Bundle Audit & Risk Assurance Committee 22 October 2019

4.7 Response to WAO Report: What's the hold up? Discharging Patients in Wales Update

Presenter: Joe Teape

SBAR What's the hold up? Discharging Patients in Wales ARAC October 2019

Discharging patients in Wales leaflet

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

PWYLLGOR ARCHWILIO A SICRWYDD RISG
AUDIT AND RISK ASSURANCE COMMITTEE

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	22 October 2019
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	What's the hold up? Discharging patients in Wales – Wales Audit Office Toolkit
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Joe Teape, Director of Operations
SWYDDOG ADRODD: **REPORTING OFFICER:**	Alison Bishop, Service Delivery Manager, Unscheduled Care

Pwrpas yr Adroddiad (dewiswch fel yn addas) **Purpose of the Report** (select as appropriate)
Er Sicrwydd/For Assurance

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

In March 2019, the Wales Audit Office (WAO) issued the "What's the hold up? Discharging Patients in Wales" report to NHS bodies, so that they could assure themselves that hospital discharge arrangements are safe and timely.

This national report was not specifically focussed on Hywel Dda University Health Board (HDdUHB) but was intended to provide Independent Board Members with lines of enquiry in relation to assurance on discharge arrangements.

This paper is a position statement against this report.

Cefndir / Background

In August 2019, the Audit & Risk Assurance Committee received a self-assessment against this report and toolkit and copies of the county integrated unscheduled care plans. The Committee were not assured, due to the lack of detail and inconsistency of the county integrated plans.

This report, therefore, gives a more focussed self-assessment on progress the UHB has made to date and areas for further development, with appropriate timescales.

Asesiad / Assessment

A review of the 6 themes contained within the WAO report has been completed, together with an assessment of progress against each theme and where applicable next steps detailed;

Theme / Assessment	Areas of good practice	Areas for further development
Information relating to discharge	Informatics teams have been working directly with the acute sites, down to ward level, to ensure that a dashboard is available, fully understood and being utilised. This dashboard provides the following information which is part of the SAFER bundle; - Admissions - % discharges before midday - average Length of Stay (LoS) - % bed occupancy	
	All counties undertake regular reviews of - LoS data, - stranded patient data (patients with a LoS > 7 days) - super stranded patients with LoS > 28 days.	There remains a need to ensure all of our sites are consistently using the same definitions to ensure delays are clearly identified.
	Discharge planning performance is a standing agenda item at the USC Programme Board. The County Director's quarterly report to Board presents regular updates on progress towards implementation of Integrated Community Models of	

	service and patient pathways. Discharge planning performance is an integral element of this report. Delayed transfers of care are part of the routine performance reports and medically optimised and ready to transfer patients are reported 3 times daily on situation reports.	
Pathways to support better discharge		Previously developed discharge standards were never agreed with partners and therefore were difficult to implement. A refreshed approach based on the 4 nationally agreed 'Discharge to Assess/Recover' (D2RA) pathways are being developed, approved with each local authority and will be implemented as part of the Unscheduled Care 3 year plan.
		The Regional Partnership Board is working closely with the Delivery Unit on the Right Sizing Community services programme. This is a demand and capacity review across all integrated community services, allows benchmarking within and across organisations and can be used to inform on where changes within the system would be most beneficial. This programme has just undertaken the first collection of the integrated system data which has highlighted several gaps where data is not available locally or nationally. Work

