Archwilydd Cyffredinol Cymru
Auditor General for Wales

Discharge Planning – **Velindre NHS Trust**

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The person who delivered the work was Elaine Matthews.

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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 or transfer.

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 straight forward or simple for 80% of patients leaving hospital. These patients can return home either without any other health or social care needs, or with a low level of needs which will not involve complex planning and delivery arrangements. 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, and from the risk of hospital acquired infections. They may need re-admission to hospital or long-term support.

5 Velindre NHS Trust (the Trust) is the health body having overall responsibility for the Velindre Cancer Centre (the Cancer Centre). The Cancer Centre provides specialist cancer services to over 1.5 million people in south east Wales and beyond.[1] Each year the Cancer Centre receives over 5,000 new referrals, provides around 50,000 new outpatient appointments and admits around 2,000 patients to inpatient wards. Around 30% of patients are admitted for either elective treatment that requires an inpatient stay, usually for a course of chemotherapy (systemic anti-cancer therapy (SACT)). However, the majority of admissions are unscheduled, arising from infections, toxicity from SACT, or palliative care and end of life care. This review is focused on the discharge planning arrangements for these acute oncology inpatients.

[1] The majority of patients attending Velindre Cancer Centre come from Cardiff, Vale of Glamorgan, Bridgend, Rhondda Cynon Taf, Merthyr Tydfil, Gwent and the south of Powys.

6 Despite the multiplicity of guidance to support good discharge planning[2, 3, 4], work undertaken in 2016 by the NHS Wales Delivery Unit (the Delivery Unit) at all Welsh hospitals, other than Velindre Cancer Centre, 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[5]; and
- better information and communication with patients and families.

7 The Delivery Unit assessed the written evidence in case notes against specific requirements set out in 'Passing the Baton' (see footnote 3) for the acute hospitals in south east Wales where many of the Cancer Centre's patients live and receive ongoing health and social care support. Findings for hospitals within Aneurin Bevan, Cardiff and Vale and Cwm Taf University Health Boards (UHB) show that the patient discharge process was largely poor when assessed against expected practice. The findings for Powys Teaching Health Board's (THB) community hospitals were mixed. Appendix 1 sets out the Delivery Unit's findings in more detail.

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

9 Accordingly, our review examined whether the Trust has sound governance and accountability arrangements in relation to discharge planning for patients with acute conditions. Appendix 2 provides details of the audit methodology. Our work focused specifically on whether the Trust has:

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

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

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

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

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

10 In parallel with this work, the Auditor General has also undertaken a review of housing adaptation. That 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, the Healthcare Inspectorate Wales has examined 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 for publication in autumn 2017.

Key findings

11 Our overall conclusion is: The Cancer Centre is taking steps to strengthen discharge planning arrangements although monitoring and reporting performance at Cancer Centre and Trust level is limited. In the paragraphs below we have set out the main reasons for coming to this conclusion.

12 **Planning:** The Cancer Centre is taking steps to improve discharge planning with policies and discharge pathways at an early stage of development. We reached this conclusion because:

- the Cancer Centre has plans to improve discharge arrangements although improvements are dependent on other providers who have their own service pressures;
- a new discharge policy has been developed, though this requires further work; and
- the Cancer Centre has yet to document the discharge pathways that support discharge planning.

13 **Arrangements for supporting discharge:** Cancer Centre staff are developing processes and resources that support effective discharge planning. We reached this conclusion because:

- discharge planning is led by ward nurses with support from the multi-disciplinary team – a relatively new approach yet to be evaluated;
- there is no dedicated area where both inpatient and daycase patients can wait before discharge; and
- ward staff collate and update information on the many outside services required to facilitate patient discharge and further staff training is planned once the discharge policy is finalised.

14 **Monitoring and reporting:** The Trust has insufficient information to monitor discharge arrangements although clear accountability arrangements are set out in the draft discharge policy. We reached this conclusion because:

- accountabilities for safe and timely discharge are clear;

- data for scrutiny of discharge performance are limited and not presented in a meaningful way; and
- board members do not feel sufficiently informed about discharge planning performance.

Recommendations

Exhibit 1: recommendations

The table sets out the recommendations arising from our audit. The Trust's management response detailing how it intends responding to these recommendations is included in Appendix 3.

Recommendations	
R1	**Development of the discharge policy:** The Cancer Centre is developing a new discharge policy. While it is a positive first draft, there are a number of additions that the Trust could add to support safe and timely discharges. These are: a. In the section on Ownership and Responsibilities, – set out the role of the 'discharging nurse' responsible for arranging a patient's discharge; – set out the role of the palliative care team in planning a patient's discharge; and – add more detail on who is responsible for the escalation process when discharge is at risk of delay. b. Add a section on the process for managing patients who might be deemed vulnerable because of social circumstances, such as homelessness. c. Add a section for those patients who meet the definition of a vulnerable adult under the Wales Interim Policy & Procedures for the Protection of Vulnerable Adults from Abuse (2010). d. Document the requirement for the supportive care team to refer all patients for a formal carer's assessment. e. Define in more detail each discharge category, including a flow chart or decision tree for selecting the appropriate discharge pathway. f. Make explicit reference to the folder of discharge information and forms, which was developed by ward staff and successfully used to support the discharge process. g. Document the procedure for keeping the folder of discharge information and forms up to date. h. Further develop the medicines management section to include the role of pharmacists in the discharge process. i. Provide training for staff in the multi-disciplinary team on the policy once it has been finalised.

Recommendations	
R2	**Consultation on the draft discharge policy:** While the Discharge Policy is still in draft, the Trust should share the draft policy to incorporate the views of key stakeholders, in particular: • district nurses based in local health boards; • lead staff from health boards and local authorities responsible for equipment stores; and • patients and carers.
R3	**Information for monitoring discharge arrangements:** Information on delayed transfers of care (DToC) are rarely reported to the Board because numbers are low. In addition to reporting on the KPI for increasing the number of patients dying in their place of choice and increasing the number of patients who access their preferred place of care, the Trust should consider collecting and reporting on the following information to the Quality and Safety Committee: a. % of discharges within 24 hours and 72 hours of the patient achieving 'optimal clinical state'; b. number and reasons for delays transferring patients to other hospitals, care homes or their home; and c. problems with discharges as recorded on the Datix patient safety system.
R4	**Discharge data on the patient administration system:** The current system, Canisc, does not have the facility to capture data on the type of discharge or delays to discharge. The Trust should ensure that any new patient administration system can capture information for monitoring and reporting on performance related to discharge processes and planning.

Detailed report

Part 1: The Cancer Centre is taking steps to improve discharge planning arrangements with policies and discharge pathways at an early stage of development

The Cancer Centre has plans to improve discharge arrangements although improvements are dependent on other providers who have their own service pressures

15 In October 2016, the Cabinet Secretary for Health, Wellbeing and Sport wrote to all NHS Chairs making clear his expectation that unscheduled care improvement plans would incorporate plans to improve discharge processes. The NHS Wales Planning Framework[6] also makes clear that organisations should specify how their plans support and improve patient flow. The focus should be on reducing admissions for the frail elderly through pro-active assessment and intervention, and discharging patients as early as clinically appropriate without unnecessary waiting.

