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Discharge Planning – **Abertawe Bro Morgannwg University Health Board**

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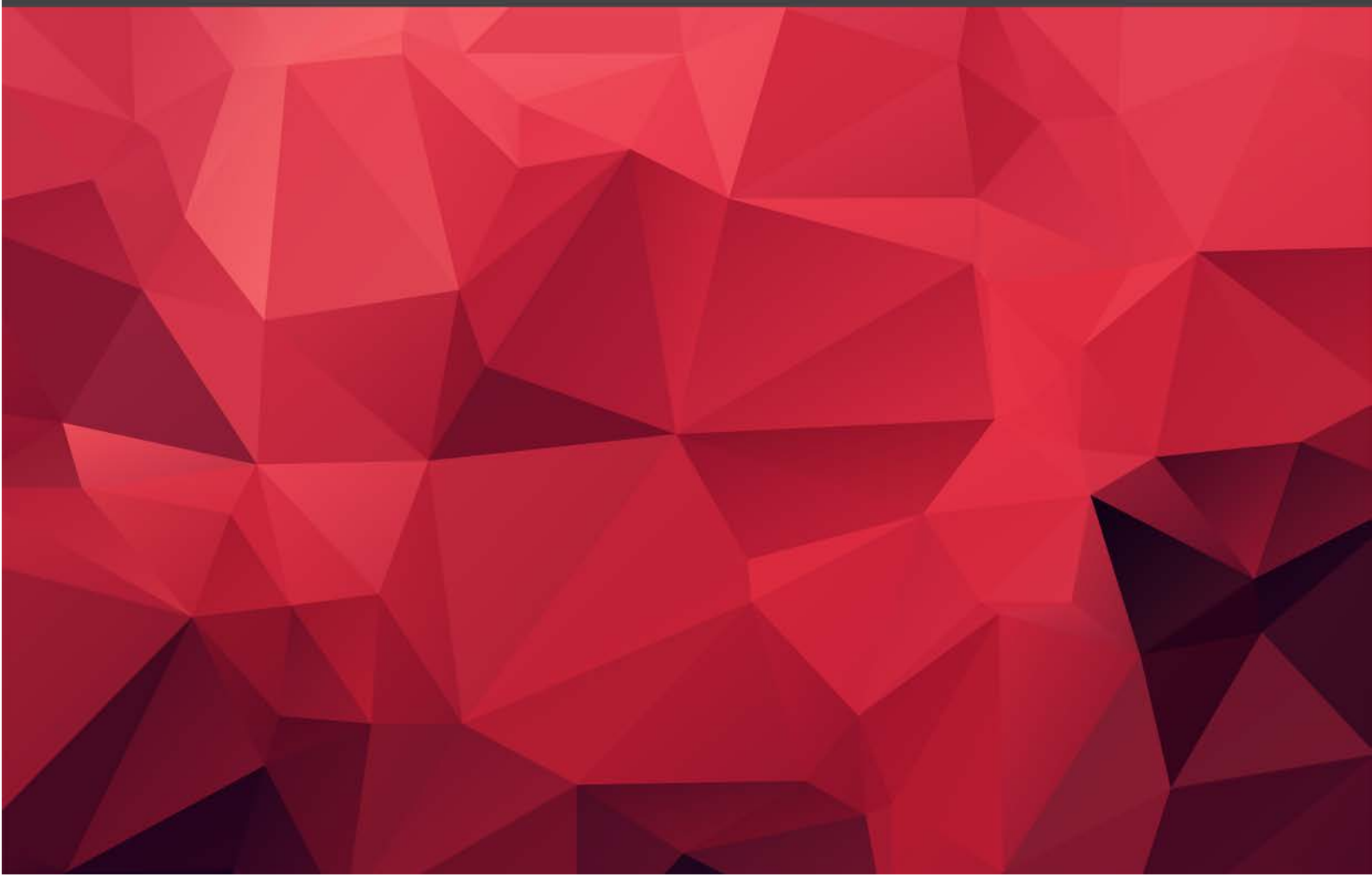

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This document is also available in Welsh.

The team who delivered the work comprised Gabrielle Smith and Katrina Febry.

Contents

The Health Board is working collaboratively with stakeholders to improve patient flow and discharge planning, and while there are improvements in performance there is still more to do.

Summary report

Background

1 Discharge planning is an ongoing process for identifying the services and support a person may need when leaving hospital (or moving between hospitals). The aim is to make sure that the right care is available, in the right place and at the right time. An effective and efficient discharge process is an important factor in good patient flow and key to ensuring good patient care and the efficient and effective use of NHS resources. Patient flow denotes the flow of patients between staff, departments and other organisations along a pathway of care from arrival at hospital to discharge.

2 Hospital beds are under increasing pressure, not least because of the loss of 1,800 beds across Wales over the last six years. Poor discharge planning can increase lengths of stay unnecessarily, which in turn can affect other parts of the hospital leading to longer waiting times in accident and emergency departments or cancellations of planned admissions.

3 Every year across Wales, there are approximately 750,000 hospital admissions and discharges. The discharge process is relatively straightforward or simple for 80% of patients leaving hospital. These patients return home with no or simple health or social care needs that do not require complex planning and delivery. For the remaining 20% of patients, discharge planning is more complex because of ongoing health and/or social care needs, whether short or long term.

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

5 Despite the multiplicity of guidance to support good discharge planning,[1] [2] [3] work undertaken in 2015 and 2016 by the NHS Wales Delivery Unit at all Welsh hospitals showed that there are opportunities to improve the discharge planning process, release significant inpatient capacity and improve patients' experiences and outcomes. Specific areas for improvement included:

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

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

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

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

6 The NHS Wales Delivery Unit assessed the written evidence in case notes against specific requirements set out in 'Passing the Baton'[2]. The findings for Abertawe Bro Morgannwg University Health Board (the Health Board) show that written evidence in relation to the patient discharge process was largely poor when assessed against expected practice. Appendix 1 sets out the findings in more detail.

7 Many of the issues highlighted by the NHS Wales Delivery Unit have been common themes for years with limited evidence to suggest that discharge planning processes are seeing any real improvement. Given the growing demand on hospital services and continuing reductions in bed capacity, the Auditor General decided it was timely to review whether governance and accountability arrangements are robust enough to ensure that the necessary improvements are made to discharge planning.

8 This review examined whether the Health Board has sound governance and accountability arrangements in relation to discharge planning. Appendix 2 provides details of the audit methodology. The work focused specifically on whether the Health Board has:

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

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

Contextual information

10 Since 2015, the Health Board's operational management arrangements have comprised six delivery units. Each delivery unit is led by a core 'triumvirate', consisting of a Service Director, Medical Director and the Nurse Director. The six delivery units are:

- Neath Port Talbot Hospital
- Mental Health and Learning Disability Services
- Morriston Hospital
- Princess of Wales Hospital
- Singleton Hospital

- Primary Care and Community Services

11 Due to the specialist nature, Morriston Hospital manages the majority of complex patients from both within the Health Board and from Hywel Dda University Health Board. To ensure Morriston Hospital has enough capacity to manage acute demand, patients who live outside of the Swansea area are discharged to hospitals nearer to their home addresses before they are fit to be discharged home.

Key findings

12 Our overall conclusion is: **the Health Board is working collaboratively with stakeholders to improve patient flow and discharge planning, and while there are improvements in performance there is still more to do**. In the paragraphs below we have set out the main reasons for coming to this conclusion.

13 **Planning**: the Health Board has clear plans for working collaboratively with local authorities to improve discharge planning supported by a generally comprehensive discharge policy but there is scope to improve its pathways:

- there are clear plans in place to improve discharge planning, which have been developed with local authorities and focus on collaborative working and responding to winter pressures;
- there is scope to strengthen the discharge policy, although overall it compares well against good practice; and
- there are a number of discharge pathways in place, however, links between generic and specific pathways are unclear and they are not clearly set out in the discharge policy.

14 **Arrangements for supporting discharge**: the Health Board has dedicated resources to support discharge planning and is training staff in the discharge process but there is scope to increase staff confidence so they discharge patients in a timely manner. We reached this conclusion because:

- dedicated multidisciplinary resources are in place in hospitals to support discharge planning, but operate on weekdays only; and
- staff training has been rolled out to increase awareness of new policies and pathways and the Health Board recognises it needs to address staff confidence to ensure safe and timely discharge.

15 **Monitoring and reporting**: Arrangements for monitoring, reporting and scrutinising discharge planning are generally effective and while there are improvements in performance there is still more to do. We reached this conclusion because:

- there are clear lines of accountability for discharge planning, with regular scrutiny of performance both strategically and operationally; and
- the Health Board uses a range of information to support timely scrutiny of patient flow, but could incorporate data that is more specific to discharge planning when reporting to board committees.

performance relating to lengths of stay and waits in Emergency Departments are showing signs of improvements, but there is more to do to reduce delays in transfers of care.

Recommendations

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

Exhibit 1: recommendations

Recommendations	
R1	**Discharge Policy.** Although the policy compares well against the good practice maturity matrix, we identified a number of areas where the Health Board's discharge policy could be strengthened. When reviewing the policy, the Health Board should ensure that its discharge policy includes reference to early discharge planning, the risk of readmission, and discharge from Emergency Departments.
R2	**Discharge pathways.** When reviewing the Health Board's pathways, we found that there were a number of improvements that could be made to strengthen the use of discharge pathways. The Health Board should review all of the current pathways in use and use the opportunity to: • consider rationalising them (eliminating any unnecessary overlaps); • make clearer the links between each of the pathways; • make clearer any explanatory information; • set out all of the pathways in one place; and • ensure that pathways are consistent across the Health Board.
R3	**Training on discharge planning.** Although staff are generally aware of the discharge planning process, there were gaps in the training arrangements and staff confidence needed to be addressed. The Health Board should: a) ensure that attendance at training is captured on the electronic staff record, which will help to improve compliance monitoring; b) develop training that helps to build staff confidence to discharge patients in a more timely way and to manage difficult conversations with patients and their families; and c) consider whether discharge training and awareness of issues and policy is required for consultants.

Recommendations	
R4	**Discharge reporting.** We found that the Board, Executive Team and the Quality and Safety Committee receive regular information relating to delayed transfers of care, but receive 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 to the Board and its Committees by including the following measures within its routine performance report: • number and percentage of patients who have an estimated discharge date; • readmissions within 28 days of discharge from hospital; • percentage of discharges before midday; • percentage of discharges that occur at night that were not planned for; and • percentage of discharges within 24 hours and 72 hours of being declared 'medically fit'.

Detailed report

The Health Board has clear plans for working collaboratively with local authorities to improve discharge planning supported by a generally comprehensive discharge policy but there is scope to improve its pathways

There are clear plans in place to improve discharge planning, which have been developed with local authorities and focus on collaborative working and responding to winter pressures

17 In October 2016, the Cabinet Secretary for Health, Wellbeing and Sport wrote to all NHS Chairs making clear his expectation that unscheduled care improvement plans would incorporate plans to improve discharge processes. The NHS Wales Planning Framework[4] also makes it clear that organisations should specify how their plans support and improve patient flow. The focus of which should be on reducing admissions for the frail elderly through pro-active assessment and intervention, and discharging patients as early as clinically appropriate without unnecessary waiting.