		is ongoing to develop a better understanding of how this data can be captured to further inform this process. The Health Board continues to have insufficient pathways out of hospital to support timely discharge and this remains a major area of focus if we are to improve our overall performance and ensure patients are treated in the most appropriate settings.
Discharge liaison teams & discharge lounges	All acute sites regularly review the availability and capacity of the discharge liaison teams and the utilisation of the discharge lounges to facilitate timely discharge.	Discharge lounges will have extended operating hours during the winter period as part of the Health Board's winter plan.
Improving discharge planning	Discharge planning forms a core part of the nursing inpatient documentation and is commenced prior to admission in the A&E Department once the decision to admit is made.	
	Each acute site has an integrated weekly patient review meeting to ensure that any delays in complex discharges are kept to a minimum and where needed delays are escalated in a timely manner.	Red2Green and the SAFER patient bundle have been rolled out in part across both acute and community hospitals. A more focused approach to this work is being undertaken as part of the LoS reduction work, supported by the quality and service improvement teams. This work will need to include a more consistent approach to Board rounds across all sites.
	Discharge planning is reviewed at ward level on a daily basis as part of board rounds.	
Training and awareness	Regular training on discharge planning and complex care management is provided to ward based staff	

	through Community Discharge Liaison teams, Social services and the Long Term Care Team support.	
	Bank Staff are encouraged to attend our discharge planning training and support to facilitate ward discharges is provided by the senior sisters and charge nurse. Discharge planning is reviewed at ward level on a daily basis as part of board rounds.	There remains work to do to embed Home First principles across the Health Board.
Patient engagement	A bi-lingual discharge leaflet was produced with unscheduled care partners, including the Community health Council, and this is provided to patients within the first 24 hours of admission.	Work is ongoing across all sites to ensure early conversations about 'what matters to them' take place with patients and relatives to facilitate timely discharge.
	Working in partnership with Welsh Ambulance Services NHS Trust (WAST) colleagues, postcards clearly setting out the Health Board's expectations in terms of Home First are provided to patients when being conveyed to hospital.	

Whilst the Health Board has some areas of good practice in relation to discharge planning (as confirmed by Delivery Unit reviews) there remains significant work to do to both embed best practice across our sites and create additional capacity out of hospital. All of the above actions will form part of the Unscheduled Care 3 year plan which is currently in development, with a first draft due for completion by 31st October 2019. The plan will include a commitment to appropriate timescales for action.

Argymhelliad / Recommendation

The Audit & Risk Assurance Committee is asked to review this report and note the areas for further improvement.

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Committee ToR Reference Cyfeirnod Cylch Gorchwyl y Pwyllgor	4.4 The Committee's principle duties encompass the following: 4.4.1 Review the establishment and maintenance of an effective system of good governance, risk management and internal control across the whole of the organisation's activities, both clinical and non-clinical. 5.18 The Committee shall review the work and findings of the External Auditor and consider the implications and management's responses to their work. This will be achieved by: 5.18.3 review all External Audit reports, including agreement of the annual Audit Report and Structured Assessment before submission to the Board, and any work carried outside the annual audit plan, together with the appropriateness of management responses;
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	Corporate Risk 629 – Unscheduled Care Score: 16
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	2. Safe Care 2.1 Managing Risk and Promoting Health and Safety 5. Timely Care
Amcanion Strategol y BIP: UHB Strategic Objectives:	4. Improve the productivity and quality of our services using the principles of prudent health care and the opportunities to innovate and work with partners.
Amcanion Llesiant BIP: UHB Well-being Objectives: Hyperlink to HDdUHB Well-being Statement	Improve Population Health through prevention and early intervention Improve efficiency and quality of services through collaboration with people, communities and partners

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	Contained within the report.
Rhestr Termau: Glossary of Terms:	Contained within the report.