16 Our audit work assessed the extent to which discharge planning is part of a wider strategic approach to improve patient flow. We found that the Cancer Centre is working to deliver three interrelated plans for reducing demand, improving acute oncology services, providing care closer to home, reducing unscheduled demand for inpatient care and improving patient flow. These plans cover the development of scheduled and unscheduled care pathways for acute oncology services in both the Cancer Centre and hospitals across the health boards. Efficient and effective discharge planning will play an important part in these plans, which are:

- the Transforming Cancer Services in South East Wales Programme sets out how to address the annual 2% increase in cancer incidence across the south east Wales region by reducing demand for services provided in Cardiff. Actions include: the development of a new Cancer Centre at Velindre; an expansion of Velindre @ Outreach Facilities based in other hospitals, such as the new radiotherapy unit at Nevill Hall Hospital in Abergavenny; and Cancer Centre staff based at other hospitals. Discharge planning will be an integral part of the scheduled and unscheduled care services provided by these developments to reduce lengths of stay and to ensure patients are discharged or transferred to more appropriate care settings.
- the Velindre NHS Trust Cancer Strategy 2016 – 2026 was approved in November 2016. It provides a vision and long-term framework to strengthen the three-year planning process and has been developed alongside Transforming Cancer Services. There is a focus on reducing admissions and

[6] Welsh Government (2016), **NHS Planning Framework 2017/20**

working with other health boards to provide unscheduled inpatient care closer to home as part of the development of acute oncology services.

- the Trust's Integrated Medium Term Plan (IMTP) for 2017-2020 makes clear the importance of good discharge planning processes and procedures for the Cancer Centre to deliver one of the strategic priorities: 'to improve care and support for patients to live well through and beyond cancer'. A number of other actions to support effective discharge planning are set out in the IMTP, including: working with the Welsh Ambulance Services NHS Trust (WAST) to improve transport services for patients being discharged or transferred; implementing the Medicines Transcriptions and Electronic Discharge system (MTedD); Implementation of the Welsh Clinical Communications Gateway (WCCG) to improve communications with primary care which would support discharges; and making improvements to the Cancer Centre's pharmacy service to speed up arrangements for dispensing medications after an inpatient stay.

17 These plans provide an opportunity for the Cancer Centre to assess all admissions to ensure that the patients admitted are those who can benefit from the specialist care it provides. Many patients choose to come to the Cancer Centre because they have a long-term relationship with it from attending outpatient services and because of its reputation for excellence. It may be more appropriate to care for some patients in hospitals closer to home if treatment, such as palliative care or platelet exchange, is available locally. However, health board hospitals may already be struggling to admit patients, and the Cancer Centre staff have access to the bed map of Wales so they can easily see when and where bed capacity is limited. The result is that if a patient can go to the Cancer Centre it frees up a bed in a district general hospital (DGH) for the other patients waiting for admission.

18 As a tertiary service, the Cancer Centre often admits patients who were previously treated in other hospitals for emergency radiotherapy or treatment for complications from SACT. Once the patient receives their care at the Cancer Centre, they may need to go back to their original hospital, transfer to a new hospital or hospice, or be discharged home. The Cancer Centre told us that there are no established discharge pathways that have been developed with local health boards to cover the flow of patients between these organisations. Our auditors found that the Cancer Centre is not generally involved in the development of health boards' discharge policies and procedures.

19 The Welsh Government recently issued a Welsh Health Circular on the NHS Wales Policy for the Repatriation of Patients[7]. However, this policy only refers to transfers between health boards and does not make any specific reference to patients transferred to and from the Cancer Centre. We were told that in previous years, patients would be admitted to the Cancer Centre for treatment and then transferred

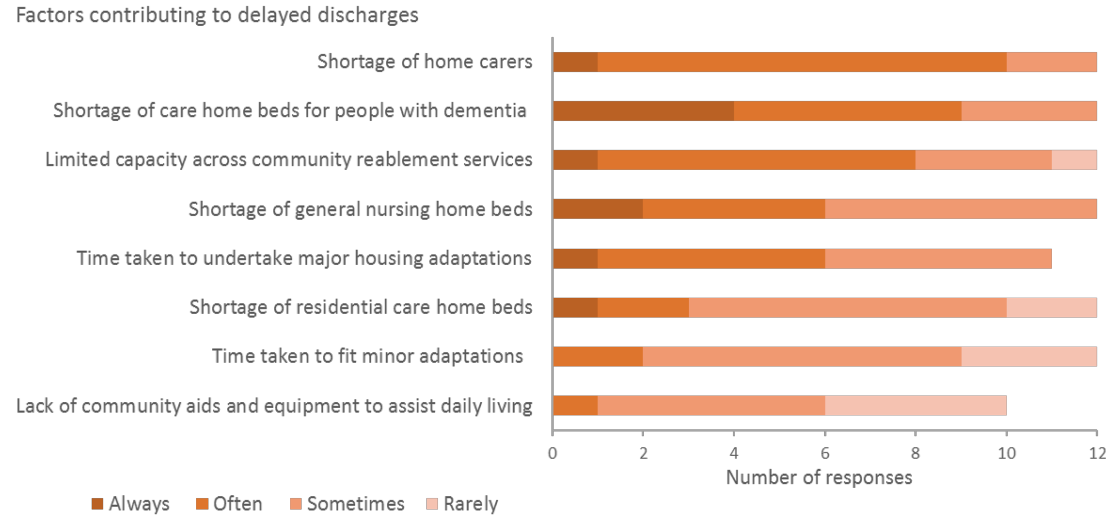
[7] Welsh Health Circular (2017) **NHS Wales Policy for the Repatriation of Patients** 2017/008.

back to the referring hospital. Now patients are 'stuck' in the Cancer Centre because hospitals can no longer hold onto their beds, even for a short time.

20 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 most problem. Exhibit 2 shows that across Wales, a shortage of home carers, a shortage of care home beds for people with dementia, and limited capacity across community reablement services are major factors in causing delays to discharge or transfer of care. It is important to recognise that the Trust, like the health boards, does not have direct control over many of these factors. It needs, however, to work with statutory and independent partners to find solutions to meet patients' needs.

Exhibit 2: factors contributing to delayed discharges or transfers of care across NHS organisations

The chart shows the factors seen to contribute to delayed hospital discharges and transfers of care.



Source: Wales Audit Office analysis of information on discharge planning returned by NHS bodies in 2017[8]

[8] 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.

21 The Cancer Centre reported that the following issues always or often caused delays:

- a lack of community aids and equipment to assist daily living eg hoists, special beds;
- the time taken to undertake major housing adaptations;
- a shortage of home carers; and
- limited capacity across community reablement services.