18 Our audit work assessed the extent to which discharge planning is part of a wider strategic approach to improve patient flow. We found that the Health Board has a number of plans and strategies either in place or under development at a hospital level and at a Health Board level with its local authority partners. These plans and strategies include:

- Patient Flow Improvement Programme
- Safety and Flow Board Round Policy
- Integrated Medium Term Plan 2016-17
- What Matters to Me
- Seasonal Pressures Capacity and Escalation Plan 2016-2017

19 The Health Board initiated a Patient Flow Improvement Programme (the PFI Programme) in January 2013. The PFI Programme has been a key area of work for the Health Board and became one of seven strategic change programmes in 2015-16. The aim of the PFI Programme is to improve patient flow to reduce the numbers of people waiting for unscheduled care and access to care outside hospitals post discharge by:

- embedding ward rounds on all wards as a way of managing flow effectively;
- redesigning emergency admission pathways for frail older people, using patient flow principles to target underlying reasons for delay; and

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

- supporting better access times for ‘front door’ emergency services at Morriston, Singleton and Princess of Wales Hospitals using patient flow principles and by investing in pharmacy, diagnostics and therapists.

20 The PFI Programme has led to the implementation of daily ward rounds[5] and led to the introduction of the Safety and Flow Board Round Policy in 2015. The Safety and Flow Board Round Policy sets out what should be discussed in ward board rounds and the responsibilities of each staff group attending.

21 The Health Board is a member of the Western Bay Partnership (the WBP), along with Bridgend County Borough Council, Neath Port Talbot County Borough Council, and Swansea City Council. The WBP was established in 2013 to deliver a standardised integrated care model for older people across the Health Board, and has been designed as a whole systems approach to addressing the challenges presented by an aging population. The WBP agreed a joint programme, called ‘What Matters to Me’, to develop a consistent tier of intermediate care service provision between the four partners. ‘What Matters to Me’ is jointly funded by the Health Board and the three local authorities. The actions taken by the WBP are discussed further in paragraphs 31 and 32.

22 At the time of our audit work, the Health Board was working to a three-year Integrated Medium Term Plan (IMTP) that set out its priorities for 2016-19. The IMTP set out the challenges facing the Health Board in relation to patient flow, and its ambition to further support the ward board rounds with electronic systems to capture information and improve the flow of discharge information from the ward to community services.

23 The Health Board’s Seasonal Pressures Capacity and Escalation Plan 2016-2017 (the Winter Plan) details the Health Board’s actions it plans to take to reduce demand, flex (increase) capacity and improve escalation. These actions are summarised in Exhibit 2.

Exhibit 2: summary of actions set out in the Seasonal Pressures Capacity and Escalation Plan 2016-17

Summary actions
To mitigate demand • The introduction of the 111 Service in 2016. A free phone number for patients to call for urgent (but not emergency) health care needs out of hours ensures that patients are assessed and managed by the most appropriate health care professional. • The development of a comprehensive flu plan, including the training of flu champions to increase the uptake of flu vaccinations in the most vulnerable categories of patients.

[5] The ward round is a discussion about what needs to happen for each patient to enable the delivery of an estimated day of discharge.

Summary actions
To mitigate demand • The development of Pulmonary Rehabilitation services across each of the 11 GP cluster networks in the Health Board. • The roll out of Anticipatory Care Planning (ACP) across our cluster networks to stratify and identify those community-based individuals most at risk of admission and developing AC plans to prevent admission to hospital or long-term care
To flex capacity • Creating extra surge capacity (including redesign of wards to provide extra beds or space to accommodate beds/trolleys. • Use of residential care home capacity to support patients awaiting a package of care start date. • Actions to expedite discharge, such as increased use of discharge lounges and discharge support. • Reduced elective work during busy periods.
To improve escalation • The renewal of all acute hospital sites' escalation plans, processes and early warning systems to divert processes.

24 In its Annual Report for 2016-17, the Health Board made clear that it intended to implement a Patient Flow 'Hearts and Minds' programme in 2017-18. The aim of this is to focus on internal processes to reduce length of stay and delays to transfers of care. To achieve this, the Health Board is focusing on embedding the SAFER flow bundle[6] to support patient flow and release bed days. It is also continuing to direct and signpost patients away from emergency departments into alternative, more appropriate pathways such as community-based services.

25 We asked NHS organisations what factors contribute to delayed discharges or transfers of care, to ascertain how well their plans seek to address the factors causing the most problem. Exhibit 3 shows that across Wales, a shortage of home

[6] The SAFER patient flow bundle is a practical tool to reduce length of stay and improve patient flow and safety. The bundle involves five elements of best practice.

S – Senior Review. All patients will have a senior review before midday by a clinician able to make management and discharge decisions.

A – All patients will have an expected discharge date and clinical criteria for discharge. This is set assuming ideal recovery and assuming no unnecessary waiting.

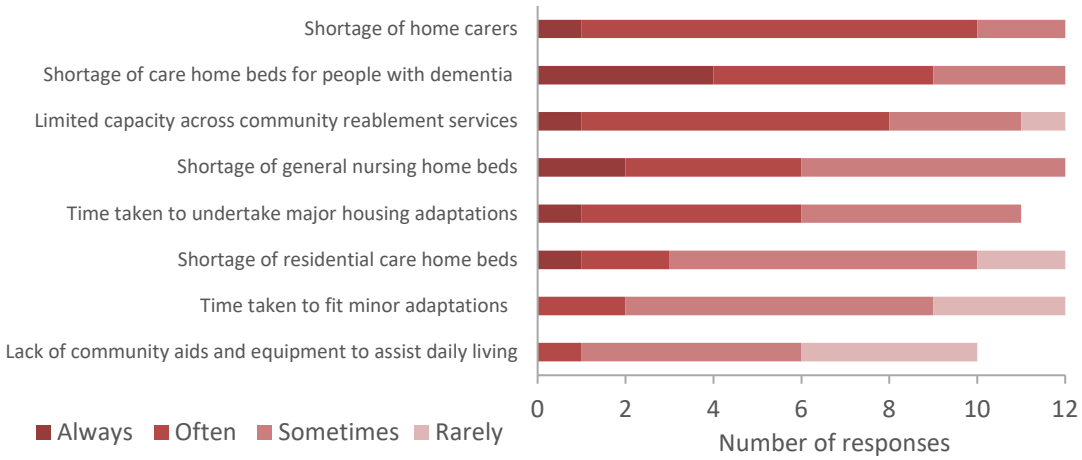
F – Flow of patients will commence at the earliest opportunity from assessment units to inpatient wards. Wards that routinely receive patients from assessment units will ensure the first patient arrives on the ward by 10 am.

E – Early discharge. A third of patients to be discharged from base inpatient wards before midday.

R – Review. A systematic multi-disciplinary review of patients with extended lengths of stay (more than seven days) with a clear 'home first' mind set.

carers, a shortage of care home beds for people with dementia, and limited capacity across community reablement services are major factors in causing delays to discharge or transfer of care.

Exhibit 3: factors contributing to delayed discharges or transfers of care across NHS organisations



Source: Wales Audit Office analysis of information on discharge planning returned by NHS bodies in 2017[7]

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

- a shortage of home carers;
- a shortage of community hospital beds;
- a shortage of care home beds for people with dementia; and
- limited capacity across community reablement services.

27 In addition, the Health Board highlighted family issues such as disputes about choice of home or financial issues, and family members being unavailable to take part in discharge planning meetings. Community service capacity, such as allocation of social workers, community nursing service provision and delays in assessment for ongoing care/aids were also cited as causing delays. Ward staff experience of working with colleagues in local authorities differed by each area. Most ward staff told us that there are good joint working arrangements with local authority colleagues, but this was not the experience of all. Patient Flow and Interface Groups have been established by the Health Board to improve patient

[7] We received responses from the seven health boards and Velindre NHS Trust. Betsi Cadwaladr and Hywel Dda University Health Boards organise discharge planning services on a locality or geographical basis and therefore we have more than one data return for these two health boards.

flow from hospital services to community services, and the WBP is working to establish a standard for responding to assessment timescales.

28 The Health Board told us that that they have reviewed the admissions process, and placed emphasis on the need for ward staff to discuss discharge needs on admission to manage patients' and families' expectations. The daily ward board rounds enable consultants, nurses and local authority staff to focus on discharge dates and focus on the actions needed to meet the estimated date of discharge.

29 Over the years, the Welsh Government has released funding streams that aim to foster greater collaboration between services, the most recent of which is the Integrated Care Fund (ICF). The ICF, introduced in 2014-15 is a pooled resource and in terms of patient flow, funds initiatives that prevent hospital admission, supports the independence of older people and reduces delayed transfers of care (DTOCs). Initially, the fund was released on a one-off basis, but in 2015-16 was changed to a recurrent fund.

30 The WBP developed a programme to transform intermediate care services in 2013, the year before the ICF was introduced. The WBP agreed to pool resources to fund the programme, and the ICF provided an opportunity to accelerate elements of the work. The main objectives of the programme are to achieve sustainable health and social services for older people, while achieving better outcomes for those receiving care. Lower costs can be realised by organisations pooling resources, and help avoid deliberations about which organisation is responsible for paying for the different elements of care.

31 The WBP's first aim was to build the foundations of a common integrated intermediate[8] service model across the three local authority areas. Whilst there is currently variability in the range of services available, a common service model remains the aspiration. The initial ICF enabled the WBF to upscale the intermediate care tier by funding additional staffing, including administrators, nurses, care home advisors and social workers for the following elements of intermediate care:

- Multidisciplinary Triage Common Access Point (CAP) – an integrated common access point that consists of a multi-disciplinary team who are able to effectively triage callers and direct them to the most appropriate service, such as urgent clinical response, reablement, or a community solution (eg housing) (see paragraph 88);
- Acute Clinical Response – a rapid clinical response (eg a doctor, nurse and/or therapist) for people who require immediate assessment, diagnosis and/or treatment who would otherwise be admitted to hospital; and
- Therapy-led intake and review reablement services – therapy-led reablement helps people to retain or regain skills that they may have lost,

[8] Intermediate care consists of interventions that address needs at a time of crisis or when people's needs change, with the aim of maximising recovery and ongoing independence.

due to hospital admission or illness, with the objective of minimising the need for ongoing domiciliary care and support;

- Support & Stay for people with dementia; and
- Step Up/Step Down intermediate reablement.

32 Since then, the ICF has also been used to:

- invest in preventative services to assist in reducing demand for acute services, in particular over the winter months;
- fund third-sector services to help maintain older people in their homes and support earlier discharge;
- fund a pilot to provide two care home beds in Neath Port Talbot Hospital with a focus on acute admission avoidance; and
- fund a joint capacity modelling exercise to determine the current capacity of community services and project future demand.

33 The standardised optimal model of intermediate care services has been active across the health board since July 2015. During this time, project plans have been developed in each local authority area to manage and monitor progress, including key milestones against the fundamental features of the model. Local progress is monitored on a regular basis by the respective Joint Partnership Boards.

34 The Health Board along with the local authority partners used the ICF in 2016 to undertake a joint capacity demand modelling exercise for community services, to inform any specific actions for seasonal pressures planning. The exercise aimed to identify gaps in current and future community services provision. The work identified that the Health Board had opportunities to reduce the length of stay of some patients and release more bed days.

35 The initial phases of the work to implement a common service platform concentrated on redesigning services and developing a consistent model across the health board. At the time of our review, staff told us that the next stages of the work needed to concentrate on embedding workforce development and strengthening partnership working with all sectors to further support integration of service delivery. Staff members told me that they did have some concerns that not all elements of the funding may continue indefinitely, and this may put in jeopardy some parts of the service.