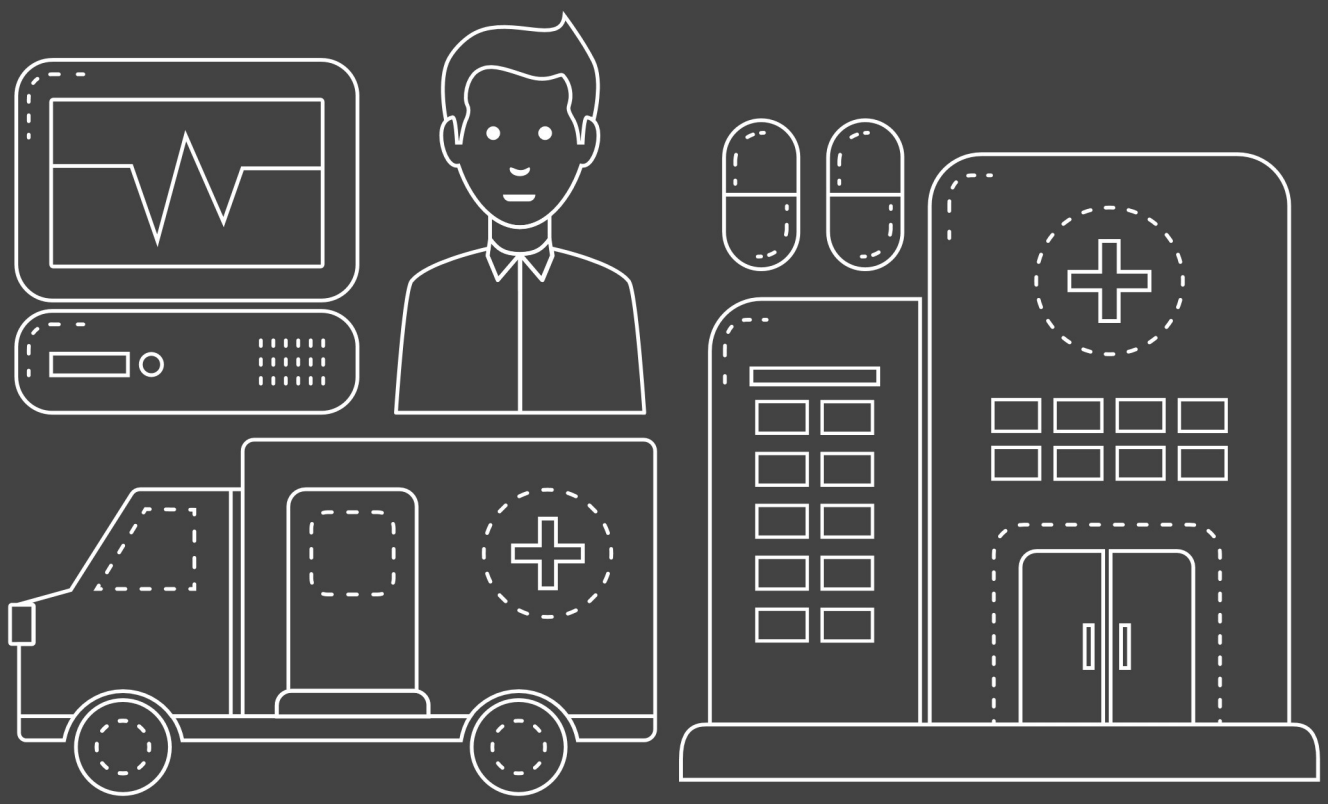
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Pwyllgor Archwilio a Sicrwydd Risg: Parties / Committees consulted prior to Audit and Risk Assurance Committee:	Executive Team Unscheduled Care Board

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Ariannol / Gwerth am Arian: Financial / Service:	Financial impacts and considerations are inherent in the report.
Ansawdd / Gofal Claf: Quality / Patient Care:	Robust winter plans ensure patient care continues to be provided throughout the winter period.
Gweithlu: Workforce:	Use of agency resources to mitigate internal human resource capacity limitations details are contained within the winter plans
Risg: Risk:	The winter period presents heightened risk to the UHB with increased demand across the unscheduled care system.
Cyfreithiol: Legal:	Not applicable
Enw Da: Reputational:	There could be significant reputational risks for the HB and partners in the event of a major incident.
Gyfrinachedd: Privacy:	Not applicable
Cydraddoldeb: Equality:	Bespoke winter plans are in place for the three counties which reflect the needs of the population within each of these counties.

WALES AUDIT OFFICE
SWYDDFA ARCHWILIO CYMRU

What's the hold up?