22 In addition, the Cancer Centre highlighted a lack of capacity across health board district nursing services. Some discharges are for those patients who need to be 'fast tracked' home with a complex package of care but arrangements vary depending upon the patient's health board of residence. The fast track discharge is often dependent on continuing healthcare funding to enable patients to receive up to five visits a day from a district nurse. Nursing staff at the Cancer Centre told us that in the past it was difficult to find a district nurse with the appropriate skills and capacity to take a referral for a fast track discharge. This process is much better since the Cancer Centre escalated the issue to the head of district nursing at Cardiff and Vale UHB. The Cancer Centre needs to phone through the referral for the fast track discharge before midday at which time the district nursing service can make a decision on the referral that afternoon or the next morning. However, nursing staff told us that referrals to district nursing services for patients whose discharge is more routine can take longer, which means patients spend longer than necessary in hospital.

A new discharge policy has been developed, though this requires further work

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

24 The Trust has been trying out different ways of managing the discharge process following the departure of the discharge liaison nurse in 2015. Meanwhile recent issues related to discharge planning highlighted the need to develop a new policy. The Trust had produced an initial draft policy at the time of our fieldwork, which we have reviewed. We are aware that the Trust has continued to develop the policy.

25 The draft policy is based on the principles set out by the NHS Wales Unscheduled Care Programme Board for early safe discharge following unscheduled admissions. The intended outcome is that patients have an appropriate length of

stay and are discharged in a planned co-ordinated way with suitable support services.[9]

26 We reviewed the Trust's draft discharge policy on discharge and transfers of care using a maturity matrix[10]. The maturity matrix assesses 16 elements of the policy, with each element assigned a score from one (less developed) to three (well developed). Exhibit 3 shows how the Trust's draft discharge policy scored against the maturity matrix. Out of the 14 elements we assessed that are relevant to the Trust, the draft policy scored '3' on 5 of the elements. The Trust could strengthen the discharge policy for those elements that scored '1' or '2' as set out in the recommendations.

Exhibit 3: Trust's performance against discharge policy good practice checklist

The table shows that some of elements of the Trust's draft discharge policy are well developed while others would benefit from further development

Elements assessed	Score	Auditor observations on the policy
Multi-agency discharge policy	1	The draft policy is an internal Trust document. It does not reference the involvement of other organisations, such as social service staff at local authorities or district nursing staff based in health boards.
Policy reviewed within the last year	3	The Trust was developing the policy at the time of the audit.
Patient/carer involvement	2	While patient and carer involvement is mentioned throughout the policy, the principles of appropriate consultation and involvement of the patient and their family/carer/advocate in the discharge process are not explicitly set out. No reference is made to carrying out a carer's assessment which may be necessary even though we understand that the Supportive Care Team refer all patients to the appropriate authority for formal carer's assessment.
Communication	3	The policy stresses the importance of communication with the individual, family and carers.

[9] NHS Wales Unscheduled Care Programme Board (2011). **Ten High Impact Unscheduled (USC) Care Transformational Steps. Step 9 Improve Discharge Planning**. Discharge Planning

[10] 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
Information	3	The policy makes reference to providing the patient with a leaflet which nursing staff should walk through with them. It also states that the estimated date of discharge must be discussed with the patient/their relative/carer as appropriate.
Vulnerable groups eg patients who are homeless	2	The draft policy does not mention vulnerable groups or make reference to protection of vulnerable adults (POVA). A section on POVA needs to be added. The section on refusal to be discharged does not list patients with no fixed abode although this had been a cause of a number of incidents.
Early discharge planning for elective admission	3	The policy does not distinguish between elective and unscheduled admissions.
Estimated discharge date set within 24 hours of admission	3	The draft policy clearly states that all patients will have an Estimated Date of Discharge (EDD) within 12 hours of admission.
Avoiding Readmission	2	There is no specific reference to avoiding readmission although there is a clear principle of not discharging patients unless they are at their 'optimal clinical state'.
Local Agreements and Protocols	N/A	Not relevant.
Assessment	2	The policy refers to the Level 3 Discharge which is defined as a patient requiring comprehensive Multidisciplinary Team assessment based on the Unified Assessment principles; it does not provide any link to a Unified Assessment policy or procedure.
Discharge from A&E	N/A	Not relevant.
Discharge directly from acute hospital care to care home	N/A	Not relevant.
Links to choice of accommodation policy	2	There is a section on patients requiring a care home/care home with nursing who refuse to engage with the choice process. The section on choice of accommodation could be developed further.
Care options	2	Levels of discharge set out what care options are available for patients at different stages of their condition although more detail is required.

Elements assessed	Score	Auditor observations on the policy
Escalation processes	2	The policy has a section on 'Patients who refuse discharge', which sets out the escalation process and is summarised in a flow chart. Further detail on who is responsible for the escalation process could be included in the Ownership and Responsibilities section.
Accessible Discharge Protocols	2	There are flow charts for delayed transfers of care and for patients who refuse to be discharged. A flow chart on the procedure for each of the categories of discharge would be beneficial.

Source: Wales Audit Office review of Velindre NHS Trust's draft discharge policy, 2017

27 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. A section within the Cancer Centre's draft discharge policy clearly outlines the roles and responsibilities of professions and teams involved in discharge planning. This includes the chief executive and the wider Trust Board, head of nursing, clinical staff, ward manager, other ward staff and therapies staff. However, there is no mention of the role of the 'discharging nurse' who is referred to in the section 'Core actions for all discharges' and who is key for the smooth running of the discharge process.

28 Staff told us that they have undertaken some work with district nurses at Cardiff and Vale University Health Board to improve discharge planning arrangements but they reported they have yet to see the changes take effect. The Cancer Centre recognises that it needs to consult with all the local health boards in south east Wales to improve discharge arrangements for its patients and would benefit from engaging with them in the development of this policy.

The Trust has yet to document its discharge pathways

29 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 coordination 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.

30 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.

31 The Welsh Government has been encouraging a 'discharge to assess' pathway or model[11, 12]. 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.

32 The Delivery Unit found the use of 'discharge to assess' pathways was limited, and recommended that NHS organisations implement them. We found that half (4 out 8) of NHS organisations had implemented a 'discharge to assess' model, although in some organisations, the model had been implemented only at specific hospital sites.

33 As part of our work, we looked at the main discharge pathways in place to assess the extent to which there was clarity of purpose, whether pathways were developed with partners and supported by algorithms, standardised documentation and measures of quality.

34 The Cancer Centre's draft discharge policy categorises five types of discharge increasing in complexity based on discharge needs. Level 1 discharges are those where patients' health and social care needs are easy or simple to meet on discharge while those categorised at levels 2 and 3 require more complex care. The other two categories include fast-track discharges and external transfers. Fast track discharges are for those patients whose life expectancy is measured in days or weeks and external transfers are for those patients transferring to care settings other than home.

35 The Cancer Centre has yet to document the discharge pathways showing the sequence of steps needed to safely discharge patients according to the category of discharge. We were, therefore, unable to review them.