There is scope to strengthen the discharge policy, although overall it compares well against good practice

36 The discharge process should be seen as part of the wider care process and not an isolated event at the end of the patient's stay. NHS organisations should have policies and procedures for discharge and or transfers of care, developed ideally in collaboration with statutory partners. In addition, NHS organisations should have a choice policy for those patients whose onward care requires them to move to a care home although in many areas choice may be limited.

37 We reviewed the organisation's policy on discharge and transfers of care using a maturity matrix[9]. The maturity matrix assesses 17 elements of the policy, with each element assigned a score from one (less developed) to three (well developed). Exhibit 4 shows how the Health Board's draft discharge policy scored against the maturity matrix.

Exhibit 4: Abertawe Bro Morgannwg University Health Board's performance against discharge policy good practice checklist

Elements assessed	Score	Auditor observations on the policy
Multi-agency discharge policy	3	The Discharge Policy applies to the Health Board staff only, its implementation is monitored by the Health Board's Unscheduled Care Supporting Delivery Board. The Choice of Accommodation Policy was a joint collaboration between the Health Board and the three local authority partners of the WBF, whilst there has been some input from local authority partners, there is no reference in the policy to patient/carer involvement in its development.
Policy reviewed within the last year	3	The Discharge Policy was renewed in April 2016, and is due for its next review in April 2018, and the Choice of Accommodation Policy was approved in September 2016, and is due for its next review in September 2018.
Patient/carer involvement	3	The Discharge Policy is patient focused and demands patient/carer involvement throughout the process. The Policy states that the 'patient wishes are paramount', and that patients, and with their permission, their relatives and carers must be consulted at every stage of the discharge process.
Communication	3	The Discharge Policy stresses the importance of communication and states that 'every effort must be made to take account of cultural, religious or language difference and sensory disabilities'.
Information	3	The Discharge Policy and Choice of Accommodation Policy between them detail the requirement for: • patients to be given a typed summary explaining the treatment and care received whilst in hospital; • appropriate, comprehensive information to be given to patients throughout every stage of the discharge process; • patients to be consulted throughout the process; and • a comprehensive assessment to be carried out of the patient.
Vulnerable groups eg patients who are homeless	3	The Discharge policy provides clarification of who may be considered to be vulnerable, such as people with a learning disability; who are homeless; with a physical; or sensory disability; people who have a mental illness and those who are old and frail. There are also links to extra guidance for those people with safeguarding risks and plans in place.

[9] Our maturity matrix is based on the Effective Discharge Planning Self-Assessment Audit Tool developed by the National Leadership & Innovation Agency for Healthcare in 2008.

Elements assessed	Score	Auditor observations on the policy
Early discharge planning for elective admission	2	Whilst there is no explicit reference to pre-admission assessment in the narrative. The pathways in the appendix of the Discharge Policy set out that pre-admission assessment is required for elective admissions.
Estimated discharge date set within 24 hours of admission	3	The Discharge Policy states that the estimated date and time of discharge should be undertaken with 24 hours of admission.
Avoiding Readmission	1	The Discharge Policy emphasises the need to ensure timely discharge, but there is no mention of the need to balance the risk of readmission. The Health Board is in the early stages of developing discharge to assess pathway. The pathways will need to ensure that patients have the appropriate advice and support to avoid preventable readmissions.
Local Agreements and Protocols	3	The Choice of Accommodation Policy forms part of the Discharge Policy. The policy also details process for when patients need equipment.
Assessment	3	The Discharge Policy details the requirement for an integrated nursing assessment, to be completed for each patient, with multi-disciplinary input. Assessment of NHS funded nursing care, continuing health care and/or social care needs are a part of the complex needs pathways.
Discharge from A&E	1	Does not include advice and support for patients discharged from A&E.
Discharge to care home	3	Clearly states that patients should not be directly admitted to a care home from acute hospital care. There is a discharge pathway for discharge to a care home or placement.
Links to choice of accommodation policy	3	The Discharge Policy has clear links to the Choice of Accommodation Policy, a protocol for managing patient choice when a care home is required.
Care Options	2	Contains information on care options in the patient pathways but little detail in the narrative.
Escalation processes	3	Contains clear escalation processes to ward leads, and, if appropriate, senior management support to deal with problematic discharges, to help remove/reduce potential delays.
Accessible Discharge Protocols	3	Policy contains appendices showing different flow charts for pharmacy pathway, homeless patients and a clear discharge flowchart showing simple, complex and supported pathways.

Source: Wales Audit Office review of Abertawe Bro Morgannwg University Health Board's discharge policies (Discharge Policy, April 2016 and Choice of Accommodation Policy, September 2016).

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

39 The Health Board's Discharge Policy was revised in 2016, to address findings from the NHS Wales Delivery Unit's review of discharge planning. The revised policy is a reference for discharge planning, and includes the discharge pathways. The Discharge Policy was developed, in collaboration with local authority partners.

40 Similarly, the Choice of Accommodation Policy was revised in September 2016, and was informed by the findings of the NHS Wales Delivery Unit's work. The policy sets out in detail the process and provides template discharge letters. The policy was developed in collaboration and is jointly badged with local authority partners.

41 Both the Discharge Policy and the Choice of Accommodation Policy make clear that the aim is to discharge patients to their normal place of residence, and that it is unsafe for patients to remain longer in hospital than necessary. Similarly, both policies indicate that patients will not be discharged from an acute hospital to a permanent placement in a care home.

42 Roles and responsibilities for effecting safe and timely discharge should be clearly defined in policies and procedures. This is so skills and knowledge are used to good effect and individual staff held to account for the role they play in the process. The discharge policy should set the standards for all staff responsible for discharge.

43 Our review of the Discharge Policy found that the policy clearly sets out the roles and responsibilities of professions and teams involved in discharge planning. This includes the Health Board's Chief Executive, Unit Directors, Site Managers, the Discharge Liaison Team, Lead Nurses, Charge Nurses, Ward Managers, clinical staff, discharge support staff, social workers and allied health professionals (for example therapies staff).

There are a number of discharge pathways in place, however, links between generic and specific pathways are unclear and they are not clearly set out in the discharge policy

44 Hospital discharge planning should be seen as a continuous process that takes place seven days a week. Although not all staff involved in planning a patient's discharge will be available all of the time, communication, planning and co-ordination should continue. Defined discharge pathways that set out the sequence of steps and timing of interventions by healthcare professionals for defined groups

of patients, particularly those with complex needs, can help ensure patients experience a safe and timely discharge.

45 As part of our work, we looked at the main discharge pathways in place. We assessed the extent to which there was clarity of purpose and use across the organisation, whether pathways were developed with local authority partners, supported by algorithms and standardised documentation and measures of quality.

46 We found that the Health Board uses three generic discharge pathways: self, simple and complex, as well as a number of specific pathways. The specific pathways focus on particular aspects of the discharge process, such as when equipment is required, discharge is to a care home, or a new or the restart of a package of care is required. We reviewed the three generic pathways against the criteria set out in Exhibit 5. This shows that the Health Board's discharge pathways are generally comprehensive, when assessed against a range of criteria, but there is scope for improvement.

Exhibit 5: elements presented within the Abertawe Bro Morgannwg University Health Boards generic discharge pathways

Elements	Pathway	
	Simple	Complex
Flow diagram/decision tree for identifying appropriate patients	Yes	Yes
Specific discharge destination, eg usual place of residence	Yes – provided in the supplementary pathways	Yes – provided in the supplementary pathways
Clear purpose	Yes	Yes
Generic or condition specific pathway	Generic	Generic
Transport or transfer logistics clearly acknowledged	Yes – provided in the supplementary pathways	Yes – provided in the supplementary pathways
Applies across all hospital sites	Yes	Yes
Applies 24 hours a day, 365 days per year	Unclear	Unclear
Developed with NHS partners, eg neighbouring LHBs, WAST or Velindre	No	No
Developed with local authority partners and applies equally across partners	Yes	Yes
Supported by generic discharge documentation	No	No
Supported by generic assessment documentation	No	No

Elements	Pathway	
	Simple	Complex
Referral processes are clear	No	No
Agreed standards for response times for assessing need	Yes	Yes
Agreed standards for response times for service delivery	Yes	Yes
Agreed standards for quality and safety	No	No
Standards for information sharing with clinical/care staff in the community, eg discharge letters	No	No

Source: Wales Audit Office review of Abertawe Bro Morgannwg University Health Board's discharge pathways

47 The Health Board provides a flow chart for each of the three generic pathways in its discharge policy. All three pathways, however, are set out on one page, which means that it is difficult to understand whether some text relates to one or all three pathways.

48 The specific discharge pathways provide helpful detail of discrete parts of the discharge process (such as when equipment is required). However, links between the generic and specific pathways are largely absent. Confusingly, one of the specific discharge pathways is for simple discharges (but with more detail than on the generic version of simple discharge). We did not review any of the specific pathways.

49 The Health Board was unable to confirm how many generic and specific pathways the organisation operated. This suggests that the Health Board may benefit from reviewing all of the discharge pathways in existence and without losing any of the detail, consider rationalising the number, and making clearer the links between each of the pathways. In addition, whilst there are discharge pathways provided in the discharge policy, it does not appear that the policy provides a comprehensive set. The Health Board told us there was an inter-hospital transfer pathway, a repatriation policy, a hospice at home policy, and a number of condition specific pathways but none of these are included in the Discharge Policy.

50 Some staff found the number of discharge pathways confusing, because there were so many different pathways. They told us the complications arise from discharging patients to different areas of the Health Board and to other health board areas.

51 The conventional approach to discharging patients, particularly the frail elderly, is to complete a series of ward-based assessments to identify the kind of support needed at home. These assessments are completed typically after the patient is declared 'medically' fit for discharge. Once assessments are completed, patients

are then discharged when all appropriate support services or other resources are in place, which may take a significant amount of time. This is known as the 'assess to discharge' pathway or model.

52 The Welsh Government has been encouraging a 'discharge to assess' pathway or model.[10] [11] This is where patients are discharged home once they are 'medically' fit for discharge and no longer need a hospital bed. On the day of discharge, members of the appropriate community health and social care team will then assess the patients' support needs at home. This enables patients to access the right level of home care and support in real time, and removes the need for patients to be inappropriately kept in a hospital bed while waiting for assessments and services to be put in place.

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

54 At the time of our review, the Health Board informed us that they were developing discharge to assess pathways. The four hospitals are developing their own pathways, rather than a Health Board-wide approach. The Health Board's Unscheduled Care Supporting Delivery Board is encouraging active participation in production of the pathways and wants the hospitals to actively use them. The Health Board has recognised that there are barriers to overcome to increase the use of the discharge to assess model; namely cultural attitudes to avoiding (appropriate) risk taking and the availability of sustainable and responsive capacity in the community.

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

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

The Health Board has dedicated resources to support discharge planning and is training staff in the discharge process but there is scope to increase staff confidence so they discharge patients in a timely manner

Dedicated multidisciplinary resources are in place in hospitals to support discharge planning, but operate on weekdays only

The Health Board has a discharge team in each of the four district general hospitals but these are available weekdays only and practice varies across hospitals

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

56 We sought information from each NHS organisation about whether they operate discharge liaison services and the scope of the services remit. Across Wales, we found that all NHS organisations, with the exception of Velindre NHS Trust, run one or more discharge liaison teams. All teams operate during weekday office hours only, with the latest finishing time at 5.30 pm. Seven out of the 15 teams reported that they manage both simple and complex discharges.

