Archwilio Cymru
Audit Wales

Discharge Planning Progress Update – Swansea Bay University Health Board

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Mae'r ddogfen hon hefyd ar gael yn Gymraeg. This document is also available in Welsh.

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Summary report

About this report

1 In 2017-18, the Auditor General reviewed discharge planning across all Health Boards in Wales. That work focused on strategic planning, arrangements for monitoring and reporting on discharge planning, and action being taken to manage discharge planning and secure improvements. Our 2018 report on discharge planning for Swansea Bay University Health Board[1] (the Health Board) found that '**the Health Board is working collaboratively with stakeholders to improve patient flow and discharge planning, and while there are improvements in performance there is still more to do'**. We made several recommendations for the Health Board to address.

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 and 2024. Our work 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 West Glamorgan region. The regional report will be available on our website once the appropriate Health Board and local authority committees have considered it.

3 As part of our regional work, we have sought to assess the progress made by the Health Board in addressing the recommendations set out in our 2018 discharge planning report. This report sets out the findings with respect to progress against the 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.

[1] At the time of our 2018 work, the organisation was Abertawe Bro Morgannwg University Health Board

Key findings

5 Data from September 2024 showed that across the Health Board's main hospital sites, there were 258 patients whose discharge had been delayed beyond 48 hours. Approximately 14% of these delays related to discharge planning issues within the Health Board, including the completion of clinical assessments.

6 In overall terms, the Health Board has made limited progress in addressing the recommendations we made in 2018 to help improve discharge planning. Our 2018 report made four recommendations that set out six 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 five of the actions; and
- work is still on-going against one action.

7 We note that the introduction of Discharge to Recover then Assess (D2RA) has altered the Health Board's approach to discharge planning and that the Health Board is now adopting the nationally mandated D2RA pathways, but it is of concern that:

- There has been limited action to develop a Health Board wide discharge policy;
- Little progress has been made to strengthen and clarify current discharge pathways to relevant staff;
- No progress has been made in providing training on discharge planning; and
- Some action has been taken to strengthen performance reporting of patient flow and discharge planning to the Board and its committees, although the measures we previously recommended are not yet captured despite the significant pressures caused by delayed discharges.

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 2018 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 2018 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 recommendations are 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 2018 work are set out in **Exhibit 2**. The Health Board should respond to these recommendations as part of the finalisation of the regional report.

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

Recommendations	
R1	The Health Board should review and document all current discharge pathways, ensuring: • there are clear links between each of the pathways; • explanatory information is available; • all pathways are set out in one place; and • pathways are consistent across the Health Board.
R2	The Health Board should review performance reporting to the Board, its committees and at an operational level, to ensure metrics included demonstrate the effectiveness and impact of current discharge planning. Examples may include: • 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

Exhibit source: Audit Wales

Exhibit 2: recommendations included in the regional report on patient flow replacing previous 2018 recommendations

Regional recommendations	
R3	The Health Board, working with local authorities, should: 3.1 Develop jointly agreed guidance to provide clarity to all staff on how the discharge planning process should work across the region. This should be based on the national guidance issued in December 2023 and should set out clearly defined roles and responsibilities, and expectations, including when referrals for ongoing care should be made.

Regional recommendations
3.2 Ensure processes are in place 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.

Exhibit source: Audit Wales

Detailed report

Implementation of previous audit recommendations

11 We considered the Health Board's progress in implementing our 2018 audit recommendations. These focus on:

- discharge policy coverage (Recommendations 1);
- discharge pathways (Recommendations 2);
- training on discharge planning (Recommendations 3a, b and c); and
- discharge reporting (Recommendation 4)

12 Overall, we found that **the Health Board has made little progress to address our previous recommendations. There is no Health Board wide discharge policy or training for staff, and discharge pathways have not been clearly documented. Although various discharge initiatives have been put in place since our previous audit, opportunities remain to further strengthen performance reporting.**

Discharge policy coverage

13 We considered whether the Health Board has ensured that its discharge policy includes reference to early discharge planning, the risk of readmission, and discharge from Emergency Departments (2018 Recommendation 1).

