clinically safe for transfer. Our review of patient records did not identify EDD amendment for non-medical reasons.	We recommend closing of this recommendation within the audit tracker.
8	Whilst the ABMU Clinical Portal prompts for reasons, the field is not mandatory. Neither SIGNAL nor the Welsh Clinical Portal provide fields seeking reasons for EDD changes, so wards using them may not capture the same level of information. Furthermore, limitations within Signal and the Clinical Portals do not provide the functionality to support the display of '+days' when a patient is medically fit for discharge but remains in hospital beyond their EDD.	Steps should be taken to ensure the systems chosen to facilitate the management of EDD promote the completeness of information required by policy. This may require working with NHS Wales partners to develop national products.	Action closed by health board in August 2022 noting the improved functionality of Signal version 3.	N/A
9	The review of 69 patients found that only one patient had an EDD recorded within patient notes and this did not provide any evidence of discussion with patient, family or carers. Through discussion at the MDT Board Round we attended at Gorseinon, there was evidence that EDDs were being discussed with patients but that this was not sufficiently recorded within patient's notes.	Further engagement with Carers via Stakeholder reference group will be undertaken and a leaflet produced that outlines what communications and involvement patients and their families can expect to receive regarding the plans for their expected date of discharge. A comprehensive training and communication programme will be developed that includes communication with families and	We did not identify revised leaflet/ communication to patients and families regarding the planning of expected date of discharge. Discussions held within fieldwork highlighted the need to refresh the Patient Choice policy to assist in the managing of expectations of families and patients. EDD are captured within SIGNAL, and we found that communication with patients, families and carers is	Recommendation superseded See Key Findings 1, 4 & 5.

Ref	Key Findings	Agreed Management Response	2024/25 Status	2024/25 outcome
		patients as part of the launch of the revised SAFER policy. The All Wales newly developed and piloted digital clinical risk assessments includes Expected date of discharge and will be rolled out across the health Board – this will improve recording of EDD and engagement with families and carers.	referenced within WNCR, however this at times was limited in detail recorded.	
10	Within Signal, the 'MDT d/c planning' column is utilised to record details and actions in relation to a patients discharge. There were wards at Morriston that had no comments this column in and very little detail recorded within patient's notes.	To be captured as a requirement within the new Audit Tools. Which will be included within the appendices to the revised policy. A case will be presented to signal user group to consider if a standardised approach to board rounds could be designed within Phase 3 of signal.	Our sample testing for Morriston confirmed use of the MDT d/c planning column as a tool for planning discharge, only one example identified where the column held no information. Review of the detail within the MDT d/c planning column was the main feature of the COP deep dive reviews taking place within the Medicine Division. SIGNAL functionality now includes a board round view to aid in the consistency of use.	We recommend closing of this recommendation within the audit tracker.
11	On ward 6 at Singleton there was evidence to suggest that arrangements for patients discharge would wait until after the patient is medically fit for discharge rather than this process being ongoing from admission.	The standards will be reflected in the rewording of the revised policy	Ward 6 Singleton is no longer in use. Within the sample of patients reviewed we identified only one example of setting of EDD taking place post patient becoming clinically optimised.	We recommend closing of this recommendation within the audit tracker.
12	There was a low level of compliance with the Red / Green Day aspect of Policy. Two of the five wards tested at Morriston Hospital did not utilise the Red to Green columns on their PSAG Boards and the remaining three did not use them as intended, instead using them to show that a patient was Medically Fit and waiting for a process (e.g. Social Worker, CHC assessment). There was no evidence of	To be captured as a requirement within the new Audit Tools. Which will be included within the appendices to the revised policy.	Review of the documentation supporting the Morriston roll out of SAFER confirmed the inclusion of R2G, and the Signal functionality is in place to reset patient status each day to prompt discussion within board rounds. Discussion with site leads highlighted that the use and embedding of R2G remained	Recommendation superseded See Key Finding 1