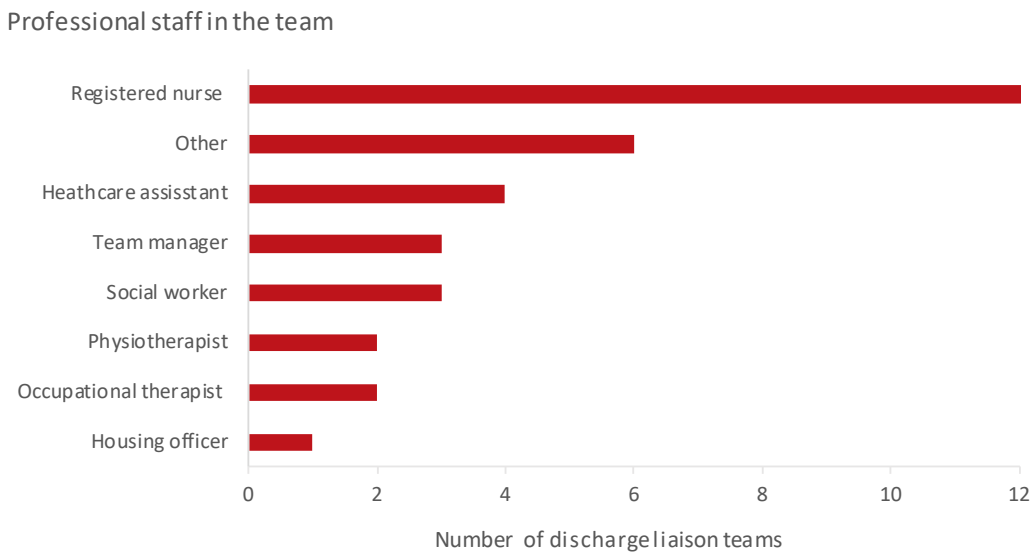
57 The Health Board operates a separate discharge liaison service (discharge team) at each of the four main hospitals on weekdays only. The operating hours are:

- Morriston Hospital – 8 am to 4 pm.
- Neath Port Talbot Hospital – 9 am to 5 pm.
- Singleton Hospital – 8.30 am to 4.30 pm.
- Princess of Wales Hospital – 9 am to 5 pm, with cover to 8 pm on three days a week.

58 The Health Board acknowledges that challenges in discharging patients at the weekend cause further pressures on the system, but that services that the complex discharges rely upon, eg social services, also operate on weekdays only.

59 Typically, discharge liaison teams are made up of nursing staff, but to better manage complex discharges, ideally, teams should be multidisciplinary. Exhibit 6 shows the different professions within discharge liaison teams across Wales. The data shows fewer than half the teams are multi-disciplinary with most teams nurse led. Discharge liaison teams range in size from two whole-time equivalent (WTE) staff to 29 WTE staff with bigger teams working across multiple hospital sites. The average number of WTE staff per team was seven.

Exhibit 6: different professional staff deployed across discharge liaison teams at 30 September 2016



Source: Wales Audit Office analysis of information collected on discharge liaison teams, 2017[12]

60 Nurse Directors are responsible for overseeing the discharge team in their respective hospital site. Each discharge team operates differently. Exhibit 7 provides a summary of each discharge team's management arrangements, staffing mix and responsibilities.

[12] The seven health boards in Wales operate discharge liaison teams. Three health boards – Abertawe Bro Morgannwg, Hywel Dda and Betsi Cadwaladr University Health Boards – operate separate teams for each hospital site. We received 15 data returns from discharge liaison teams although not all data returns were complete. Other staff includes, for example, administrative staff and pharmacists.

Exhibit 7: Abertawe Bro Morgannwg University Health Board's discharge team management arrangements and team composition at Morriston Hospital

Discharge team management arrangements and team composition	
Morriston Hospital	
Operational Management	• Via the Hospital-wide Emergency Care and Hospital Operations Team.
Staff mix	• 2.0 WTE Discharge Liaison Nurses. • 1.0 WTE additional Discharge Liaison Nurse is jointly funded between Morriston Hospital and the Primary and Community Services Delivery Unit to support the 'pull of patients' from the hospital into community reablement services in Swansea. • Co-located with social workers.
Specialties covered	• All specialties.
Type of hospital discharges managed or co-ordinated	• Manages some of the complex hospital discharges.
Neath Port Talbot Hospital	
Operational Management	• Via the Head of Patient Flow Senior Matron.
Staff mix	• 3.0 WTE Discharge Liaison Nurses.
Specialties covered	• Covers the four inpatient medical/care elderly wards (excludes the neuro-rehabilitation ward).
Type of hospital discharges the discharge team manages or co-ordinates	• Manages all complex hospital discharges.
Princess of Wales Hospital	
Operational Management	• Via the Head of Patient Flow Senior Matron.
Staff mix	• 3.0 WTE Discharge Liaison Nurses – each dedicated to a number of wards. • 1.6 WTE Healthcare Assistants/Support Workers.
Specialties covered	• All specialties other than paediatrics.
Type of hospital discharges the discharge team manages or co-ordinates	• Manages all complex hospital discharges.
Singleton Hospital	
Operational Management	• Via the Lead Nurse for Patient Flow.
Staff mix	• 1.4 WTE Discharge Liaison Nurses. • 2.8 WTE Healthcare Assistants/Support Workers.
Specialties covered	• All specialties.

Discharge team management arrangements and team composition	
Morriston Hospital	
Type of hospital discharges the discharge team manages or co-ordinates	• Manages both complex and simple hospital discharges.

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

61 The Health Board told us the challenge was to see how to make the best use of discharge teams to facilitate discharge, but without deskilling ward staff. The combined cost of 13 of the 15 discharge liaison teams across Wales totalled £2.9 million with individual team costs ranging from £43,000 to £692,000. At the Health Board, the cost of three of the four discharge liaison teams was £515,000 between October 2015 and September 2016, compared with the average cost per discharge liaison team in Wales of £244,000.

62 As well as the investments made by the Health Board using the ICF (see paragraphs 29 to 35) and the actions set out to respond to winter pressures (see Exhibit 2), the Health Board appointed additional patient flow navigators and co-ordinators in autumn 2016. The extra staff are working in emergency departments to redirect non-urgent cases to alternative, more appropriate services.

63 Gaps in information on staffing, activity and service costs make it difficult to establish the relative value for money of the discharge liaison teams between or within NHS organisations. Only four of the 15 discharge liaison teams across Wales provided the information that we requested. Based on the information provided by these four teams, we compared the number of discharges with the WTE number of staff. The number of discharges per WTE staff ranged from 50 discharges to 250; the average was 117 discharges per WTE staff. The Neath Port Talbot team managed 50 discharges per WTE staff while the Princess of Wales team managed 72 discharges per WTE staff. We do not have information on the number of discharges managed by the other two discharge liaison teams to provide full comparative information.

64 Three of the hospitals evaluated or reviewed the work of their discharge teams in 2016. At the time of our review, Singleton Hospital had not reviewed their service because the service had only been in operation for six months.

65 We asked discharge liaison teams to describe how frequently they carried out a range of activities to support discharge planning. Appendix 4 shows a summary of the types of activities carried out by discharge liaison teams across Wales. At the Health Board:

- Morriston Hospital Discharge Liaison Service told us they often carry out each of the activities listed (see Appendix 4), with the exception of offering housing options advice and signposting families to advice for maintaining independence at home which they told us they sometimes undertake;

- Neath Port Talbot Discharge Liaison Service told us they always or often carry out each of the activities, with the exception of providing housing options advice, which they told us they never provide;
- Princess of Wales Hospital Discharge Liaison Service told us they always or often carry out each of the activities with the exception of offering housing options advice which they told us they sometimes undertake; and
- Singleton Hospital Discharge Liaison Service told us they always carried out each of the activities.

66 The range of activities undertaken by the discharge services compares favourably with our findings across Wales.

Discharge lounges are available at Morriston and Princess of Wales Hospitals, but operate weekdays only

67 A discharge lounge can also support effective discharge planning and patient flow by providing a suitable environment in which patients can wait to be collected by their families or by hospital transport. Thus releasing beds promptly for other patients being admitted. Some patients may also be sent to the lounge whilst they wait for medication to be dispensed.

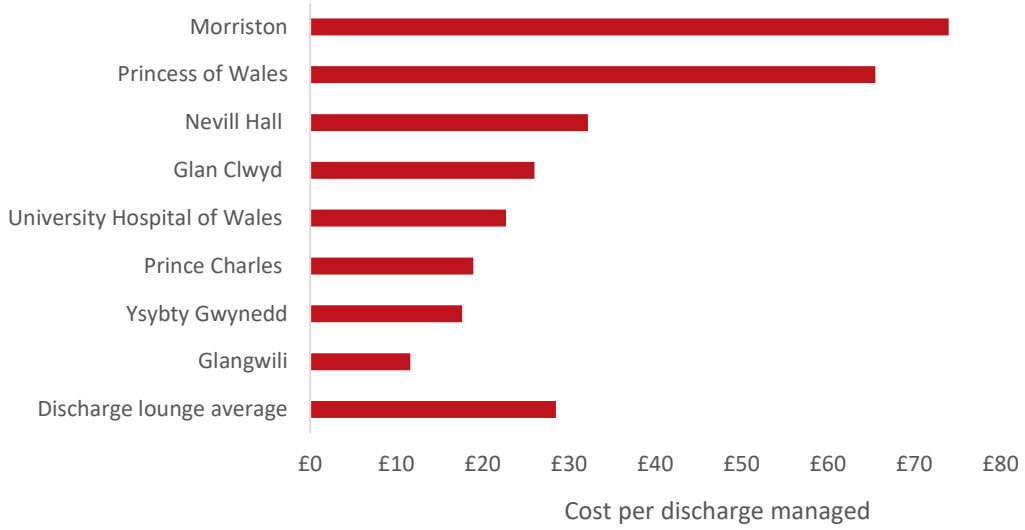
68 We asked NHS organisations about their discharge lounge facilities. Across Wales, we found that all health boards, except Powys, operate discharge lounges in their acute hospitals. At the time of our audit work, discharge lounges had capacity to support 192 patients awaiting discharge; the average capacity per discharge lounge was 11. Across Wales, discharge lounges operate for between eight and 12 hours on weekdays and are generally staffed by registered nurses and healthcare support workers. There are also food and toilet facilities available for patients.

69 The Health Board operates a discharge lounge at Morriston Hospital and Princess of Wales Hospital. Both discharge lounges operate on weekdays (excluding bank holidays). The Morriston Hospital discharge lounge operates from 8 am to 6 pm while the Princess of Wales Hospital discharge lounge operates from 8 am to 7 pm. The discharge lounges can each accommodate 12 patients respectively. Between October 2015 and September 2016, just under 1,900 discharges were managed through the Morriston Hospital discharge lounge, and just over 1,900 patients were managed through the Princess of Wales discharge lounge.

70 We also requested information on staffing, costs and activity for discharge lounges. The information from NHS bodies was more complete than that for the discharge liaison teams. The number of staff deployed across hospital discharge lounges ranges from less than one WTE to five WTE staff; the average was three WTE staff. The combined cost for 12 of the 14 discharge lounges totalled £1 million between 1 October 2015 and 30 September 2016 with individual service costs ranging from £25,000 to £139,000. At the Health Board, the respective costs for the discharge lounges at Morriston Hospital and Princess of Wales Hospital were £139,000 and £126,000 compared with the Wales average of £86,600.