36 The Cancer Centre uses the 'assess to discharge' model and not the 'discharge to assess' model. It does this because patients are unlikely to be declared medically fit in the conventional sense due to their ongoing cancer diagnosis or because they are on an end of life pathway requiring palliative care and a lot of arrangements need to be in place before they can be safely discharged. Patients are only

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

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

discharged once they are considered to have reached a ‘clinically optimal state’ and appropriate caring arrangements are in place.

Part 2: Cancer Centre staff are developing processes and resources to support effective discharge planning

Discharge planning is led by ward nurses with support from the multi-disciplinary team – a relatively new approach yet to be evaluated

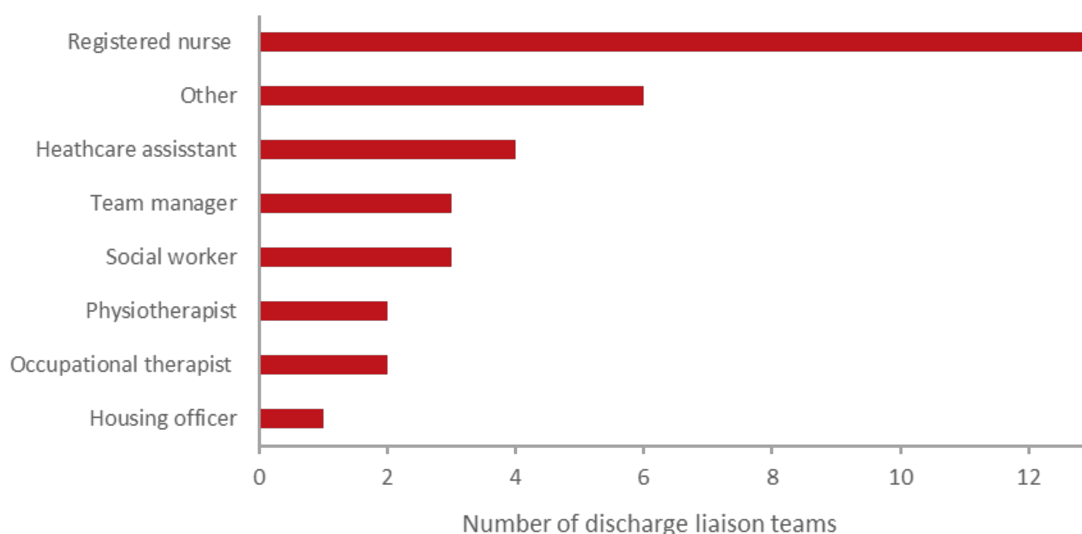
37 A discharge liaison team is a specialist team aimed at supporting the safe and seamless discharge or transfer of care of patients moving from hospital to community service provision. These teams can provide valuable support and knowledge to ward staff and offer help to facilitate complex discharges.

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

39 Typically, discharge liaison teams are made up of nursing staff, but to better manage complex discharges ideally teams should be multidisciplinary. Exhibit 4 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 4: different professional staff deployed across discharge liaison teams at 30 September 2016

The chart shows that across Wales discharge liaison teams are primarily nurse-led with very few multidisciplinary teams.



*Other includes pharmacist and administrative

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

40 For a number of years the Cancer Centre employed a discharge liaison nurse. We were told that the individual nurse fulfilled her role well and had lots of expertise and knowledge but she was the only one who knew how to arrange discharges. This meant ward nurses became deskilled and less confident when arranging discharges when the liaison nurse was unavailable. When the post became vacant in July 2015, the Cancer Centre took the opportunity to review discharge arrangements. In November 2015 the multi-disciplinary team (MDT) produced a paper reviewing the inpatient discharge arrangements. The paper recommended that the weekly MDT meetings needed to be shorter, more frequent

[13] 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.

and more focused to identify and support early discharge requirements and referrals.

41 At the Cancer Centre the process for discharge planning starts with the MDT ‘board round’ meetings which take place three times a week, Mondays, Wednesdays and Fridays. These meetings are always attended by nurses (from the wards, palliative care and infection control), occupational therapists, physiotherapists, and complimentary therapist. No social workers or housing officers attend the ward meetings. While medical staff have an invitation to attend, we observed that junior doctors were not always present for the whole meeting. One ward manager told us that the MDT meetings work well but could improve by setting clearer goals and deadlines otherwise the team risks having the same conversation each time. Everyone needs to be clear who is doing what and by when and they need to know when a referral to other services has been made.

42 The plan going forward is to train all registered nursing staff in discharge planning to increase their confidence. One of the registered nurses would be allocated, on a rotational basis, to work with each ward on the same days as the MDT meetings (Monday, Wednesday and Friday) to help with discharge forms, liaising with social workers, community services, etc. The Cancer Centre retained 50% of the funding for the discharge liaison nurse post, which it plans to use to provide back fill on the wards to give the ward staff time to complete discharge arrangements.

43 A key part of the discharge team are the occupational therapists. It is their role to carry out initial assessments of the patient’s functional abilities and to assess the patient’s home environment. They then make arrangements for suitable equipment to be delivered to the patient’s home. The occupational therapist works with equipment stores in each of the health boards and they all use a system called CEquip. We were told that the arrangement at Cardiff and Vale UHB works well as the occupational therapists can access the system online and order equipment directly. However, other health boards do not allow the occupational therapists to have direct access which results in long delays liaising with health board staff to place and amend orders on the telephone. Similar issues exist with social services stores although the occupational therapists have to deal with the additional problem of more organisations eg five boroughs in the Aneurin Bevan UHB area which all had their own stores with their own processes. The occupational therapists have seen an increase in their workload in recent years and since the recent arrival of a new head of therapies have been reviewing their workloads and processes.

44 Pharmacy is another important part of the discharge process. The discharge policy states that providing medications for a patient to take home (TTH) to be presented to pharmacy at least 24 hours before discharge is planned. However, interviewees highlighted a number of issues around the length of time it takes to provide the patient with drugs to take home. The pharmacist told us that the drugs are usually complicated courses of SACT and there are frequently new oncology drugs which require additional pharmacy time to process. The prescription is taken to the pharmacy before discharge and pharmacy checks and dispenses them. However,

pharmacy staff said that when the pharmacists find errors it takes time to find a doctor to amend the prescription and sign it off. The pharmacist was also concerned that the TTH is not completed before the consultant does their ward round in the afternoon (they do clinics in the mornings). Once the prescription has been dispensed, a nurse then needs to talk through the drugs with the patient before they can go home. All of these processes add to the time that it takes to discharge a patient. The Trust recognises the importance of the role of pharmacy to support discharges and the IMTP contains specific actions to improve the pharmacy service to speed up discharges.