Discharging patients in Wales

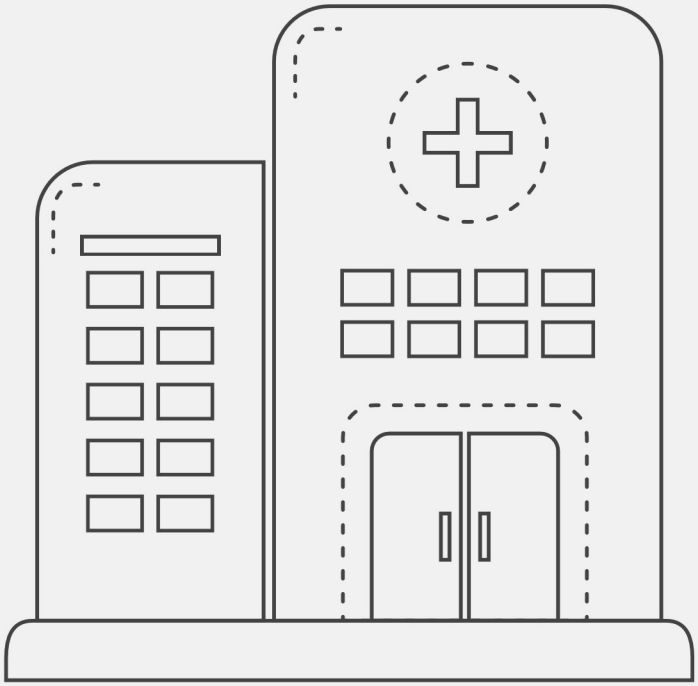


Background

One of the biggest challenges facing NHS bodies in Wales is the problem known as delayed transfer of care. This is when a patient does not need to be in that hospital any longer, but something is preventing them from moving on. When patients are not discharged from hospital promptly, the whole healthcare system 'backs up' as hospital capacity fills up and it gets harder to admit people who need hospital treatment. Clearly it is not good for the patient either – making it harder for them to regain their independence.

The Auditor General and others have focused on this challenge in a range of work with local NHS bodies and community organisations. The Auditor General's audit work was done during 2017, with further work on the Integrated Care Fund (ICF) carried out during 2018. This document complements our formal audit reports and highlights important issues that board members should be sighted of when seeking assurance that patients are discharged from hospital in safe and timely ways.

The findings from our discharge planning audits at health boards and Velindre NHS Trust are available on the Wales Audit Office website.

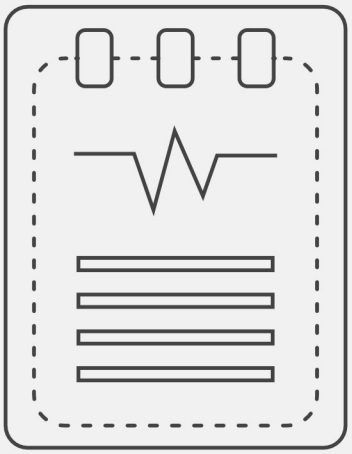


How NHS bodies and their partners are doing

Planning to discharge people from hospital is a theme in many delivery plans and strategies, not least winter plans. The sheer number of synergies and alignments needed for this planning creates problems of overcomplexity.

NHS bodies told us 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. Healthcare professionals need to work with others to find and plan solutions that meet peoples' needs on discharge and ensure the best recovery possible.

There have been many initiatives to improve discharge arrangements, such as the SAFER patient flow bundle, 'red2green',[1] 'end PJ paralysis'[2] and last 1000 days[3]. The Welsh Government has also created funding to foster greater collaboration between health, social care, housing and the third sector. For example, the ICF gives relatively short-term funding to initiatives to make sure only people who really need to be in hospital are there. During 2019, the Auditor General intends to publish a report on how this fund is being used by public bodies across Wales.



1 'red2green' is a visual system to identify wasted time in a patient's journey; patients on the red list no longer benefit from being in an acute hospital bed while those on the green list are still benefitting from their admission.

2 'End PJ Paralysis aims to get patients up and about and out of their pyjamas as soon as they are able to improve recovery and prevent complications.

