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Discharge Planning Progress Update – Aneurin Bevan University Health Board

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Summary report

About this report

1 In 2017, the Auditor General reviewed discharge planning across all Health Boards in Wales. That work focussed on strategic planning, arrangements for monitoring and reporting on discharge planning, and action being taken to manage discharge planning and secure improvements. Our 2017 report on discharge planning for Aneurin Bevan University Health Board (the Health Board) found that '**the Health Board has well-developed plans for improving discharge planning, however performance fluctuates and there is scope to improve the discharge policy, pathways and training'**. We made several recommendations for the Health Board to address as part of that report.

2 The Auditor General had originally included work in his 2021 local audit plans to examine whole system issues affecting urgent and emergency care services, including the discharge of patients from hospital. The COVID-19 pandemic resulted in this work being postponed and brought back on stream in 2023-24. Our work has sought to examine whether health boards and local authorities have effective arrangements in place to ensure the timely discharge of patients out of hospital. The findings from that work are set out in a separate report to the Health Board and its local authority partners in the Gwent region. The regional report will be made available on our website once considered by the appropriate Health Board and local authority committees.

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

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

Key findings

5 Data from February 2024 showed that across the Health Board's main sites, there were 240 patients whose discharge had been delayed beyond 48 hours. Approximately, 17% of these delays related to discharge planning issues within the Health Board, including the completion of clinical assessments.

6 Our 2017 report made four recommendations that set out seven specific actions for the Health Board. Noting that the Health Board had accepted these recommendations, our follow up work found that:

- no progress has been made against one of the actions;
- work is still ongoing against four of the actions; and
- two of the actions have been implemented.

7 Specifically, we found that:

- the Health Board has made progress developing supporting tools for discharge, but these have not been developed with partners and the communication and monitoring of the tools need improving;
- there is clear guidance setting out when patient transport should be used but there is a lack of awareness of the transport booking policy and communicating predicted waiting times continues to be reliant on local arrangements;
- the Health Board has taken steps to improve its induction training in relation to discharge but needs to go further to improve refresher training and embed joint training with other partners; and
- there is no access for health staff to up-to-date information about waiting times for needs assessments or services to commence, although there are examples of positive integrated working which provide information on a case-by-case basis.

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

Recommendations

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

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

Exhibit 1: new recommendations arising from this follow-up work

Recommendations
Discharge pathways R1 The Health Board should ensure future and updated tools to support discharge pathways are developed with partners (where relevant), communicated to staff and displayed prominently on wards.
Patient transport R2 The Health Board should strengthen arrangements for managing patient transport by: 2.1. ensuring staff have easy access to relevant transport policies and information and their use is monitored to ensure they are operating as intended; and 2.2. putting in place a formal mechanism to monitor waiting times for patient transport to enable any themes to be highlighted and challenges to be addressed.
Waiting times for services to commence R3 The Health Board should work with its local authority partners to identify ways of providing staff with up-to-date information on waiting times for needs assessments for community-based services and the lead-in time for those services to commence.

Source: Audit Wales

Exhibit 2: recommendations included in the regional report on patient flow replacing previous 2017 recommendations

Recommendations
Improving training and guidance R1 The Health Board and local authorities should embed processes to communicate discharge planning guidance to all relevant health and social services staff, including those working on a temporary basis, supported by an ongoing programme of refresher training and induction training for new staff. Where possible, this should be done on a joint basis.

Recommendations

Improving the quality and sharing of information

R8 The Health Board and local authorities should implement ways in which patient information can be shared more effectively, including opportunities to provide wider access to organisational systems and ultimately joint IT solutions.

Source: Audit Wales

Detailed report

Implementation of previous audit recommendations

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

- discharge pathways (2017 Recommendations 1);
- discharge lounge (2017 Recommendations 2a and b);
- discharge planning training (2017 Recommendations 3a, b and c); and
- information on community services (2017 Recommendation 4).

12 Overall, we found that **the Health Board has made progress developing supporting tools for discharge and a clear process for arranging patient transport. But discharge training should be more impactful and regular, and integrated data sharing needs to be developed to ensure staff have the relevant information they need for efficient discharge.**

Discharge pathways

13 We considered whether the Health Board has:

- developed supporting tools for the main discharge pathways in an appropriate format, for example flow-charts or tables. These documents should have been developed with partner organisations, appended to the revised discharge policy, and displayed prominently (2017 Recommendation 1).