45 Transport arrangements are another important part of the discharge process. While some patients will be able to go home with family and friends, for many with advanced cancers this is not possible. The Cancer Centre has a dedicated vehicle provided by the Welsh Ambulances Service NHS Trust (WAST) that is primarily used to transport patients with spinal cord compression. We were told that this is a good service but it is not always available when needed. Staff can also call on the St John's ambulance service which they do a few times a month although not frequently enough to require a contract with them. The Cancer Centre would like to design a bespoke transport service and is working with the WAST to improve the non-emergency transport options that it has available for its frail patients.

46 The Cancer Centre has a palliative care team who are involved with patients and participate in the multidisciplinary team meetings. However, there is no mention of their role in the discharge policy. The role of the palliative care team in discharge planning needs to be added to the policy.

47 The Cancer Centre uses a paper form, 'Transfer Document (Nursing)', that is completed in triplicate and the green copy is kept at the front of the patient's notes. The form documents the patient's social work contacts, discussions with patients and carers etc. We were told that ward staff find this paper record helps with planning. Nursing staff at ward level are responsible for compiling information for each patient on a patient specific basis and it is then documented in the patient's clinical record.

There is no dedicated area where both inpatient and day case patients can wait before discharge

48 A discharge lounge can support effective discharge planning and patient flow by releasing beds promptly for other patients to be admitted. A discharge lounge provides a suitable environment in which patients can wait to be collected by their families or by hospital transport or while waiting for medication to be dispensed.

49 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, these discharge lounges had the capacity to support 192 patients at any one time who were awaiting discharge; the average capacity per discharge lounge was 11. Across Wales, discharge lounges

operate for between 8 and 12 hours weekdays only and are generally staffed by registered nurses and healthcare support workers. There are also food and toilets facilities available for patients.

50 The Cancer Centre does not operate a discharge lounge. This is because it is impractical due to the small number of patients being discharged on a daily basis. Currently ward patients can sit in the day rooms on the wards whilst waiting for transport home. The rooms are comfortable and covered by catering staff. Patients have access to toilets and still have nursing staff input if required.

51 Cancer Centre staff told us that it may be something to consider in future as part of planning for the new Cancer Centre because patients who have left the ward or finished outpatient treatment for the day can find themselves hanging around in different parts of the hospital waiting for their transport, provided by either WAST or relatives. Staff felt it would benefit patients if there was a designated space where they could wait in comfort for their transport while making it easier for staff to keep an eye on patients.

Ward staff collate and update information on the many outside services required to facilitate discharges and further staff training is planned once the discharge policy is finalised

52 Generally, responsibility for assessment and discharge planning rests with the ward team. Ward staff should be engaged in the discharge planning process and see it as part of the care continuum with ward staff and operational managers held to account for effective discharge planning. 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.

Training on discharge planning will recommence once the draft discharge policy has been approved

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

54 Exhibit 5 shows that across Wales, fewer than half of NHS organisations include discharge planning in nurse induction programmes while more than half offer regular refresher training. The Cancer Centre told us that they provide training on discharge planning in the induction programmes for nurses but have not provided refresher training for more than two years. Nursing staff told us that they provide training on how to use the discharge folder for new staff when they come onto the ward.

55 The Cancer Centre plans to provide training for all nursing staff on the inpatient wards once the new discharge policy has been approved. They would also like to invite district nurses to training events to ensure that everyone knows what the discharge procedures are and increase the confidence of district nurses in caring for patients with cancer.

Exhibit 5: availability of training on discharge planning for nursing staff

The table shows which NHS organisations provide training for discharge planning as part of nurse induction programmes and whether regular refresher training is provided for nursing staff.

NHS organisation	Training on discharge planning included in nurse induction programmes for new starters	Refresher training on discharge planning provided regularly for nurses[1]
Abertawe Bro Morgannwg	No	Yes
Aneurin Bevan	No	No
Betsi Cadwaladr		
• 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	No
Powys	No	No
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)

Barriers to timely discharge are mostly related to accessing services provided by other health boards and social services

56 In its review of discharge arrangements in general hospitals, the 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. From our interviews, we heard that the Cancer Centre is not under the same sorts of pressures as other hospitals to discharge patients quickly because patients are waiting to be admitted from A&E. We were told that the pressure comes more from the desire to get patients to the best possible place to meet their ongoing needs.

57 From our attendance at the multi-disciplinary ward briefing we could see that planning for discharge is an important part of a patient's management. Staff know how long some patients need for a course of SACT or radiotherapy but they do not know how long a patient will need to stay until the treatment is underway as it affects people differently. Planning for discharge will therefore only start once they know how a patient has been affected and what sort of after care will be needed.

58 The Delivery Unit's audit of case notes at the health boards found limited evidence in patient records that patients' expectations of discharge were discussed with them. We were told that patients and carers are always involved in planning their discharge and the occupational therapy team will carry out home visits where necessary. The Cancer Centre provides a leaflet 'Getting ready to leave hospital' which they talk through with patients and carers on admission. The input of carers was discussed at the multi-disciplinary ward briefing that we attended. The Cancer Centre needs to know if a relative or friend can take on the carer role which may require them to take time off work. They are also aware that not all relatives or friends wish to or feel able to take on this role, which requires additional planning. However, a formal carer's assessment was not set out in the discharge policy although we understand that the Supportive Care Team refer all patients to the appropriate authority for formal carer's assessment. The Trust should document the requirement for the Supportive Care Team to refer all patients for a formal carer's assessment.

59 The biggest barrier raised is that the Cancer Centre does not have any control over the services provided by other health boards and social services. They are dependent on the relationships they have developed with health board staff in order to support patient discharges from the Cancer Centre.

[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 patients' best interest.

Ward staff collect information about community services to support patient discharge and keep it up to date

60 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 6 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 6: number of health bodies who reported collating a range of information on community services

The table shows the number of health bodies that collate a range of information about 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/Trust'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)

61 As the Cancer Centre admits patients from across south east Wales they have to liaise across many organisations located in 5 health boards and 11 local authorities plus numerous third sector organisations. These organisations each have their own processes that add to the complexity that staff at Velindre have to address.

62 To help nursing staff make appropriate discharge arrangements, some of the nurses in the Cancer Centre compiled a paper reference folder. This folder collates information on the community services provided by the Trust and by other health boards, social care services and the third sector. This folder is seen as the ‘go to guide’ that ward staff use when planning a discharge. The file has copies of the different forms and contact details of statutory agencies and third sector services. The nurses keep it up to date and use it on a regular basis. Staff said that they have chosen to use a hard copy folder rather than put it on a computer because they find it easier to access and complete the forms manually.

Part 3: The Trust has insufficient information to monitor discharge arrangements although clear accountability arrangements are set out in the draft discharge policy

Accountabilities for safe and timely discharge are clear

63 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.

64 Accountability for discharge of patients is documented in the draft discharge policy. The director of operations is the nominated executive lead and is responsible for ensuring structures and processes are in place to assure delivery a high quality and effective structured discharge process. The executive lead will report to Trust Board as required. The head of nursing is responsible for ensuring their clinical workforce is capable of delivering the requirements of the policy and do so. The head of nursing is also responsible for ensuring there are performance monitoring mechanisms to guarantee the highest standards of service relating to the discharge planning, and that these should be reviewed regularly and action taken if improvement is required. Responsibilities of other staff, including ward managers, consultants and other clinical staff are set out clearly in the draft policy and were understood by staff we interviewed.