14 We found that **the Health Board does not have a single Health Board wide discharge policy which reflects current arrangements for discharge planning.**

15 The Health Board has adopted the Welsh Government Discharge to Recover and Assess (D2RA) national guidance but there is no formal and widely available local discharge policy which encourages early discharge planning, risk of readmission and discharge from Emergency Departments.

16 The Health Board developed an Integrated Discharge Strategy (IDS), approved in May 2024. This was a collaborative exercise including both Swansea and Neath Port Talbot local authorities and the third sector. It includes four programmes, one of which was the launch of the Integrated Discharge Hub (IDH). The IDH is a developing initiative designed as a 'single point of access for all ward referrals' which require primary and community services. The programme aims to coordinate a smooth patient journey from hospital into the community aligned with D2RA principles. There is a strategic model for how a patient should 'flow' through the IDH but at the time of our review there was no approved and widely available guidance to ensure staff are aware of the process.

17 There is also ad hoc information in place which can be used to support the discharge process. These include a 'Planning Your Discharge from Hospital' letter for patients. This usefully outlines the Health Board's intention to plan for discharge upon the patient's arrival and the benefits of recovering at home compared to in a

hospital setting. There is also a web page on the Health Board's website explaining the role of the Discharge Lounge in Morriston Hospital and how staff can refer patients into it. However, it is unclear how this information is used and made available to patients and staff and how it underpins the Health Board's discharge process.

18 To bring together the various discharge activity, there is a need to develop an updated discharge policy which better reflects the current arrangements and projects in place and aligns with relevant Welsh Government guidance. This should also include as previously recommended, early discharge planning, the risk of readmission, and discharge from Emergency Departments and should set out clearly defined roles and responsibilities, and expectations, including when referrals for ongoing care should be made. We therefore consider that **no action has been taken on recommendation 1 (replaced with Regional Recommendation 3.1).**

Discharge pathways

19 We considered whether the Health Board has reviewed all the current pathways in use and used the opportunity to:

- consider rationalising them (eliminating any unnecessary overlaps);
- make clearer the links between each of the pathways;
- make clearer any explanatory information;
- set out all the pathways in one place; and
- ensure that pathways are consistent across the Health Board (Recommendation 2).

20 We found that **the Health Board has various discharge pathways in place across sites, but work remains to ensure they are clear and consistent and formalised across the Health Board.**

21 As previously identified, the Health Board's new Integrated Discharge Strategy describes the steps a patient will move through once referred into the Integrated Discharge Hub. This includes a multidisciplinary team review of the referral prior to a 'What Matters' conversation, identification of an agreed discharge pathway and an onward referral to an appropriate service. This was piloted in Morriston Hospital in Summer 2024 and has now been extended to both Neath Port Talbot and Singleton Hospitals. The model is expected to be embedded as business as usual going forward.

22 As identified in paragraph 15, there is no current single discharge policy which is informed by a review of all previous pathways and brings existing pathways together with explanatory information. There are various discharge initiatives in place which are contributing toward improved pathways. These pathways are being expanded across the Health Board sites, but work remains to formalise this process and ensure consistent discharge pathways are clear and accessible to all staff and patients and available in one place. We therefore consider that **no action**

has been taken on recommendation 2 (replaced with 2025 Recommendation 1).

Training on discharge planning

23 We considered whether the Health Board has:

- ensured that attendance at training is captured on the electronic staff record, which will help to improve compliance monitoring (2018 Recommendation 3a);
- developed training that helps to build staff confidence to discharge patients in a timelier way and to manage difficult conversations with patients and their families (2018 Recommendation 3b); and
- considered whether discharge training and awareness of issues and policy is required for consultants (2018 Recommendation 3c).