71 Exhibit 8 shows the variation in the cost per discharge supported by discharge lounges, which ranged from £12 to £74 per discharge. The cost per discharge was £74 at Morriston Hospital, and £65 at Princess of Wales, compared with the discharge lounge average of £28.50.

Exhibit 8: comparison of the cost per discharge managed by individual discharge lounges between 1 October 2015 and 30 September 2016

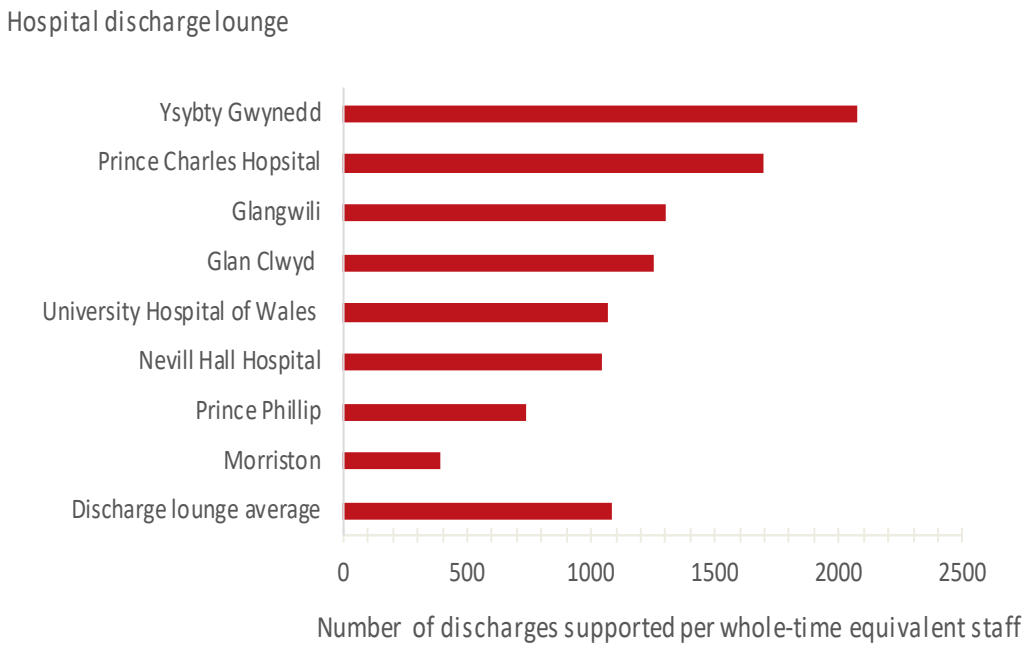


Source: Wales Audit Office analysis of information collected on hospital discharge lounges, 2017[13]

72 Again, we compared the number of discharges supported through the discharge lounge with the WTE number of staff. Based on the information provided by eight of the 14 discharge lounges, the number of discharges per WTE staff varied between 1 October 2015 and 30 September 2016 from just under 400 per WTE staff to just over 2,000 per WTE (Exhibit 9). At Morriston Hospital, the discharge lounge supported 391 discharges per WTE staff compared with the Wales average of 1,086 discharges per WTE staff. We are unable to calculate the figures for Princess of Wales.

[13] We received information from 14 discharge lounges but only eight returns provided all relevant information to compare costs per discharge from the discharge lounge.

Exhibit 9: Number of discharges per whole-time equivalent (WTE) staff supported through hospital discharge lounges between 1 October 2015 and 30 September 2016



Source: Wales Audit Office analysis of information collected on hospital discharge lounges, 2017 (See Footnote 13)

73 Singleton and Neath Port Talbot Hospitals, whilst not operating formal discharge lounges (ie with dedicated staff), do operate informal lounges using available space on one or more wards. These are dependent on there being enough staff available on these wards to support any additional patients waiting for discharge.

Staff training has been rolled out to increase awareness of new policies and pathways and the Health Board recognises it needs to address staff confidence to ensure safe and timely discharge

74 Generally, responsibility for assessment and discharge planning rests with the ward team. Ward staff should be engaged in the discharge planning process and see it as part of the care continuum with ward staff and operational managers held to account for effective discharge planning. This should be supported by clear awareness of policies and pathways, access to appropriate levels of training, and a good awareness of the range of services available to support discharge.

Staff training has been provided on new discharge policies and pathways

75 Refresher training on discharge planning has been provided to staff, to highlight changes made in the Health Board in response to recent discharge planning reviews, but the Health Board cannot confirm how many staff have attended.

76 As part of our audit work, we met with a group of nursing staff to talk about a range of issues related to discharge planning. They highlighted that measures to improve escalation procedures had been positive. They were clear who they needed to refer escalation matters to. This is helped by each hospital having a senior Patient Flow Manager available seven days a week, supported by an on-call manager.

77 Front line staff should receive regular training appropriate to their role in the discharge process. This training should be part of both induction programmes, and regular specific updates, particularly where related policies rely on assessment and care planning. Ideally, training is provided on a multi-agency and or multi-professional basis to ensure discharge planning is everyone's business.

78 Exhibit 10 shows that across Wales, only half of NHS organisations include discharge planning in nurse induction programmes and offer regular refresher training. The Health Board told us that they do not include discharge planning in their induction training for nursing, medical, physiotherapy or occupational therapy staff. However, refresher training on the discharge process is provided annually for nursing and medical staff, and biennially for physiotherapy and occupational therapy staff.

Exhibit 10: Availability of training on discharge planning for nursing staff

NHS organisation	Training on discharge planning included in induction programmes for new starters	Refresher training on discharge planning provided regularly[1]
Abertawe Bro Morgannwg	**No**	**Yes**
Aneurin Bevan	No	No
Betsi Cadwaladr (hospitals)		
• Ysbyty Gwynedd	Yes	Yes
• Wrexham Maelor	Yes	Yes
• Glan Clwyd	Yes	No
Cardiff and Vale	No	Yes
Cwm Taf	No	Yes
Hywel Dda (county teams)		
• Pembrokeshire	Yes	No
• Ceredigion	No	No
• Carmarthenshire	No	Yes
Powys	No	No

NHS organisation	Training on discharge planning included in induction programmes for new starters	Refresher training on discharge planning provided regularly[1]
• Velindre	Yes	Yes
[1]Refresher training is provided at least annually or biennially for nursing staff		

Source: Wales Audit Office analysis of information on discharge planning returned by NHS bodies in 2017 (See Footnote 8)

79 Training on the discharge process is generally led by Discharge Liaison Nurses. Training undertaken since the NHS Wales Delivery Unit's review in 2016 has highlighted findings from the review, including case studies and has been supported by the NHS Wales Delivery Unit. The training has included the revisions to policies, such as the Discharge Policy and the Choice of Accommodation Policy. Staff from other organisations with a role in the discharge process are welcome to attend discharge training events. The Health Board was unable to provide us with the percentage of Health Board staff that had attended the most recent training.

There is a greater focus on discharge planning and some positive changes have been made, but there remain barriers to ensuring timely discharge, and staff confidence needs to be addressed

80 In its review, the NHS Wales Delivery Unit found a culture of risk aversion across Wales with staff speaking openly of a 'cwtch' culture[14] and insufficient time dedicated to managing the discharge process. The NHS Wales Delivery Unit's reports for each of the four hospitals all highlighted examples of multi-disciplinary teams (predominantly nurses and social workers) waiting to plan discharge until patients were deemed medically fit, extending the stay unnecessarily for some patients.

[14] The Delivery Unit described a 'cwtch' culture (cwtch is the Welsh word for hug) whereby some staff were reluctant to discharge patients to their own home because they thought patients might be at risk. Whilst staff may be acting out of kindness, they may not be acting in the patients' best interest.

81 During our fieldwork, some ward staff told us that that they continue to struggle to find the time to manage the discharge process. Some ward staff indicated that because discharge teams can deal with so many discharges, that this can lead to disempowering or de-skilling ward staff. Some ward staff also indicated that despite nursing staff feeling that the patient was ready for discharge, there were outside factors that delayed discharge, including:

- for patients transferred from another hospital, the discharge process not being initiated in the first hospital.
- some consultants being risk adverse, and delaying discharge.
- consultants not being available to sign off patients as ready for discharge on weekends.
- whilst, generally, there are good working arrangements and communication between nursing staff and social workers, some nursing staff expressed frustration that social workers will not agree an assessment date until the patient is medically fit for discharge. This results in a delay before assessment and a further delay waiting for actions to be put in place to enable the patient to be discharged.

82 The Executive Team at the Health Board highlighted staff confidence as one of their challenges to address in 2017-18. The Health Board is eager to encourage staff to be less risk-averse and to take the time to understand what matters to patients. However, staff remain worried about making the wrong decision and the Health Board's management team recognise that this may be because they need further support and encouragement. The patient flow teams are empowered to challenge decisions to keep patients in hospital when it is appropriate to discharge them.

83 The NHS Wales Delivery Unit found limited evidence in patient records that patients' expectations of discharge were discussed with them. Whilst this was not a factor identified in the Health Board's NHS Wales Delivery Unit reports, they did highlight that whether a discharge was likely to be simple or complex was not generally recorded early in a patient's stay. This omission can lead to delays in discussing expectations of outcomes with patients.

84 Since the NHS Wales Delivery Unit review, the Health Board's revised discharge policy sets out clearly the expectation that the estimated date of discharge must be recorded and updated daily. Ward staff told us that they regularly held meetings with patients, and where appropriate carers and families to keep them informed of expectations of discharge. The Health Board told us that discussions about discharge must begin early with patients. The discharge policy sets out that patient and carer involvement is considered an essential element of discharge planning and patient choice. Health-Board-wide patient and family information has been redesigned to support ward staff in implementation of the policy.

85 In 2017-18 the Health Board is encouraging wards to implement the 'End Pyjama Paralysis' initiative. The initiative focuses on encouraging patients in hospitals, where possible, to stop wearing their pyjamas or hospital gown when they do not

need to. The reason being, wearing pyjamas for many patients reinforces the ‘sick role’ and can prevent a speedier recovery.

Information about community services is available, but differences between each local authority area cause some confusion, however, the Health Board is taking steps to increase staff awareness of the services available in each area

86 Having a good understanding of the range and capacity of community health and social care services is an important part of ensuring timely discharge. Health bodies should hold up-to-date information about the availability of community services that can help patients once they have been discharged. These services can be available through NHS organisations, local authorities and third-sector organisations. We asked health bodies the types of information they collated on community services. Exhibit 11 shows that few organisations compile information about community services provided by other NHS organisations and housing options. In addition, relatively few collate information about waiting times for needs assessment and waiting times before services commence.

Exhibit 11: Number of health bodies who reported collating a range of information on community services

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

Source: Wales Audit Office analysis of information on discharge planning returned by NHS bodies in 2017 (See Footnote 8)

87 At the Health Board, the Primary and Community Services Delivery Unit is responsible for collating information on the community services available. The information collated includes the range of services provided by the Health Board, social care services, the third sector and the independent sector (care homes).

Information on each service includes the availability, eligibility criteria and the referral process. The information is updated regularly (some daily, some weekly). The Health Board does not collate information about the estimated waiting time for assessment or for a service to commence, information about community services provided by other NHS bodies or what housing adaptions are available. None of the data is available electronically, but the Health Board told us they hope that the Welsh Community Care Information System[15] will help enable much of this information to be available electronically in one place.