Data for scrutiny of discharge performance are limited

65 Having the right information on discharge planning performance is crucial for both monitoring and reporting. Delayed transfers of care (DToC) is the only national measure, for both NHS organisations and local authorities, and as such health boards regularly monitor, report 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.

66 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.

67 As part of this audit, we looked at the type of performance information on discharge planning and patient flow that is reported to operational groups and the Board which help inform discharge planning performance and how well patients are flowing though the hospital system. We found that there are no indicators that cover patient flow, discharges or delayed transfers of care reported to the Trust's planning and performance committee or to the Board.

68 Exhibit 7 shows the very small number of patients experiencing a delayed transfer of care over the last two years. All seven DToCs reported during 2015-16 and 2016-17 were delayed by less than three weeks with delays due to other healthcare providers or community provision.

Exhibit 7: change in number of delayed transfers of care at Velindre NHS Trust by length of delay between 2015-16 and 2016-17

The table shows that the number of delayed transfers of care are very low.

Length of delay	Number of delayed transfers of care (DToC)	
	2015-16	2016-17
0-3 weeks	4	3
4-6 weeks	0	0
7-12 weeks	0	0
13-26 weeks	0	0
26+ weeks	0	0
Total DToCs	4	3

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

69 Cancer Centre staff acknowledge that any delayed discharge is a problem for their patients. For this reason, the Cancer Centre has been encouraging staff to use the Datix system to record any incident of delays to discharge regardless of whether it fits the national definition of a DToC. This information is used to immediately address the reasons for delay. Six incidents were recorded between October and December 2016 with another two in January 2017. These incidents were due to:

- problems accessing social services;
- delays with take home medications;
- lack of agency capacity once continuing healthcare funding approved;
- no capacity in the Community Resource Team; and
- no special hospital bed available for the patient's home.

70 At the time of our audit, staff planned to review all recorded incidents in July 2017 to see a pattern for delays was emerging and what further action would be needed.

71 The Trust provides regular reports to the Board on patient experience. These reports indicate very high levels of satisfaction, most months exceeding the 80% target for people rating their overall satisfaction score as 9/10 or 10/10.

Furthermore, the Cancer Centre did not receive any complaints, either formal or informal, about discharge planning arrangements. Cancer Centre staff are aware of the 'halo' effect where patients may be reluctant to voice criticisms of their services. To address the 'halo' effect, the Cancer Centre has been developing patient engagement methods to ensure that they can gather honest feedback to support improvement.

72 The Trust's IMTP sets out a performance indicator (VCC 057) related to inpatient discharges. The indicator is to increase the number of patients that die in their preferred place and to increase the number of patients who access their preferred place of care. The Trust's Quality and Safety Committee has responsibility for the scrutiny of this indicator. The committee report in April 2017 rated the indicator status, forecast status and risk as green although no detail was provided on the number or proportion of patients dying in their preferred place or accessing their preferred place of care.

73 The Trust acknowledges that it does not benchmark its performance with other cancer hospitals although they are taking steps to benchmark performance in some areas such as length of stay. They also reviewed how Clatterbridge Hospital carries out discharges for its cancer patients and found that Clatterbridge employs their own social worker.

74 Further information that could prove helpful to understand discharge planning performance but not currently reported to the Trust's Board or Committees could include:

- % of discharges within 24 hours and 72 hours of the patient achieving 'optimal clinical state';
- number and reasons for delays transferring patients to other hospitals, care homes or home; and
- number of Datix incidents reported relating to problems with discharges.

75 We asked NHS organisations what information could be captured on their patient administration systems. Exhibit 8 shows that most organisation's 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 8: data fields on NHS organisations' patient administration systems related to the discharge process

The table shows that most NHS organisations' patient administration systems can record a small range of data related to the discharge process to support operational monitoring.

Data fields on patient administration systems related to the discharge process	Number of NHS organisations responding positively	Response by Velindre
Expected date of discharge	12	Yes
Date of discharge from hospital	12	Yes
Time of discharge from hospital	12	Yes
Discharge destination eg home, residential, care home, etc	12	Yes
Date the patient was declared medically fit for discharge	8	No
Whether the discharge is simple or complex	5	No

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

76 The Cancer Centre's patient administration system – Canisc – captures four of the same data fields that other NHS organisations' systems capture. The Cancer Centre does not declare patients medically fit for discharge due to their cancer diagnosis although it uses the categorisation of 'optimal clinical state'. The system does not differentiate between simple of complex discharges.

77 Staff at the Cancer Centre told us that they have poor patient level data. They use paper records and Canisc as the patient administration system. While Canisc is useful for some things, for example medical and therapy staff can see all patient information in one place, including the scanned results and notes from MDT meetings. However, nurses do not use Canisc and data are held on both paper records and Canisc. Another problem with Canisc is that it is difficult to generate reports using the data on admissions and discharges. Consequently, they have no data that is reported or analysed.

78 We were told that the Cancer Centre is waiting for an all Wales IT solution to Canisc. Any new patient administration system needs to be able to capture information for report and monitoring discharges as currently information required for audit purposes has to be found by trawling through paper and electronic records.

Board members do not feel sufficiently informed about discharge planning performance

79 The Trust has limited information available to support timely scrutiny of discharge planning arrangements. In 2016, as part of our 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. We found:

- four out of eight the Trust's board members (50%) agreed or strongly agreed that they received sufficient information to understand the factors affecting patient flow compared with 75% across Wales;
- five out of eight of the Trust's board members (63%) agreed or strongly agreed that they understood the reasons for delays in discharging patients from hospitals within the organisation compared with 82% across Wales; and
- one out of eight of the Trust's board members agreed (12.5%) that the Board and its committees regularly scrutinises the effectiveness of discharge planning compared with 56% of across Wales.

80 Comments from Trust board members at that time indicated that discharge planning was not seen as an issue because of the small numbers of DToCs. These views chime with those of individuals we met as part of this audit. Information on DToCs was not seen as helpful to the Board or its committees because the very small numbers made it difficult to discern trends. However, concerns were also expressed that the Board and its committees did not receive information about discharge planning that was seen as useful or easily understood.

Appendix 1

NHS Wales Delivery Unit's quantitative findings from discharge planning audits at acute hospitals in the south east Wales area

Exhibit 9: the RAG status[15] of the Delivery Unit's assessment of written evidence in the case notes against specific requirements set out in Passing the Baton[16] in acute hospitals in Aneurin Bevan University Health Board

The table shows that written evidence in relation to the patient discharge process was largely poor in June 2016 when assessed against expected practice.