Ref	Key Findings	Agreed Management Response	2024/25 Status	2024/25 outcome
	use of Red to Green days at Singleton Hospital or NPTH.		variable at NPT, Singleton and Gorseinon sites. We were informed that the health board will instead be emphasising the use of criteria to reside as a tool for the identification of patient need for treatment within an acute setting and this will assist in identification of delays to patient discharges.	
13	Staff at Singleton ward 8 highlighted that patient notes available at ward level were not comprehensive - interventions provided by staff from Therapies were held separately.	Revised policy will clarify how discharge planning will be recorded following the introduction of new systems.	Review of records and discussion with leads confirmed that there remains variation in where therapies staff record information.	Recommendation superseded See Key Finding 1
14	There were mixed findings in relation to Information Governance with different wards having different concepts relating to the amount of patient data permitted to be displayed within patient and visitors view. However, in general, full patient names were visible on most Signal PSAG Boards with some Wards displaying dates of birth, area of residence and detailed health information. These screens should be switched off when not in use for Board Rounds to limit the visibility to patients and visitors, however there were several instances when a Board was left unattended by staff and visible to passers-by.	The Quality & Safety Governance Group will develop a standard for inclusion of key requirements and management of PSAG "know how you are doing" boards.	Action closed by the health board in June 2023 noting that guidance in relation to PSAG Boards had been shared with Service Groups.	N/A
15	A review of Signal at Singleton in particular, has shown that staff are populating the system with detailed patient information which is not duplicated within patient notes. Staff report the system has had a positive impact at ward levels, reducing workloads and making patient information more accessible - However, once Signal is optimised across	This identified risk will be escalated to the Signal User Group and any unresolved risk assessed and added to the corporate risk register for monitoring until action is identified to resolve it.	There has been substantial change to the infrastructure/platform that supports SIGNAL, and patient data is transferred to a data warehouse for secure long term storage. Our sample testing noted that SIGNAL contained clearer outline of discharge planning progression, with WNCR retaining clinical detail.	We recommend closing of this recommendation within the audit tracker.

Ref	Key Findings	Agreed Management Response	2024/25 Status	2024/25 outcome
	the Health Board, it will only have capacity to store information for a maximum of 30,000 patients which translates to storing information for approximately 6 months post patient discharge. After which, all of the detailed entries within Signal will be deleted. It is noted that the introduction of electronic nursing notes will overcome some of the above, however this system only includes entries from Nurses and assessments undertaken.			
16	(Summary issue added following discussion of draft report) The audit has highlighted a number of areas of non-compliance with policy	Development of a new Corporate Audit Management Tool, and standard operating procedure outlining the roles, responsibilities and expectations (including frequency) for service group audit of compliance, and to identify improvements and actions relating to the discharge policy.	This has not been progressed, and whilst the roll out of SAFER on the Morriston site included quality improvement support and follow up reviews, this was not replicated across other sites, and has not continued in the structured format.	Recommendation superseded See Key Finding 3

Appendix B

Assurance Opinion

 **Substantial**	Few matters require attention and are compliance or advisory in nature. **Low impact** on residual risk exposure.
 **Reasonable**	Some matters require management attention in control design or compliance. **Low to moderate impact** on residual risk exposure until resolved.
 **Limited**	More significant matters require management attention. **Moderate impact** on residual risk exposure until resolved.
 **Unsatisfactory**	Action is required to address the whole control framework in this area. **High impact** on residual risk exposure until resolved.
 **Advisory**	Given to reviews and support provided to management which form part of the internal audit plan, to which the assurance definitions are not appropriate. These reviews are still relevant to the evidence base upon which the overall opinion is formed.

Prioritisation of Findings

Priority	Explanation
High	Significant risk to achievement of a system objective OR evidence present of material loss, error, or misstatement. Poor system design OR widespread non-compliance.
Medium	Some risk to achievement of a system objective. Minor weakness in system design OR limited non-compliance.

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Public Sector Internal Audit Standards

Audit work undertaken by NHS Wales Audit and Assurance Services conforms with the International Standards for the Professional Practice of Internal Auditing and associated Public Sector Internal Audit Standards as validated through the external quality assessment undertaken by the Chartered Institute of Public Finance & Accountancy in April 2023.

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