88 The Health Board told us that their discharge teams were well sighted on the range of community services available and are able to provide support and guidance to ward staff with less knowledge of the services available. However, some staff we spoke to told us that the differences between the community services available across the Health Board can cause difficulties for ward staff to understand what help may be available to a patient, depending on where they live. Hospital staff are encouraged to refer patient discharge needs to the CAP, to allow the Community Resource Team to match individual patient needs with community services.

89 We asked ward staff about their knowledge of the range of community services to support patients on discharge. The ward staff told us about 'speed-dating' sessions held in 2016, which included Welsh Ambulance Services NHS Trust staff, hospital services staff and community services staff to improve the collective understanding of changes to pathways, models of care and the range of community services available.

Arrangements for monitoring, reporting and scrutinising discharge planning are generally effective

There are clear lines of accountability for discharge planning, with regular scrutiny of performance both strategically and operationally

90 If arrangements are to be effective, there needs to be clear lines of accountability, and regular scrutiny of discharge planning performance. This is important to ensure there is a sustained focus to improve discharge processes and to maintain patient flow through hospitals.

[15] The Welsh Community Care Information System is a computer system being introduced in Wales to be used by all health boards and local authorities. The system will allow staff involved in community social and healthcare work to record and access information about the treatment that patients are receiving from the differing services.

91 Operational responsibilities for discharge planning are set out in the discharge policy. Discharge planning is the responsibility of all ward staff and there are escalation mechanisms that all ward staff can access set out in the Discharge Policy and the Policy for Management of Safety and Flow Board Rounds. Ward teams are supported by the Delivery Unit's Discharge Team.

92 Ward Sisters and Charge Nurses are responsible for ensuring that the ward rounds are held at least on a daily basis (see footnote 5). The Policy for Management of Safety and Flow Board Rounds sets out that attendees to the ward round should be multi-disciplinary to focus on the tests, assessments, inputs needed by each patient. The meeting looks at what steps could be taken to free up a bed by dealing with blockages. The estimated date of discharge and the discharge-fit date are recorded and updated on a daily basis for all patients. The information is recorded on a white board in the ward to focus staff attention on the estimated discharge dates for each patient. Discharge is led by ward staff and/or the discharge teams.

93 Each hospital holds bed management meetings at least twice a day to identify the number of beds likely to become free that day, and to discuss any issues. This meeting is attended by bed managers and patient flow team members. These meetings enable timely escalation to Lead Nurses and when appropriate to the Delivery Unit's Nurse Director, Medical Director and Service Director. Escalation processes are in place to advance individual cases. Staff told us that they thought that the accountability arrangements within each Hospital were clear.

94 Each hospital holds weekly trigger meetings with the local authority, and representatives from primary and community care services at which performance is discussed to assist with pathway issues identified in community hospitals and/or community services.

95 The Health Board has the following groups to discuss discharge planning:

- Unscheduled Care Supporting Delivery Board – comprises the Chief Operating Officer, the Director of Nursing, a hospital Delivery Unit Director (representing all hospital Delivery Units), the Primary Care and Community Services Delivery Unit Director, the Mental Health and Learning Disability Services Director and representatives from Informatics, the 111 Service, GPs and the Welsh Ambulance Service NHS Trust; and
- Community Services Board – comprises the Heads of Social Services for each of the three local authorities, the Health Board's Chief Operating Officer, Directors from the hospital Delivery Units, the Primary Care and Community Service Delivery Unit and the Mental Health and Learning Disability Services and representatives from the Third Sector.

96 In 2017, the Health Board established a Capacity Redesign Workstream as part of the Health Board's programme to identify financial savings whilst improving or at least maintaining service quality. The work undertaken to review the capacity of community services identified that the Health Board had opportunities to reduce the length of stay of some patients and release more bed days. The Capacity

Redesign Workstream has been established to manage a programme to reduce lengths of stay and identify further opportunities to increase capacity.

97 The Health Board told us that reports on unscheduled care and patient flow performance are presented to the Quality and Safety Committee usually twice a year. Community data is also reviewed at the three Joint Partnership Boards and fed into the Community Services and Planning group.

98 In recognition of an absence of a committee to consider all performance-related matters, the Health Board created a new board committee in 2017, the Performance and Finance Committee. The Committee has met twice in 2017, and work is progressing within the Health Board to refine the remit of each of the board committees to ensure there is no overlap or gaps in the areas each committee is responsible for. The Performance and Finance Committee is expected to receive reports on performance relating to discharge and patient flow once the purpose of the Committee has been fully established.

99 As part of our 2016 structured assessment work, we asked board members across the seven health boards and Velindre NHS Trust the extent to which they agreed with a number of statements about patient flow and discharge planning. Our board member survey found that at the Health Board, 12 of the 15 (80%) board members responding agreed or strongly agreed that the Board and its committees regularly scrutinise the effectiveness of discharge planning. This compares to 56% across Wales.

100 As good discharge planning relies on partner organisations working together, as well as internal challenge, joint scrutiny arrangements should also be in place. Work undertaken via the Community Services Board has established jointly agreed performance measures and objectives for each local authority area that relate to flow across the whole health and social care system. Monitoring of performance takes place on a monthly basis through the Community Services Board. The WBP has a Leadership Group and the Health Board and each local authority each take responsibility for elements of the programme of work.

The Health Board uses a range of information to support timely scrutiny of patient flow, but could incorporate data that is more specific to discharge planning when reporting to board committees

101 Having the right information on discharge planning performance is crucial for both monitoring and reporting. Delayed transfers of care is the only national measure, for both NHS organisations and local authorities, and as such is regularly monitored, reported and scrutinised. There are no other national measures related to discharge planning, and information about the quality and effectiveness of discharge planning is not readily available.

102 However, to understand delays in discharging patients from hospital, good practice dictates that NHS organisations should have a suite of performance measures, including information about patients' experience and outcomes from the discharge process. These can be a mixture of hard and soft measures.

103 As part of our review, we looked at the type of performance information reported to operational groups and the Board or its sub-committees which helps inform discharge planning performance and how well patients are flowing through the hospital system. Exhibit 12 sets out the performance indicators and updates reported to the Board at the Health Board.

Exhibit 12: range of performance information reported to the Abertawe Bro Morgannwg University Health Board during 2016-17

Discharge planning	Patient flow
• Number of delayed transfer of care delivery per 10,000 population – mental health (all ages). • Number of delayed transfer of care delivery per 10,000 population – non mental health (aged 75+). • Percentage of completed discharge summaries.	• Percentage of patients waiting more than one hour for an ambulance handover (target is zero). • Percentage of patients spending 12 hours or more in an Emergency Department (target is zero). • Percentage of new patients spending no longer than four hours in an Emergency Department (target is 95% spend less than four hours). • Percentage of patients who had their procedure postponed on more than one occasion and then had their procedure within 14 days or at the patient's earliest convenience. • Number of inpatient falls. • Number of cancelled operations.

Source: Wales Audit Office review of papers presented to the Board at Abertawe Bro Morgannwg University Health Board

104 All wards have access to electronic dashboards providing data (updated every 24 hours) on performance which includes the number of bed days lost and number of patients awaiting transfer.

105 Performance information is collated in reports setting out trend performance and includes a narrative setting out a brief summary of how each hospital site and the Health Board as a whole is performing, actions that are being undertaken and any risks associated with performance. Information presented to the Board committees tends to be collated at Health Board level, but narrative summaries of individual hospital sites are included.

106 In response to our board member survey:

- 13 of the 15 (87%) board members responding agreed that they received sufficient information to understand the factors affecting patient flow, compared to the all-Wales average of 75%; and
- 13 of the 15 (87%) board members responding agreed or strongly agreed that they understood the reasons for delays in discharging patients from hospitals within my organisation, compared to the all-Wales average of 82%.

107 Further information that would prove helpful to understand discharge planning performance in particular but not currently reported to the Board at Abertawe Bro Morgannwg University Health Board includes;

- the number and percentage of patients who have an estimated discharge date;
- readmissions within 28 days of discharge from hospital;
- percentage of discharges before midday;
- percentage of unplanned discharge at night; and
- percentage of discharges within 24 hours and 72 hours of being declared 'medically fit'.

108 We asked NHS organisations what information could be captured on their patient administration systems. Exhibit 13 shows that most organisations' patient administration systems have the ability to capture a range of data to aid discharge planning. However, less than half can record whether the discharge is simple or complex.

Exhibit 13: data fields on NHS organisations' patient administration systems related to the discharge process

Data fields on patient administration systems related to the discharge process	Number of NHS organisations responding positively
Expected date of discharge	12
Date of discharge from hospital	12
Time of discharge from hospital	12
Discharge destination eg home, residential, care home, etc.	12
Date the patient was declared medically fit for discharge	8
Whether the discharge is simple or complex	5

Source: Wales Audit Office analysis of information on discharge planning returned by NHS bodies in 2017 (See Footnote 8)

109 The Health Board told us that they electronically record admission and discharge dates, anticipated dates of transfers, estimated discharge date and discharge-fit dates to support bed management and discharge planning.

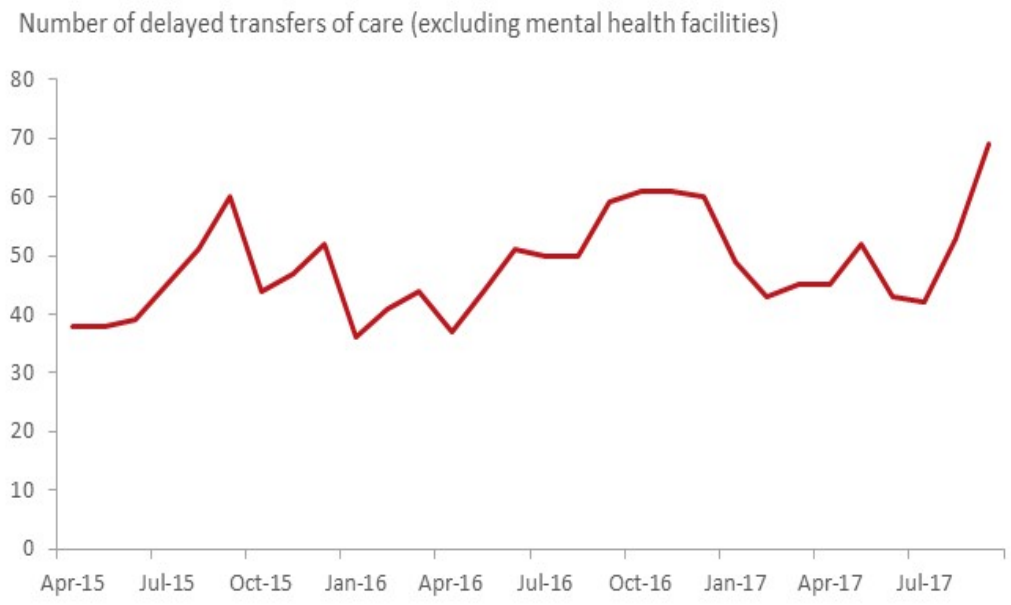
Performance relating to lengths of stay and waits in Emergency Departments are showing signs of improvement, but there is more to do to reduce delays in transfers of care

110 The NHS Wales Delivery Unit undertook their review of discharge planning at the Health Board in October and November 2015. In addition, in 2016, Internal Audit undertook a review to provide assurance that discharge planning processes were in place across hospital sites in the Health Board. Since then the Health Board has taken a number of steps to address the findings of these reviews, including:

- investing in Patient Flow Teams in each of the four hospitals. The Patient Flow Teams look at all parts of the patient pathway to improve efficiency. Each of the discharge teams either work within the Patient Flow Teams, or alongside them;
- a SAFER flow policy has been developed (see paragraph 24), and is being embedded across the Health Board;
- the Discharge Policy and the Choice of Accommodation Policy were revised in 2016 (see paragraphs 39 and 40);
- the development of Health-Board-wide pathways in some areas (ie Hospice at home);
- using the ICF to enhance community services to support admission avoidance and earlier discharge of patients (see paragraphs 29 to 34);
- holding workshops across the Health Board in order to inform staff of the findings, and provided training to staff on the revised discharge policy and pathways; and
- taking steps to ensure that the estimated date of discharge and whether a discharge is anticipated to be simple or complex is recorded on admission and reviewed throughout the patient stay.