Discharge process	Expected practice	Royal Gwent Hospital (RGH)	Neville Hall Hospital (NHH)
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.		
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 is given the contact details of the named professional who will act as their care co-ordinator.		

[15] The RAG (red, amber, green) traffic light system provides a simple colour-coding system to visualise where performance is less than optimal.

[16] See Footnote 2

Discharge process	Expected practice	Royal Gwent Hospital (RGH)	Neville Hall Hospital (NHH)
	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 only 35% (RGH) and 16% (NHH) of case notes reviewed found evidence that the EDD had been recorded.	
	Discharge plans are reviewed daily and there is evidence of actions completed.		
	Potential constraints are identified and actioned/escalated.		
	The patient and their family/carers are regularly updated on progress with the discharge plan.		
Complex discharges	Alternative community pathways are considered to facilitate early discharge and optimise independence.		
	The 'discharge/transfer' to assess model is considered in all complex discharges.		
	Timely MDT assessment is collated by the care co-ordinator.		
	A tailored discharge plan is co-produced with the patient/carer, reflecting their strengths and what is most important to them.		
	Third sector provision is considered where appropriate.		
	Where required (eg to discuss onward placement or to determine CHC eligibility) MDT meetings are arranged in a timely manner.		
	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'.		
	Information on care homes in the area.		
	Information on the Choice Policy.		
	Information on where they can access help in looking for a suitable home if they require it (eg third sector).		
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 Aneurin Bevan University Health Board, June 2016

Exhibit 10: the RAG status of the Delivery Unit's assessment of written evidence in the case notes against specific requirements set out in Passing the Baton in acute hospitals in Cardiff and Vale University Health Board

The table shows that performance in relation to the patient discharge process was variable and largely poor in February 2016 when assessed against expected practice.

Discharge process	Expected practice	University Hospital of Wales	University Hospital Llandough
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.		
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 is 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.		

Discharge process	Expected practice	University Hospital of Wales	University Hospital Llandough
Stage 4 All discharges	The EDD is clearly communicated to the patient and their family/carers.		
	The EDD can be flexed according to an individual's response to treatment, in order to provide a realistic date for discharge.	Evidence this occurred but only 22% to 24% of case notes reviewed found evidence that the EDD had been recorded.	
	Discharge plans are reviewed daily and there is evidence of actions completed.		
	Potential constraints are identified and actioned/escalated.		
	The patient and their family/carers are regularly updated on progress with the discharge plan.		
Complex discharges	Alternative community pathways are considered to facilitate early discharge and optimise independence.		
	The 'discharge/transfer' to assess model is considered in all complex discharges.		
	Timely MDT assessment is collated by the care co-ordinator.		
	A tailored discharge plan is co-produced with the patient/carer, reflecting their strengths and what is most important to them.		
	Third sector provision is considered where appropriate.		
	Where required (eg to discuss onward placement or to determine CHC eligibility) MDT meetings are arranged in a timely manner.		
	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 as none of the cases reviewed required a new care home placement.
	Information on care homes in the area.		
	Information on the Choice Policy.		
	Information on where they can access help in looking for a suitable home if they require it (eg third sector).		
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 Cardiff and Vale University Health Board, February 2016

Exhibit 11: the RAG status of the Delivery Unit's assessment of written evidence in case notes against specific requirements set out in Passing the Baton in acute hospitals in Cwm Taf University Health Board

The table shows that written evidence in relation to the patient discharge process was largely poor in June 2016 when assessed against expected practice.

Discharge process	Expected practice	Royal Glamorgan Hospital	Prince Charles Hospital
Stage 1 All discharges, within 24 hours of admission	Simple/complex discharge is identified on, or shortly after, admission to hospital.		
	A conversation will be had with the patient to establish how they were managing before admission, so that any discharge requirements can be identified, and planned for, from the admission date.		
	A conversation will be had with the patient's main carer (where appropriate) to establish any discharge requirements early in the hospital admission.		
	Long-term conditions will be identified on admission, and the patient's perception of their current status established.		
	Existing care co-ordination and support in the community 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.		
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 is 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 only a fifth of case notes reviewed found evidence that the EDD had been recorded.	

Discharge process	Expected practice	Royal Glamorgan Hospital	Prince Charles Hospital
	Discharge plans are reviewed daily and there is evidence of actions completed.		
	Potential constraints are identified and actioned/escalated.		
	The patient and their family/carers are regularly updated on progress with the discharge plan.		
Complex discharges	Alternative community pathways are considered to facilitate early discharge and optimise independence.		
	The 'discharge/transfer' to assess model is considered in all complex discharges.		
	Timely MDT assessment is collated by the care co-ordinator.		
	A tailored discharge plan is co-produced with the patient/carer, reflecting their strengths and what is most important to them.		
	Third sector provision is considered where appropriate.		
	Where required (eg to discuss onward placement or to determine CHC eligibility) MDT meetings are arranged in a timely manner.	Not applicable	
	If a care home placement is required, the patient and carer are provided with 'Clear information on the category of home they should by looking for'.	Not applicable	
	Information on care homes in the area.	Not applicable	
	Information on the Choice Policy.	Not applicable	
	Information on where they can access help in looking for a suitable home if they require it (eg third sector).	Not applicable	
Stage 5 All discharges	A checklist is completed to ensure that the practicalities of discharge are addressed.		

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

Exhibit 12: the RAG status of the Delivery Unit's assessment of written evidence in case notes against specific requirements set out in Passing the Baton in community hospitals in Powys Teaching Health Board

The table shows that written evidence in relation to the patient discharge process was variable when assessed against expected practice

Discharge process	Expected practice	Community hospitals
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.	
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 is 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.	

Discharge process	Expected practice	Community hospitals
Stage 4 All discharges	The EDD is clearly communicated to the patient and their family/carers.	
	Discharge plans are reviewed daily and there is evidence of actions completed.	
	Potential constraints are identified and actioned/escalated.	
	The patient and their family/carers are regularly updated on progress with the discharge plan.	
Complex discharges	Alternative community pathways are considered to facilitate early discharge and optimise independence.	
	The 'discharge/transfer' to assess model is considered in all complex discharges.	
	Timely MDT assessment is collated by the care co-ordinator.	
	A tailored discharge plan is co-produced with the patient/carer, reflecting their strengths and what is most important to them.	
	Third sector provision is considered where appropriate.	
	Where required (eg to discuss onward placement or to determine CHC eligibility) MDT meetings are arranged in a timely manner.	
	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.	
	Information on care homes in the area.	
	Information on the Choice Policy.	
	Information on where they can access help in looking for a suitable home if they require it (eg third sector).	
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 Powys Teaching Health Board, 2016

Appendix 2

Audit method

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

Exhibit 13: audit methodology

The table shows the range of activities undertaken as part of the audit process.

Method	Detail
Data Collection Form – Discharge Planning (Trust 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 Trust submitted the completed data collection form.
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 Trust did not submit a form as they do not have a discharge lounge.
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 Trust did not submit a form as they do not have a discharge liaison team.