24 We found that **there is no formal discharge training for staff because a single Health Board wide discharge policy has not yet been developed.**

25 As referenced in paragraph 21, there is a need for the Health Board to bring together the various discharge activity and develop an updated discharge policy which better reflects the Health Board's current arrangements. As there is no single discharge policy in place, there is no Health Board wide training to communicate and promote a single discharge policy to staff and patients which sets out clear roles and responsibilities and includes refresher training and induction training for new starters. As a result, there is no way of addressing the aspects of the previous recommendations 3a, 3b and 3c. We therefore consider that **no action has been taken on recommendation 3a, 3b and 3c (replaced with 2025 Regional Recommendation 3.2)**

Discharge reporting

26 We considered whether the Health Board has strengthened its performance reporting to the Board and its committees (2018 Recommendation 4) by including the following measures within its routine performance report:

- number and percentage of patients who have an estimated discharge date;
- readmissions within 28 days of discharge from hospital;
- percentage of discharges before midday;
- percentage of discharges that occur at night that were not planned for; and
- percentage of discharges within 24 hours and 72 hours of being declared 'medically fit'.

27 We found that **while the Board and committees monitor some aspects of discharge planning performance, there remain opportunities to strengthen performance reporting.**

28 The Health Board receives a variety of updates on discharge out of hospital and patient flow through its routine performance reports to Board and committee

including the number of clinically optimised patients at each Health Board site and the number of elective procedures cancelled due to lack of beds.

29 The Quality and Safety Committee has also received updates on the progress of the Integrated Discharge Strategy since its launch in May 2024 as well as relevant performance information on quality associated with discharge out of hospital. The updates include key performance indicator data on the Integrated Discharge Hub outlining the impact the project is having. As part of the Health Board's Integrated Discharge Strategy and associated Integrated Discharge Hub (IDH), several additional performance measures have been developed. These include but are not limited to the 'average time between referral to the IDH and referral onward to appropriate service' and '% of individuals being placed on the correct D2RA pathway for discharge'.

30 However, the performance indicators we previously recommended are not reported. Operationally, we reviewed quarterly clinically optimised patient reports which were monitored by the Management Board. The reports were comprehensive, covering the current position regarding clinically optimised patients by hospital site as well as a timeline of relevant projects and events which could impact discharge from hospital, such as the SAFER rollout and decommissioning of step-down beds. However, this report stopped in March 2024.

31 Given the significant and ongoing pressure caused by poor patient flow, it is important that the Health Board is monitoring the effectiveness of its discharge process, with key performance measures reported at Board and committee level. We therefore consider that there is **ongoing action to address recommendation 4 (replaced with 2025 Recommendation 2).**

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 • Operational and strategic plans relating to urgent and emergency care • Standard Operating Procedure for discharge planning
Interviews	We interviewed the following: • Urgent and Emergency Care Programme Manager • Chief Operating Officer • Service Group Medical Director for Primary Care, Community Services and Therapies • Service Group Director for Morriston Hospital
Observations	We also observed the following: • Discharge Coordinator in Swansea and Neath Port Talbot • Performance and Finance Committee
Data analysis	We analysed the monthly delayed discharges dataset submitted to the NHS Executive. 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 32 case notes relating to emergency medicine patients discharged in October 2022 with a length of stay greater than 21 days (excluding those who died).

Element of audit methods	Description
Self-assessment	We asked the Health Board to complete and submit a self-assessment, setting out its view of progress against our 2018 recommendations.

Appendix 2

A summary of progress against our 2018 recommendations

Exhibit 4 sets out the recommendations we made in 2018 and our summary of progress

Recommendations	Progress
Discharge Policy R1 Although the policy compares well against the good practice maturity matrix, we identified a number of areas where the Health Board's discharge policy could be strengthened. When reviewing the policy, the Health Board should ensure that its discharge policy includes reference to early discharge planning, the risk of readmission, and discharge from Emergency Departments	**No action** – see paragraphs 15 – 18 (replaced with 2025 regional recommendation 3.1).
Discharge pathways R2 When reviewing the Health Board's pathways, we found that there were a number of improvements that could be made to strengthen the use of discharge pathways. The Health Board should review all of the current pathways in use and use the opportunity to: • consider rationalising them (eliminating any unnecessary overlaps); • make clearer the links between each of the pathways; • make clearer any explanatory information; • set out all of the pathways in one place; and • ensure that pathways are consistent across the Health Board.	**No action** – see paragraphs 21 – 22 (replaced with 2025 Recommendation 1).