14 We found that **the Health Board has made progress developing supporting tools for discharge, but these have not been developed with partners and the communication and monitoring of the tools need improving.**

15 A range of tools to support effective discharge are in place but these have not been developed with partners. The updated Health Board's discharge policy in October 2023 is aimed at all health care professionals, voluntary and third sector staff involved in discharge in a clinical setting so would benefit from being collaboratively created. This is a missed opportunity to develop integrated approaches to discharge across partners which could make the process more efficient and improve awareness and communication of the policy. This is especially relevant for sites which have social care staff embedded with health teams such as the Caerphilly Council social care team and on the Integrated Frailty Ward.

16 The discharge policy provides links to several useful tools, such as the choice of accommodation policy or the policy for managing patients reluctant to discharge from hospital. The discharge policy also usefully appends the D2RA[1] pathways which provide the journey patents should move through for each stage. However, it is not clear how the discharge policy is communicated to operational staff to enable its intended impact.

17 A Standard Operating Procedure (SOP) was developed for the 'Homeward Bound' ward[2] in November 2022 which outlines the purpose of the ward in promoting independence for medically optimised patients. Discharge letters are appended to the SOP along with a flow chart for 'assessment escalation of a deteriorating patient'. Whilst this is a useful tool and approach to promote discharge of medically optimised patients, it is not clear who is responsible for communicating this or how it is embedded into staff training and induction. The development of the 'Ready to Go Unit'[3] may want to consider these challenges.

18 We saw no evidence of the Health Board assessing compliance with its discharge policy. Although the policy states that an annual programme of learning would be reported annually to the Patient Quality, Safety, and Outcomes Committee, at the time of our review we did not see any evidence that this had occurred.

19 All the Health Board's documents with respect to discharge must be accessed online to prevent old versions being used. While this is understandable, it is not always helpful to busy ward staff, and makes it difficult for these documents to be displayed prominently. A number of these support tools are, however, included in the staff handbooks for each of the hospital sites.

20 We therefore consider that **ongoing action is needed to address recommendation 1 (replaced with 2024 Recommendation 1).**

Discharge lounge

21 We considered whether the Health Board has:

- developed clear transport booking guidance for nurses (2017 Recommendation 2a); and

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

[2] The purpose of the Nurse Led Ward is to provide an environment for patients who are medically optimised for discharge but still require support and nursing interventions. The ward promotes a philosophy of independence, whilst improving patient experience through streamlined support within an Enhanced Local General Hospital.

[3] This unit at Royal Gwent Hospital is co-located alongside the Discharge Lounge to help prepare patients for discharge supporting physical, psychological and social wellbeing needs.

- fostered better communication with the non-emergency ambulance service so nurses can communicate predicted waiting times to patients (2017 Recommendation 2b).

22 We found that **there is clear guidance setting out when patient transport should be used but there is a lack of awareness of the transport booking policy and communicating predicted waiting times continues to be reliant on local arrangements.**

23 Guidance within the discharge policy explicitly states to staff that patients should be encouraged to arrange their own transport, and that family, friends and voluntary organisations should be used before relying on the Patient Transport Service run by the Welsh Ambulance Services NHS Trust. A discharge planning 'Guide for Patients, Families and Carers' has also been appended to the main discharge policy. This reiterates in accessible language that patients should arrange their own travel arrangements with hospital transport only available to those with a medical need.

24 The policy also accommodates for unexpected 'on the day' discharges and refers readers to a separate linked document on Transport Booking for Patient Discharge and Transfer Policy. However, staff awareness of this policy is low, and it is not easily accessible meaning its impact is limited, although the use of discharge lounges and whether patients are eligible for patient transport is included in the staff handbook for each hospital site. We therefore consider that **recommendation 2a has been implemented** but further work is required to raise staff awareness **(2024 recommendation 2.1).**

25 During our review of discharge planning in 2017, staff expressed concerns about long waits for patients in the discharge lounges due to patient transport delays and not being able to tell patients how long their wait will be. Since our previous work, the Health Board has developed a Flow Centre which co-ordinates most inter-site patient transport. However patient discharge transport is booked directly from wards through a dedicated phone number and staff maintain communication with the Patient Transport Service for updates, as expected times of collection are not given when booking. These ongoing checks can be time intensive, and patients do not know how long they will have to wait in discharge lounges before being collected. Although discharge lounges are in use, patients can frequently be waiting in different parts of the hospital, resulting in lots of different points of contact. Whilst there were no known issues of escalation at the time of our work, the Health Board cannot be assured this mechanism is effective if there is no formal way of measuring and monitoring the waiting times. The Health Board should put in place a mechanism to understand and monitor patient waiting times at the point of discharge. This will help identify and address any themes and challenges which arise. We therefore consider **ongoing action is needed to address recommendation 2b (replaced with 2024 recommendation 2.2)**.