3 The last 1000 days is a concept that reinforces the value of patients' time as the most important currency in healthcare and to create a sense of urgency to act.

Questions for board members on working with partners

- Does the Board receive information about the effectiveness of partnership working to support discharge planning arrangements and improve patient outcomes?
- Is the organisation evaluating what difference ICF funded initiatives have made in facilitating safe and timely discharge?
- Has the organisation mainstreamed successful ICF funded initiatives that support discharge planning?
- Is the organisation evaluating the impact of initiatives, such as the SAFER patient flow bundle, red2green, end PJ paralysis or last 1000 days, on patient flow and patient outcomes?

Encouragingly, we found relatively clear lines of accountability, and regular scrutiny of discharge planning performance. A range of information is generally available to support timely scrutiny and board members feel well informed. It is clear then, that leaders of Welsh NHS bodies generally understand the importance of effective discharge arrangements.

However, delayed transfers of care are the only national measure of discharge. They are regularly monitored, reported and scrutinised by health and local government bodies. Hospital IT systems can capture a range of data to support monitoring and reporting but, fewer than half of Welsh NHS bodies recorded whether a discharge was simple or complex while only a third recorded the date a patient was declared medically fit for discharge.

Questions for board members on information relating to discharge

- Is the organisation's patient information system supporting the accurate recording of data for monitoring and reporting on operational performance related to discharge planning?
- Is the organisation developing and implementing operational performance metrics and outcome measures to monitor the effectiveness of discharge planning arrangements, for example:
  - the number of patients discharged before midday;
  - the number of patients whose expected date of discharge is recorded;
  - the date patients are medically fit for discharge;
  - whether the discharge is simple or complex;
  - the number of readmissions avoided because of good discharge planning;
  - the number of patients who do not need longer term support;
  - the number of permanent placements in residential care settings avoided?
- Is the organisation regularly collating and reporting on patients' experience of being discharged from hospital?
- Is discharge planning performance, other than delayed transfers of care, regularly reported to the Board or its committees?

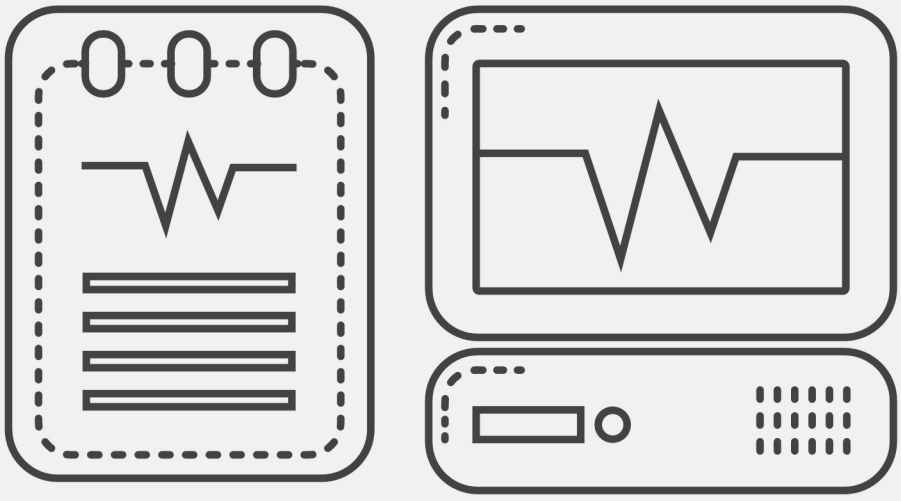
Steps towards improvement

Defined discharge pathways set out steps that healthcare professionals should take when discharging different types of patients. They can be very helpful. Most Welsh NHS bodies had set out some of these pathways, but they varied widely in approach and were not used consistently.