Recommendations	Progress
Training on discharge planning R3 Although staff are generally aware of the discharge planning process, there were gaps in the training arrangements and staff confidence needed to be addressed. The Health Board should: a) ensure that attendance at training is captured on the electronic staff record, which will help to improve compliance monitoring; b) develop training that helps to build staff confidence to discharge patients in a timelier way and to manage difficult conversations with patients and their families; and c) consider whether discharge training and awareness of issues and policy is required for consultants.	**No action** – see paragraph 25 (replaced with 2025 regional recommendation 3.2).
Discharge reporting R4 We found that the Board, Executive Team and the Quality and Safety Committee receive regular information relating to delayed transfers of care but receive limited information specific to discharge planning that would support a better understanding of the reasons behind the Health Board's performance. The Health Board should strengthen its performance reporting to the Board and its Committees by including the following measures within its routine performance report: • number and percentage of patients who have an estimated discharge date; • readmissions within 28 days of discharge from hospital; • percentage of discharges before midday; • percentage of discharges that occur at night that were not planned for; and • percentage of discharges within 24 hours and 72 hours of being declared 'medically fit'.	**Ongoing action** – see paragraphs 28 – 31 (replaced with 2025 recommendation 2).

Exhibit 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)
R1 The Health Board should review and document all current discharge pathways, ensuring: • there are clear links between each of the pathways; • explanatory information is available; • all pathways are set out in one place; and • pathways are consistent across the Health Board.	The current discharge pathways align to the NHS Wales / Six Goals / D2RA pathways. A promotion campaign was undertaken during 2024 following changes to the Pathway definitions implemented by the Six Goals National Team. This has led to leaflets, posters and a specific website section being developed alongside staff engagement sessions. In June 2024 an Integrated Discharge Hub (IDH) was launched with responsibility for managing discharges onto the D2RA pathways. This is a single location for all activity and information.	All actions described are in place as at the point of this response.	Emily Warren Associate Director Operations, PCCT

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 pathways are interchangeable dependant on the needs of the patients and they are now co-ordinated via the IDH. The pathways are explained in the same terms as set out by national Six Goals documentation. The pathways are consistent for all patients Health Board wide. There is continued development work to fully resource an IDH Model that is operational across all sites, including front and back door.		
R2 The Health Board should review performance reporting to the Board, its committees and at an operational level, to ensure metrics included demonstrate the effectiveness and impact of current discharge planning. Examples may include: • the number of patients discharged before midday; • the number of patients whose expected date of discharge is recorded;	As part of the delivery of the SBUHB/West Glam Pathways of Care delay Action Plan, a weekly operational assurance meeting is in place to review performance. A weekly performance pack is then prepared and sent to Executives in the HB and Directors of Social Services. A number of initiatives have been implemented over recent months to facilitate more active, real time monitoring of flow. These include: • A new BI POCD Dashboard developed and live from February 2025, pulling directly from our patient discharge planning system SIGNAL.	All points noted in this section are in place. However, improvement in flow remains an ongoing priority for the HB and as such each item remains iterative and ongoing in nature.	Assistant Director of Operations – Urgent and Emergency Care

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 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; and • the number of permanent placements in residential care settings avoided.	• The discharged date/time is recorded in WPAS , and this measure is available in the SAFER dashboard Home - SAFER - Power BI • The EDD data is recorded in Signal, and this measure is available in the SAFER dashboard • Clinically Optimised status is recorded in Signal and we have a few reports that look at measures around this Home - Clinically Optimised Patients and Pathways of Care Delays - Power BI • This language relates to the 'Passing the Baton' discharge guidance, which dates back to 2008. Complex discharges in the D2RA pathways would be pathway 3 defined as complex support - this information is collected. • Readmission rates are reviewed in line with WG measurement guidance ie, within 30 days. However they are not categorised as to reason for readmission • A weekly summary report, shared with – Execs – attached.		

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