Discharge planning training

26 We considered whether the Health Board has:

- included discharge planning on induction programmes for staff that will be involved in discharge planning (2017 Recommendation 3a);
- offered regular refresher training (2017 Recommendation 3b); and
- for consistency, considered offering training to staff from partner organisations, who are involved in discharge planning (2017 Recommendation 3c).

27 We found that **the Health Board has taken steps to improve its induction training in relation to discharge planning but needs to go further to improve refresher training and embed joint training with other partners.**

28 To ensure smooth discharge across all sectors, discharge training at induction needs to be impactful and consistent. The Health Board's corporate induction programme includes the discharge policy, and discharge planning training is provided to all newly registered nurses along with competency checks. In addition, all Band 4 nurses undertake competency checks in relation to discharge planning. Local ad-hoc training is also provided to new starters via a buddy mechanism, and when there are large groups of new starters such as the onboarding of overseas nurses, group training sessions take place. We therefore consider that **recommendation 3a has been implemented.**

29 The Health Board's programme of refresher training on discharge planning was impacted by the pandemic and further work is required to ensure that this training is consistently implemented across each hospital site. The need for such training is evidenced by inconsistencies in current approaches to discharge across hospital sites and by the fact that we heard differing views from operational staff as to whether refresher training is offered. We therefore consider that **ongoing action is needed to address recommendation 3b (replaced by 2024 Regional Recommendation 1).**

30 Whilst operational staff reported good working relationships across health and social care, no action has been taken against the previous recommendation around offering joint training to staff across health and social care. Notwithstanding that capacity issues and the number of statutory bodies involved can make this challenging to organise, there are still benefits to be secured in terms of ensuring guidance is understood and consistently adopted, and that expectations between partners are both understood and managed. **Recommendation 3c has therefore been replaced by 2024 Regional Recommendation 1.**

Information on community services

31 We considered whether the Health Board has:

- considered including information about waiting times for needs assessments and for services to commence within the wider information it collates on community service provision (2017 Recommendation 4).

32 We found that **typically health staff do not have access to up to-date information about waiting times for needs assessments or for community-based services to commence, although there are examples of positive integrated working which provide information on a case-by-case basis**.

33 Many staff are unaware of the complete range of community-based services that exist and the associated waiting times for those services to commence. This was noted as part of our work as a significant training need. To address this, the Health Board should work with its local authority partners to identify ways of providing staff with up-to-date information on waiting times for needs assessments for community-based services and the lead in time for those services to commence.

34 At an operational level the Health Board has regular multi-disciplinary operational meetings to discuss patient discharge. This includes ward rounds and length of stay meetings with input from social workers to help understand the waits for services to commence. In addition, ward-based discharge co-ordinators can access both health and local authority systems, as can the Integrated Frailty Team. These are further examples of good integrated information sharing, albeit that the capacity of discharge co-ordinators is limited.

35 However, waiting times for community-based services such as housing adaptations are not well known. This is made more complicated by cross-authority service provision and the lack of shared IT solutions across health and local government to provide information on waiting times for needs assessment and for services to commence. In the absence of such systems, there is a reliance on staff making time consuming manual enquiries for each patient on a case-by-case basis. We therefore consider that **ongoing action is needed to address recommendation 4 (replaced with 2024 Recommendation 3).**

Appendix 1

Audit methods

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

Exhibit 3: audit methods

Element of audit methods	Description
Documents	We reviewed a range of documents, including: • Board and committee papers • Updates on the Six Goals Programme and urgent and emergency care to committees • Operational and strategic plans relating to urgent and emergency care • Standard Operating Procedure for discharge planning • Corporate risk registers and performance reports • Operational documents, such as proformas and checklists, escalation processes, staff handbooks and leaflets and guidance
Interviews	We interviewed the following: • Head of Patient Discharge • Executive Director of Operations • General Manager Family & Therapies • General Manager Urgent Care • Assistant Head of Patient Discharge • General Manager for Medicine • Deputy Head of Operations • Divisional Operations Manager • Director of Primary and Community Care and Mental Health • Chief Officer of Aneurin Bevan Community Health Council (now Llais)