Method	Detail
Document request	We reviewed documents from the Trust 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.
Interviews	We interviewed the following staff: • Medical Director • Director of Operations • Director of Nursing • Head of Nursing • Supportive Care Nursing Lead • Ward manager • Occupational Therapy Lead • Palliative Care Lead • Pharmacist • Independent Member with responsibility for quality and safety • Patient Experience Lead • Community Health Council officer
Use of existing data	We used existing sources of information wherever possible such as the Delivery Unit's work on discharge planning from 2016, data from the StatsWales website for numbers of delayed transfers of care, hospital beds, staff, admissions, patients spending 12 hours or more in accident and emergency departments and lengths of stay.

Appendix 3

The Trust's management response to the recommendations

The Trust's management response will be inserted once the response template has been completed. The appendix will form part of the final report to be published on the Wales Audit Office website once the report has been considered by the Audit and Corporate Governance Committee.

Exhibit 14: management response

The table sets out the report's recommendations and the actions that the Trust intends to take to address them.

Ref	Recommendation	Intended outcome/benefit	High priority (yes/no)	Accepted (yes/no)	Management response	Completion date	Responsible officer
R1	**Development of the discharge policy:** The Cancer Centre is developing a new discharge policy. While it is a positive first draft, there are a number of additions that the Trust could add to support safe and timely discharges. These are: a. In the section on Ownership and Responsibilities:	Clear policies and procedures that can support effective discharge planning.	Yes	Yes	The draft that was reviewed as part of the audit process has been further developed and takes account of the recommendations made at R1.	13/10/17	L Padwick, Inpatient Service Improvement Lead

Ref	Recommendation	Intended outcome/benefit	High priority (yes/no)	Accepted (yes/no)	Management response	Completion date	Responsible officer
	• set out the role of the 'discharging nurse' responsible for arranging a patient's discharge; • set out the role of the palliative care team in planning a patient's discharge; and • add more detail on who is responsible for the escalation process when discharge is at risk of delay.						
	b. Add a section on the process for managing patients who might be deemed vulnerable because of social circumstances, such as homelessness.			Yes	Already completed	4/9/17	L Padwick, Inpatient Service Improvement Lead

Ref	Recommendation	Intended outcome/benefit	High priority (yes/no)	Accepted (yes/no)	Management response	Completion date	Responsible officer
	c. Add a section for those patients who meet the definition of a vulnerable adult under the Wales Interim Policy & Procedures for the Protection of Vulnerable Adults from Abuse (2010).			Yes	Already completed	4/9/17	L Padwick, Inpatient Service Improvement Lead
	d. Document the requirement for the supportive care team to refer all patients for a formal carer's assessment.			Yes	In progress	1/1/18	M Pengelly, Supportive Care Lead Nurse
	e. Define in more detail each discharge category, including a flow chart or decision tree for selecting the appropriate discharge pathway.			Yes	In progress	1/11/17	L Padwick, Inpatient Service Improvement Lead

Ref	Recommendation	Intended outcome/benefit	High priority (yes/no)	Accepted (yes/no)	Management response	Completion date	Responsible officer
	f. Make explicit reference to the folder of discharge information and forms, which was developed by ward staff and successfully used to support the discharge process.			Yes	In progress	1/11/17	L Padwick, Inpatient Service Improvement Lead
	g. Document the procedure for keeping the folder of discharge information and forms up to date.			Yes	Added into the role of the Discharge Coordinator	1/11/17	L Padwick, Inpatient Service Improvement Lead
	h. Further develop the medicines management section to include the role of pharmacists in the discharge process.			Yes	Already completed	29/9/17	L Padwick, Inpatient Service Improvement Lead
	i. Provide training for staff in the multi-disciplinary team on the policy once it has been finalised.			Yes	In progress	1/12/17	L Padwick, Inpatient Service Improvement Lead

Ref	Recommendation	Intended outcome/benefit	High priority (yes/no)	Accepted (yes/no)	Management response	Completion date	Responsible officer
R2	**Consultation on the draft discharge policy:** While the Discharge Policy is still in draft, the Trust should share the draft policy to incorporate the views of key stakeholders, in particular: • district nurses based in local health boards; • lead staff from health boards and local authorities responsible for equipment stores; and • patients and carers.	Ensure that the policy reflects the views of key stakeholders	Yes	Yes (with caution)	VCC's unique situation, requires it to work with all Health Boards. Each of which work in different ways, and sometimes different areas within a Health Board can work in different ways for both services and equipment. To try to muster a general consensus is impractical. We will: • undertake an audit to show the length of time it takes to access equipment; • liaise with Aneurin Bevan regarding a possible pilot trial for VCC occupational therapists directly accessing equipment rather than through the HB; • ask for feedback from Social services and District nursing from our immediate neighbours of Cardiff and Vale Health Board; • Service Level Agreements are to be addressed in 2018 regarding the access to equipment; and • the policy will be presented to the Patient Liaison Group, and the Patient Dignity Group for feedback.	1/1/18	L Padwick, Inpatient Service Improvement Lead. M Pengelly, Supportive Care Lead Nurse K Johnson, Clinical Lead Occupational Therapist

Ref	Recommendation	Intended outcome/benefit	High priority (yes/no)	Accepted (yes/no)	Management response	Completion date	Responsible officer
					• The policy will be added to the Trust Internet Site and can be accessed by professionals and the public.		
R3	**Information for monitoring discharge arrangements**: Information on delayed transfers of care (DToC) are rarely reported to the Board because numbers are low. In addition to reporting on the KPI for increasing the number of patients dying in their place of choice and increasing the number of patients who access their preferred place of care, the Trust should consider collecting and reporting on the following information to the Quality and Safety Committee:	Better insight into problem discharges will provide opportunities to improve the process	Yes	Yes	The discharge group has met with our Datix team to help refine our data capture process to consider the KPI's detailed in this report.	19/10/17	M Pengelly, Supportive Care Lead Nurse

Ref	Recommendation	Intended outcome/benefit	High priority (yes/no)	Accepted (yes/no)	Management response	Completion date	Responsible officer
	a. % of discharges within 24 hours and 72 hours of the patient achieving ‘optimal clinical state’; b. number and reasons for delays transferring patients to other hospitals, care homes or their home; and c. problems with discharges as recorded on the Datix patient safety system.						

Ref	Recommendation	Intended outcome/benefit	High priority (yes/no)	Accepted (yes/no)	Management response	Completion date	Responsible officer
R4	**Discharge data on the patient administration system:** The current system, Canisc, does not have the facility to capture data on the type of discharge or delays to discharge. The Trust should ensure that any new patient administration system can capture information for monitoring and reporting on performance related to discharge processes and planning.	Improved understanding of service performance to inform and support continuous improvement.		Yes	A solution to a Canisc replacement is currently being developed as part of the IMTP for IM&T. We will ensure this requirement is included in the specification. However, any developments to the Canisc rely on external dependencies which could cause delays in developments.	01/11/2019	

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