The Welsh Government is encouraging a new model where going home is the default pathway given most patients benefit from assessment in their normal place of residence with the ability to cope in familiar surroundings. The 'home first: discharge to recover and assess' pathway means patients are discharged home once they are medically fit and no longer need a hospital bed. Patients' immediate support needs will have been assessed prior to discharge and the necessary arrangements put in place. Ongoing assessment of patients' support needs can be safely continued at home by members of the appropriate community health and social care team. The approach means patients are not kept in a hospital bed longer than is necessary. We found that just four out of eight NHS bodies were using this model at all or some hospitals. The challenge is enabling community services to respond as soon as patients are discharged and making the discharge to recover and assess approach standard practice.

Questions for board members on pathways to support better discharge

- Is the organisation implementing the discharge to recover and assess pathway?
- Is the organisation identifying and addressing the barriers to implementing the discharge to recover and assess pathway?
- Is the organisation and its partners assessing the capacity of community-based services to underpin discharge to recover and assess pathways?
- Is the organisation evaluating the impact and outcomes of discharge pathways, including the discharge to recover and assess approach?



Across Wales, all NHS health boards operated one or more discharge liaison teams. These teams represent a significant investment of funding and have the potential to help things improve. But, we found that the teams tended to be available weekdays only, with a range of alternative arrangements for outside office hours. Most teams were nurse led rather than being truly multi-disciplinary. We also found that discharge lounges were often under-used. Discharge lounges can provide a suitable environment in which patients can wait to be collected, by either their family or hospital transport, or while medication is dispensed.

Questions for board members on discharge liaison teams and discharge lounges

- Is the organisation regularly reviewing the availability and capacity of the discharge liaison team(s) to provide support seven days a week?
- Is the composition of the discharge liaison team changing to ensure a multidisciplinary approach to discharge planning?
- Is the organisation actively promoting the use of the discharge lounge(s) to support patient flow and release beds promptly for patients waiting admission?
- Is the organisation monitoring and reporting on the efficiency and effectiveness of the discharge lounge(s)?

Important challenges

It is important that staff understand clearly how patients are discharged. We reviewed discharge policies and protocols and found that most NHS bodies set out their approach quite well.

Across Wales, ward staff are generally confident about what needs to be done to support safe and timely discharge, but staff cited several challenges that sometimes make it difficult. These challenges include: underestimating the time needed to effectively plan patient discharge; failing to start the discharge process on admission; discharge assessments undertaken only when the patient is declared fit for discharge; and reliance on temporary staff who may be unfamiliar with discharge processes and the availability of community services.

Questions for board members on improving discharge planning

- Is the organisation taking steps to encourage a culture where 'discharge planning is everyone's business' and a key part of the patient care continuum?
- Does the discharge planning process start on admission?
- Does the organisation know what the key barriers are to safe and timely discharge and is it addressing them?
- Is simple guidance available for bank and agency nursing staff to enable them to contribute effectively to discharge planning arrangements?

Ward staff also speak of a culture of risk aversion, whereby staff are reluctant to discharge patients because they might be at risk for fear they would not cope at home. Whilst staff may be acting out of kindness, they may not be acting in a patient's best interest. Training and information are important tools in improving staff understanding of discharge arrangements and the range and capacity of community health and social care services available to support people in their own homes. There were a lot of materials and resources available, but they were usually locally-produced and not well promoted. We found that access to information on community services was often patchy and training was not done well or not sufficiently frequent. We also found that the discharge liaison teams played only a limited role in helping to train other staff.

Questions for board members on training and awareness raising

- Is information on the range and availability of community health and social care services readily available to ward staff when planning a discharge?
- Are staff involved in, or responsible for, discharge planning supported by regular training?
- Does the discharge liaison team play a role in training staff on discharge planning?