Element of audit methods	Description
Observations	We observed the following meeting(s): • Cross site flow meeting via Teams • Flow Meeting (Gwanwyn MDT) • Flow Meeting (Education Centre Ysbyty Ystrad Fawr) • Six Goals Urgent Care Meeting • System Leadership and Response Meeting We also observed the following individual(s): • Discharge Co-ordinator at Neville Hall Hospital
Data analysis	We analysed the following national data: • Monthly social services dataset submitted to the Welsh Government • Monthly delayed discharges dataset submitted to the NHS Executive • StatsWales data • Ambulance service indicators We also analysed data provided by the Health Board relating to all emergency medicine patients discharged in October 2022 with a length of stay greater than 21 days (excluding those who died).
Case note review	We reviewed a sample of 29 case notes relating to emergency medicine patients discharged in October 2022 with a length of stay greater than 21 days (excluding those who died).
Focus Groups	We undertook focus groups with the following: • Discharge co-ordinators
Self-assessment	We asked the Health Board to complete and submit a self-assessment, setting out its view of progress against our 2017 recommendations.

Source: Audit Wales

Appendix 2

Summary of progress against our 2017 recommendations

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

Recommendations	Progress
Discharge pathways R1 Whilst discharge pathways are in place, we found no evidence of documents to support staff to implement them. The Health Board should develop supporting tools for the main discharge pathways in an appropriate format, for example, flow-charts or tables. The documents should be developed with partner organisations, appended to the revised discharge policy, and displayed prominently.	**Ongoing –** see paragraphs 15-20 (replaced with 2024 Recommendation 1).
Discharge lounge R2 Ward staff expressed concerns about patients waiting for long periods of time in discharge lounges, mainly due to issues with nonemergency patient transport and staff not booking the right form of transport. The Health Board should: a) Develop clear transport booking guidance for nurses. b) Foster better communication with non-emergency ambulance services so nurses can communicate predicted waiting times to patients.	**Implemented –** see paragraph 24 **Ongoing –** see paragraph 25 (replaced with 2024 Recommendation 2.2)

Recommendations	Progress
Discharge planning training R3 We found induction programmes for nursing, medical and therapy staff did not include training on discharge planning. The Health Board should: a) Include discharge planning on induction programmes for staff that will be involved in discharge planning. b) Offer regular refresher training. c) For consistency, consider offering training to staff from partner organisations, who are involved in discharge planning.	**Implemented –** see paragraph 28 **Ongoing –** see paragraph 29 (replaced with 2024 Regional Recommendation 1) **No action –** see paragraph 30 (replaced with 2024 Regional Recommendation 1)
Information on community services R4 We found the Health Board regularly collates information about community services; however, waiting times are not included. The Health Board should consider including information about waiting times for needs assessments and for services to commence.	**Ongoing –** see paragraphs 33 to 35 (replaced with 2024 Recommendation 3)

Source: Audit Wales

Appendix 3

Management response to audit recommendations

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

Exhibit 5: management response

Recommendation	Management response Please set out here relevant commentary on the planned actions in response to the recommendations	Completion date Please set out by when the planned actions will be complete	Responsible officer (title)
Discharge pathways R1 The Health Board should ensure future and updated tools to support discharge pathways are developed with partners (where relevant), communicated to staff and displayed prominently on wards.	Policy: • The Health Board will review its Discharge Policy in light of the new National Policy published in September 2024. • The Policy will include standard operating procedures (SOP) for Discharge to ensure that there is clarity for staff. • A communication plan for staff, partners and managers will be completed and posters for ward areas will be developed which set out simply the SOPs. Pathways: • Clinical Workstation 2 (CWS2), which is currently being rolled out across the health	January 2025 November 2024	Executive Director of Nursing Executive Director of Nursing