111 Exhibit 14 shows fluctuations in the monthly number of DTOCs over the last two years with the number of DTOCs rising. The total number of DTOCs (excluding those in mental health facilities) increased by 14% from 535 in 2015-16 to 610 in 2016-17 with the proportion of patients delayed by seven or more weeks increasing (Exhibit 15).

Exhibit 14: trend in delayed transfers of care at Abertawe Bro Morgannwg University Health Board (excluding mental health facilities) between April 2015 and September 2017



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

Exhibit 15: change in number of delayed transfers of care (excluding mental health facilities) by length of delay between 2015-16 and 2017-18

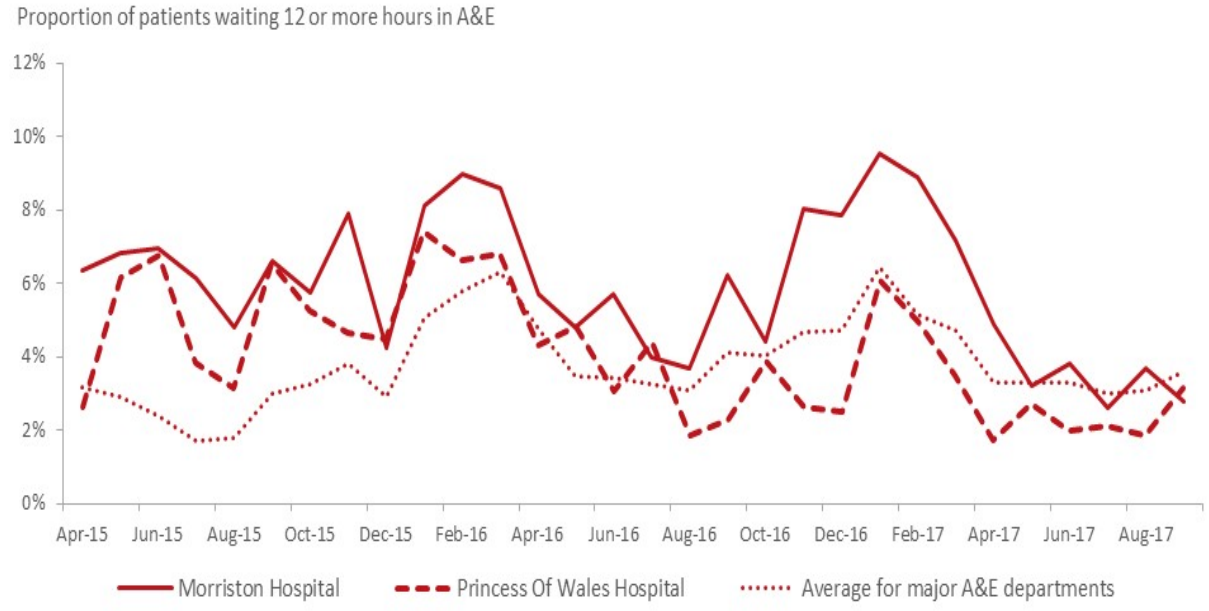
Length of delay	Number of delayed transfers of care (DTOC)		
	2015-16 (April – March)	2016-17 (April – March)	2017-18 (April – September)
0-3 weeks	160	146	96
4-6 weeks	219	233	105
7-12 weeks	96	140	64
13-26 weeks	50	77	34
26+ weeks	10	14	5
Total DTOCs	535	610	304

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

112 No patients should wait more than 12 hours in accident and emergency (A&E) departments to be admitted, transferred or discharged. Patients waiting 12 or more

hours in A&E are often indicative of problems with patient flow. Exhibit 16 compares the proportion of patients waiting 12 hours or more at the Health Board's major A&E departments with the Wales average over the last two years. Neither Morriston's nor Princess of Wales' A&E department achieved the target of zero patients waiting 12 or more hours over the last two years, with performance at Morriston Hospital comparatively worse. There are signs of improvement despite the small rise (2%) in A&E attendances between 2015-16 and 2016-17. The number of patients waiting 12 hours or more at the Health Board's major A&E departments reduced by 14% between 2015-16 and 2016-17 compared with a 23% increase across Wales.

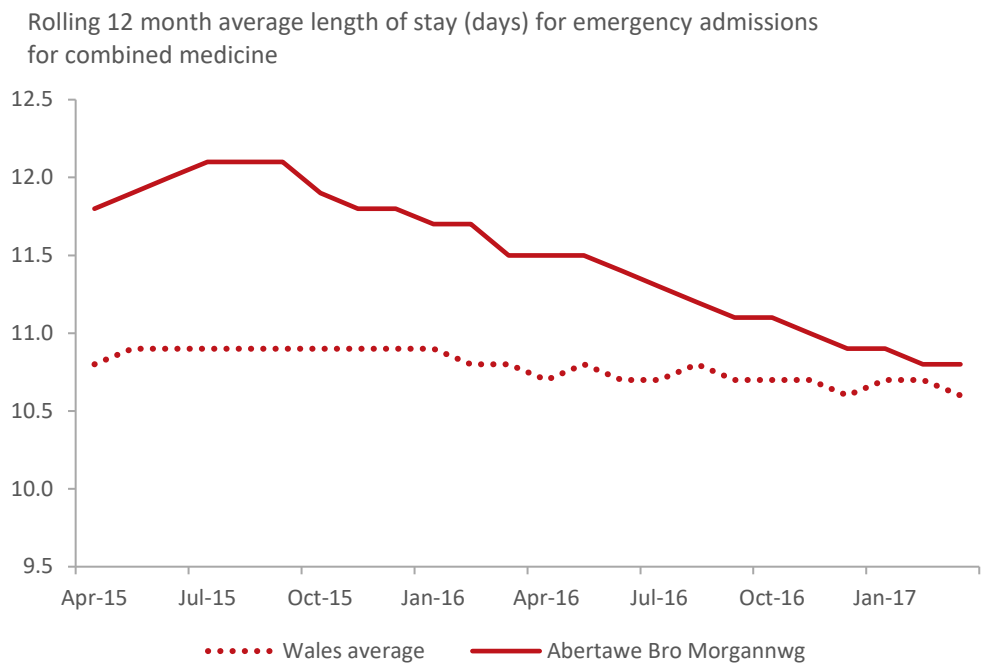
Exhibit 16: proportion of Health Board patients waiting more than 12 hours in accident and emergency compared to all-Wales average between April 2015 and September 2017 compared with the average for major accident and emergency departments in Wales



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

113 NHS bodies are expected to reduce lengths of stay for emergency medical admissions. Performance is measured on a rolling 12-month basis (the performance reported for any single month therefore representing the average over the previous 12 months rather than the in-month performance). Exhibit 17 shows, month by month over the last two years, the rolling average length of stay for emergency medical admissions at the Health Board, with the average length of stay just above the Wales average.

Exhibit 17: trend in the 12 month rolling average length of stay (days) for emergency admissions for combined medical wards between April 2015 and March 2017



Please note that the y-axis does not start at zero.

Source: Wales Audit Office analysis of NHS Wales efficiency data provided by the NHS Wales Informatics Service, March 2017

Appendix 1

NHS Wales Delivery Unit's quantitative findings from discharge planning audits at the Health Board's acute hospitals

Exhibit 18: the RAG status[16] of the NHS Wales Delivery Unit's assessment of written evidence in case notes against specific requirements set out in Passing the Baton[17]

Discharge process	Expected practice	Morriston Hospital	Princess of Wales Hospital	Singleton Hospital	Neath Port Talbot Hospital
Stage 1 All discharges, within 24 hours of admission	Simple/complex discharge is identified on, or shortly after, admission to hospital.				
	A conversation will be had with the patient to establish how they were managing before admission, so that any discharge requirements can be identified, and planned for, from the admission date.				
	A conversation will be had with the patient's main carer (where appropriate) to establish any discharge requirements early in the hospital admission.				
	Long-term conditions will be identified on admission, and the patient's perception of their current status established.				
	Existing care co-ordination and support in the community is identified.				
	Patients and their families are provided with written information on what they should expect from the discharge process, and what is expected from them.				

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

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

Discharge process	Expected practice	Morriston Hospital	Princess of Wales Hospital	Singleton Hospital	Neath Port Talbot Hospital
Stage 2 Complex discharges	Early conversations take place with existing service provision to identify and pro-actively address any developing issues.				
	Existing care co-ordinator is identified.				
	In complex discharges, the patient and carer are given the contact details of the named professional who will act as their care co-ordinator.				
	In complex discharges, and MDT case conference is arranged to consider assessments and agree a discharge plan with the patient/carer.				
Stage 3 All discharges	An estimated date of discharge (EDD) is set.				
	The EDD takes account of both acute and rehabilitation phases, where applicable.				
Stage 4 All discharges	The EDD is clearly communicated to the patient and their family/carers.				
	The EDD can be flexed according to an individual's response to treatment, in order to provide a realistic date for discharge.	Evidence this occurred but EDD recorded in only 26%, 21%, 11% and 7% of case notes respectively.			
	Discharge plans are reviewed daily and there is evidence of actions completed.				
	Potential constraints are identified and actioned/escalated.				
	The patient and their family/carers are regularly updated on progress with the discharge plan.				

Discharge process	Expected practice	Morriston Hospital	Princess of Wales Hospital	Singleton Hospital	Neath Port Talbot Hospital
Complex discharges	Alternative community pathways are considered to facilitate early discharge and optimise independence.				
	The 'discharge/transfer' to assess model is considered in all complex discharges.				
	Timely MDT assessment is collated by the care co-ordinator.				
	A tailored discharge plan is co-produced with the patient/carer, reflecting their strengths and what is most important to them.				
	Third-sector provision is considered where appropriate.			Not applicable	
	Where required (eg to discuss onward placement or to determine CHC eligibility) MDT meetings are arranged in a timely manner.			Not applicable	Not applicable
	If a care home placement is required, the patient and carer are provided with clear information on the category of home they should by looking for			Not applicable	Not applicable
	Information on care homes in the area			Not applicable	Not applicable
	Information on the Choice Policy			Not applicable	Not applicable
	Information on where they can access help in looking for a suitable home if they require it (eg third sector)			Not applicable	Not applicable
Stage 5 All discharges	A checklist is completed to ensure that the practicalities of discharge are addressed.				