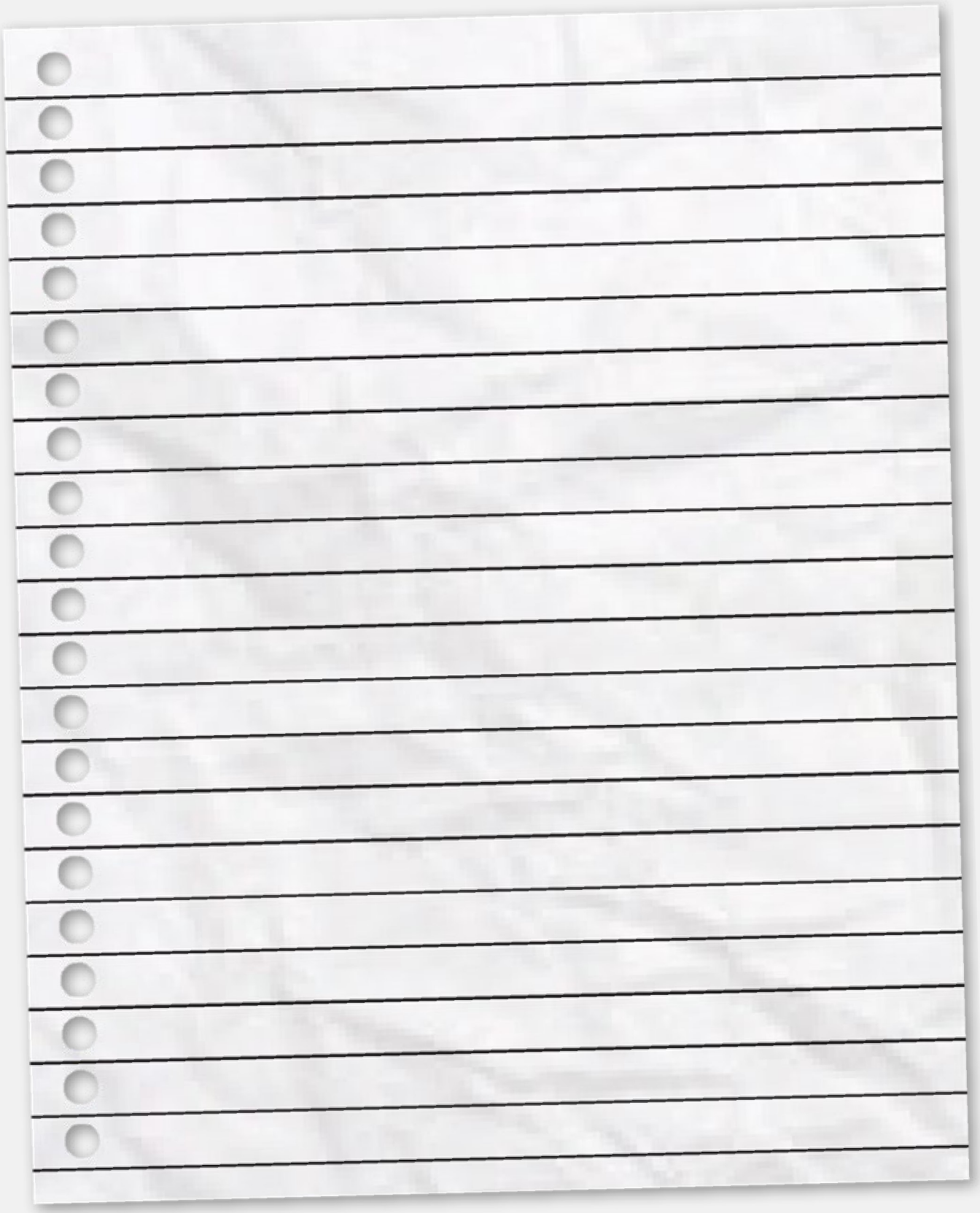
Patients and their families or carers need to understand the discharge process and the support that they can get when they leave hospital if recovery is to be maximised and readmission or long-term residential placement avoided. Across Wales as a whole, we found that the information given to patients and their families or carers was limited.

Questions for board members on patient engagement

- Is the organisation preparing general written information for patients and families on what they should expect from the discharge process and what is expected of them?
- Do staff talk with patients about 'what matters to them'[4] to ensure that discharge is safe, timely and effective?

4 'What matters to you' is a campaign to encourage and support more meaningful conversations between people who provide health and social care and the people, families and carers who receive health and social care.

Notes



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