Recommendation	Management response Please set out here relevant commentary on the planned actions in response to the recommendations	Completion date Please set out by when the planned actions will be complete	Responsible officer (title)
	board has the functionality to assign the correct pathway to each patient: this will integrate with Qlik to ensure daily live capture of patient pathways.		
	• 'Complex List' to be developed into CWS2 with daily data feedbacks, local authority and health staff to have access to the digital system.	March 2024	Executive Director of Nursing/Director of Digital
	• Agreement has been reached to develop an app called 'Ask Annie: this app will provide access to information on Integrated Discharge Pathways and Services. This app is in the early stages of development.	April 2025	Executive Director of Nursing/Director of Digital
	• A series of workshops are planned to develop a single integrated pathway for Discharge – this will aim to reduce complexity and duplication by creating single access points for discharge services and advice and guidance. This follows a successful piece of work on integrating front door pathways.	January 2025	Executive Director of Nursing
	• An optimal ward project 'Perfect Ward' is planned which will right size the processes, capacity and capability within ward environments to optimise patient flow and discharge.	March 2025	Executive Director of Nursing/Chief Operating Officer
	• Audit and evaluation of the Discharge improvements, plans and pathways will be undertaken post implementation.	June 2025	Executive Director of Nursing

Recommendation	Management response Please set out here relevant commentary on the planned actions in response to the recommendations	Completion date Please set out by when the planned actions will be complete	Responsible officer (title)
	• A patient discharge leaflet will be developed to reinforce the 'what matters' conversation and discharge planning at point of admission. Training: • The Health Board and its partners have secured additional funding to pilot the Balancing Rights and Responsibilities Training – the first cohort took place in November 2024 and following evaluation will be embedded within the discharge programme. • Further review of the training for new registrants and additional update training will be scoped in the context of the above training and the development of the app. • Embedding of the Optimal Hospital Flow Framework across all sites – Red to Green, SAFER, D2RA, Deconditioning	April 2025 June 2025 April 2025 April 2025	Executive Director of Nursing Executive Director of Nursing/Director of Workforce & OD Executive Director of Nursing Executive Director of Nursing
Patient transport R2 The Health Board should strengthen arrangements for managing patient transport by:	The Health Board will: • Review current guidance on transport booking that is on the Intranet and update as required. • Develop communication plan with the Health Board's Communications Team to	December 2024 December 2024	Chief Operating Officer Chief Operating Officer

Recommendation	Management response Please set out here relevant commentary on the planned actions in response to the recommendations	Completion date Please set out by when the planned actions will be complete	Responsible officer (title)
2.1 ensuring staff have easy access to relevant transport policies and information and their use is monitored to ensure they are operating as intended; and 2.2 putting in place a formal mechanism to monitor waiting times for patient transport to enable any themes to be highlighted and challenges to be addressed.	disseminate information across the Health Board. • Roll out renewed guidance to service users. • Discuss potential for live reporting system with the National NEPTS Delivery Action Group and Joint Commissioning Committee. • Utilise current WAST reports available to provide monthly updates on waiting times and themes. Arrange for standing agenda item at Tier 3 Transport Group meeting. • Discharge Lounges to be operational across all sites, to ensure timely patient transport.	January 2025 March 2025 January 2025 February 2025	Chief Operating Officer Chief Operating Officer Chief Operating Officer
Waiting times for services to commence R3 The Health Board should work with its local authority partners to identify ways of providing staff with up-to-date information on waiting times for needs assessments for community-based services and the lead in time for those services to commence.	Further work to improve the flow of information will be addressed through the 'Perfect Ward' project which will create the optimal environment for clinical teams working with social care colleagues to optimise discharge. Agreement has been reached to develop an app called 'Ask Annie': this app will provide access to information on Integrated Discharge Pathways and Services. This app is in the early stages of development.	March 2025 April 2025	Executive Director of Nursing Executive Director of Nursing/Director of Digital

Recommendation	Management response Please set out here relevant commentary on the planned actions in response to the recommendations	Completion date Please set out by when the planned actions will be complete	Responsible officer (title)
	The Integrated Discharge Board will be formalised as a Tactical sub-group of the RPB. It is intended and has been agreed that greater transparency in reporting will be developed. A dashboard providing access to waiting times for community assessment and service availability will be included.	September 2025	Executive Director of Nursing/Chief Operating Officer
	Weekly review of Pathway of Care Delays, patients over 100 days, working local authority partners.	December 2025	Executive Director of Nursing

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