Source: NHS Wales Delivery Unit, Discharge Audit at Abertawe Bro Morgannwg University Health Board, June 2016

Appendix 2

Audit methodology

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

Exhibit 19: audit methodology

Method	Detail
Data Collection Form - Discharge Planning (Health Board level information)	We sought corporate-level information about the extent of shared priorities for discharge and transfers of care; the services or teams available to support timely discharge; the landscape of community-based services; training to support discharge planning; performance management related to discharge planning; and the extent to which information about housing adaptation services is shared with NHS organisations. The information returned has supported both the discharge planning audit and the Auditor General's study on housing adaptations. The Health Board submitted the completed data collection form on 20 March 2017.
Data Collection Form –Discharge Lounge	We asked NHS organisations that operated a discharge lounge services to tell us about each discharge lounge. We sought information about operational hours, the staffing profile, numbers of patients accommodated and the environment for patients. The Health Board submitted two forms for: • Morriston Hospital • Princess of Wales Hospital
Data Collection Form – Discharge Liaison Team	We asked NHS organisations to tell us about the discharge liaison team where these existed. We sought information about operational hours, the staffing profile, team/service costs and types of activities. Where multiple discharge liaison teams operate, one form was completed for each main acute hospital, provided teams operated independently of each other. If the discharge liaison team service operated as a single integrated service, one form was completed. The Health Board submitted four forms, one for each of the discharge liaison teams operating at the following hospitals: • Morriston Hospital • Neath Port Talbot Hospital • Singleton Hospital • Princess of Wales Hospital

Method	Detail
Document request	We reviewed documents from the Health Board which covered strategies and plans for managing patient flow and unscheduled care, policies related to discharge and transfer of care and home of choice, discharge pathways, action plans to improve discharge planning processes and patient flow, and performance reports, including those related to patient experience or information on complaints and incidents related to discharge processes. We also relied on information set out in the reports prepared for the Welsh Government by each health board or regional partnership summarising how the Intermediate Care Fund was used and its impact in 2015-16.
Interviews	We interviewed a number of staff including: • Interim Chief Operating Officer • Independent Board Member (Social Services) • Assistant Chief Operating Officer • Assistant Director of Nursing • Acting Head of Information • 3x Delivery Unit Nurse Director • 2x Delivery Unit Service Director • 1x Delivery Unit Head of Occupational Therapy • 2x Bed Managers • 2x Patient Flow Team members • 4x Ward Managers • 2x representatives from the Community Health Council
Use of existing data	We used existing sources of information wherever possible such as the NHS Wales Delivery Unit's work on discharge planning from 2016, data from the StatsWales website for numbers of delayed transfers of care, hospital beds, staff, admissions, patients spending 12 hours or more in accident and emergency departments and lengths of stay.

Source: Wales Audit Office

Appendix 3

The Health Board's management response to the recommendations

Exhibit 20: management response

Ref	Recommendation	Intended outcome/benefit	High priority (yes/no)	Accepted (yes/no)	Management response	Completion date	Responsible officer
R1	The Health Board should ensure that its discharge policy includes reference to early discharge planning, the risk of readmission, and discharge from Emergency Departments.	Accessible and easily understood Discharge Policy that covers all necessary information and that staff feel confident when discharging patients.	Yes	Yes	The Health Board's extant discharge policy will be reviewed to reflect the Wales SAFER flow guidance which is expected to be published imminently, to reinforce the benefits of early discharge and to highlight the risks associated with long stays in hospital including: • patient deconditioning; • hospital acquired infection; and • patient falls and pressure ulcers. The refresh of the policy will incorporate feedback and learning obtained from across Health and Social care from 'Breaking the Cycle' and the learning obtained which took place between 8 and 22 January 2018.	March 2018 for approval by the Health Board in April	Unit Nurse Director Singleton hospital

Ref	Recommendation	Intended outcome/benefit	High priority (yes/no)	Accepted (yes/no)	Management response	Completion date	Responsible officer
R2	The Health Board should review all of the current pathways in use and use the opportunity to: • consider rationalising them (eliminating any unnecessary overlaps); • make clearer the links between each of the pathways; • make clearer any explanatory information; • set out all of the pathways in one place; and • ensure that pathways are consistent across the Health Board.	Accessible and easily understood pathways that cover all necessary information and that staff feel confident in applying when discharging patients.		Yes	The Health Board will continue to develop and agree pathways in partnership with LAs and WAST and patients across the whole of the unscheduled care pathway to support admission avoidance and more timely discharge. A particular focus in 2018-19 will be a review of the falls pathway for patients who have not sustained a bony injury. Western Bay discharge pathway standards have been agreed to ensure the development of a consistent approach across the Health Board. Further progression toward the agreed Western Bay optimal model will help to simplify current discharge pathways and make clearer the links between pathways.	Quarterly review April 2018 Agreed and in place Ongoing through Western Bay programme – quarterly review	Chief Operating Officer Assistant Chief Operating Officer Unit Nurse Directors

Ref	Recommendation	Intended outcome/benefit	High priority (yes/no)	Accepted (yes/no)	Management response	Completion date	Responsible officer
					During 2018-19 there will also be a particular focus on developing capacity and supporting staff to implement the discharge to assess and trusted assessor model to ensure consistency and reduce variation. The Unit Directors of Nursing are developing a unified Health Board approach to Green to Go#End/Pj Paralysis.	March 2018	Unit Nurse Directors and Heads of therapy Unit Nurse Directors
R3a	Ensure that attendance at training is captured on the electronic staff record, which will help to improve compliance monitoring.	Better discharge planning because all staff are well trained, and the Health Board has a record of training compliance.	Yes	Yes	It is planned to reinstate the 'speed dating' sessions for hospital staff on discharge planning. Staff attending all training sessions will be encouraged to ensure that attendance is captured via ESR records.	April 2018 on a rolling basis	Unit Nurse Directors/Heads of Therapies

Ref	Recommendation	Intended outcome/benefit	High priority (yes/no)	Accepted (yes/no)	Management response	Completion date	Responsible officer
R3b	Develop training that helps to build staff confidence to discharge patients in a more timely way and to manage difficult conversations with patients and their families.	Better discharge planning, leading to reduced lengths of stay, more available bed days and better outcomes for patients.	Yes	Yes	The Health Board's discharge policy will be reviewed to reflect the Wales SAFER flow guidance which is expected to be published in February 2018, to reinforce the benefits of early discharge and to highlight the risks associated with long stays in hospital including: • patient deconditioning; • hospital acquired infection; and • patient falls and pressure ulcers. SAFER flow workshops have been arranged for 8 and 9 February 2018, to support staff with building confidence and to reinforce the importance of initiating early conversations with families and patients on the benefits of early and timely discharge. Develop a trusted assessor role for the therapists at A&E to directly commission front line support services from the LA within a four	The Policy will be refreshed during February/ March for the Health Board approval in April 2018 February 2018 From March 2018 and ongoing	Unit Nurse Director Singleton Assistant Chief Operating Officer Head of Therapies

Ref	Recommendation	Intended outcome/benefit	High priority (yes/no)	Accepted (yes/no)	Management response	Completion date	Responsible officer
					hour time frame (services to be reviewed by community services within 48 hours). This will require a phased approach to: • confirm the number of trusted assessors; • to develop a training programme to support the provision of a sustainable trusted assessor model; and • to evaluate the impact of the trusted assessor role on patient flow and outcomes. Refresh nurse led discharge in a new context of right clinician led discharge (to include therapists). A clinical governance framework to promote and encourage nurse and therapy led discharge is currently under development.	April 2018	Unit Directors of Nursing and Head of Therapies

Ref	Recommendation	Intended outcome/benefit	High priority (yes/no)	Accepted (yes/no)	Management response	Completion date	Responsible officer
R3c	Consider whether discharge training and awareness of issues and policy is required for consultants.	Better discharge planning, leading to reduced lengths of stay, more available bed days and better outcomes for patients.		Yes	The Health Board recognises the benefits of strong clinical leadership and clinical handover of care as a key quality/safety driver. Ensuring awareness and consistent implementation of the SAFER patient flow guidance by all professions will reduce variation in patient flow and discharge processes. Attendance by all clinicians at the SAFER flow workshops and the launch of the Welsh Safer flow guidance in February is being encouraged. Attendance by medical staff at all levels is being promoted by Medical Director. Discussions have taken place with the University regarding training on SAFER flow/patient discharge as this is not currently included within the medical training programme.	February 2018 January 2018	Medical Director Executive Nurse Director

Ref	Recommendation	Intended outcome/benefit	High priority (yes/no)	Accepted (yes/no)	Management response	Completion date	Responsible officer
R4	Strengthen its performance reporting to the Board and its Committees by including the following measures within its routine performance report: • number and percentage of patients who have an estimated discharge date; • readmissions within 28 days of discharge from hospital; • percentage of discharges before midday; • percentage of discharges that occur at night that were not planned for; and • percentage of discharges within 24 hours and 72 hours of being declared 'medically fit'.	A Board that is well sighted of the performance of the Health Board with regard to discharge planning, is aware of the experience that patients have during the discharge planning process and is sighted of any negative effect on patient outcome as a result of discharge planning.		Yes	The patient flow programme has agreed standardised metrics to determine the impact of improvements in process on patient flow and these measures will be reported to the Health Board's performance and finance committee from 2018-19. The metrics will include: • number and percentage of patients who have an estimated discharge date; • readmissions within 28 days of discharge from hospital; • percentage of discharges before midday; • percentage of patients discharged from the discharge lounge before midday; and • percentage of patients discharged from the discharge lounge.	From April 2018 with monthly monitoring	Assistant Chief Operating Officer.

Ref	Recommendation	Intended outcome/benefit	High priority (yes/no)	Accepted (yes/no)	Management response	Completion date	Responsible officer
					Further work and training of staff is required to populate the percentage of discharges within 24 hours and 72 hours of patients being declared 'medically fit'. It is planned to pilot the full implementation of the ward dashboards on two wards in each delivery unit in the first instance to assist with the full data capture of the relevant ward metrics. The Health Board does not plan to discharge patients at night, although patients can sometimes self-discharge out of hours. The Health Board does not currently record the percentage of unplanned discharges at night, however, the Health Board intends to undertake a six monthly snapshot audit to provide the assurance that there are no issues relating to unplanned discharges late at night.	April 2018 Six monthly audits in April and September	Unit Directors of Nursing Unit Directors of Nursing

Appendix 4

Activities undertaken by discharge liaison teams

As part of this review, we asked health boards how frequently their discharge liaison teams undertake a range of various discharge planning activities. Exhibit 21 shows the frequency with which the 15 discharge liaison teams across Wales undertake the activities listed.

Exhibit 21: frequency with which the discharge liaison teams undertake a range of activities

	Always	Often	Sometimes	Rarely	Never
Participate in ward rounds or multi-disciplinary meetings	33%	40%	20%	7%	0%
Support staff to identify vulnerable patients who could be delayed	53%	40%	7%	0%	0%
Ensure individual discharge plans are in place for patients with complex needs	60%	27%	13%	0%	0%
Liaise with other public bodies to facilitate hospital discharge and avoid readmission	60%	27%	7%	7%	0%
Provide a central point of contact for health and social care practitioners	67%	33%	0%	0%	0%
Work with operational managers to develop performance measures on hospital discharge	27%	20%	40%	7%	7%
Validate data on delayed transfers of care	87%	7%	0%	0%	7%
Provide training and development for clinical staff to effect timely discharge	33%	13%	40%	13%	0%

	Always	Often	Sometimes	Rarely	Never
Update bed managers with information on hospital discharges	67%	20%	0%	7%	7%
Provide housing options advice and support to patients and their families	27%	27%	20%	7%	20%
Signpost patients and their families to advice and support for maintaining independence at home	33%	27%	27%	7%	7%

Source: Wales Audit Office analysis of information on discharge planning returned by NHS bodies in 2017 (See Footnote 12)

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