Meeting Date	**24 May 2022**	**Agenda Item**	**4.4**
Report Title	**HIW Inspection & Review Assurance Report**		
Report Author	Neil Thomas, Assistant Head of Risk & Assurance		
Report Sponsor	Hazel Lloyd, Interim Director of Corporate Governance		
Presented by	Neil Thomas, Assistant Head of Risk & Assurance		
Freedom of Information	Open		
Purpose of the Report	The purpose of this report is to highlight matters arising in respect of Healthcare Inspectorate Wales (HIW) inspections and reviews, and to provide assurance regarding action to address issues raised.		
Key Issues	• Two inspections have recently concluded in directly managed services. The health board has submitted an immediate assurance plan in respect of one and awaits the draft report and wider improvement recommendations currently. For the other, an improvement plan has been submitted in response to a draft report – its acceptance and the finalisation of that report are awaited. • There are 8 services for which actions remain to be confirmed as complete. In total, 43 individual actions remain currently (142 have already been confirmed as complete for the same inspections). • The HIW review of healthcare provision within HMP Swansea is ongoing. • HIW inspectors are currently reviewing arrangements in place within SBU health board, in support of a national review of Patient Flow, focusing on the Stroke Pathway. • Updates are provided in respect of: o National Review of Mental Health Crisis Prevention in the Community (Mar 2022) o National Review of Maternity Services (November 2020) o Patient Safety, Privacy, Dignity and Experience whilst Waiting in Ambulances during Delayed Handover (Oct 2021) o Joint Inspectorate review of Child Protection Arrangements (JICPA)(Sep 2021)		
Specific Action Required ***(please choose one only)***	**Information** ☐	**Discussion** ☐	**Assurance** ☒	**Approval** ☐
Recommendations	Members are asked to: • **NOTE** the update in relation to HIW activities and the health board responses to issues raised. • **CONSIDER** any areas requiring further assurance.		

HIW UPDATE REPORT

1. INTRODUCTION

The purpose of this report is to highlight matters arising in respect of Healthcare Inspectorate Wales (HIW) inspections and reviews, and to provide assurance regarding action to address issues raised.

2. BACKGROUND

The Healthcare Inspectorate Wales (HIW) looks at the quality, safety and effectiveness of the services that are being provided to people and communities, drawing attention to good practice where it is found and highlighting practices that could cause harm to those who are receiving it and areas for improvement. It inspects NHS services in Wales, and regulates and inspects the independent healthcare sector. HIW also works with other review and inspectorate bodies to consider the quality of healthcare delivered in non-healthcare settings such as prisons.

In addition to inspections, HIW undertakes a programme of reviews to look in depth at national or more localised issues. As part of its work it makes recommendations to make improvements, immediate and longer term, where appropriate.

This report presents information in respect of reviews/inspections approaching or in progress, and those recently concluded and reported.

Where reviews/inspections identify areas for improvement, HIW presents recommendations against which improvement plans may be developed by the health board and shared. Progress against these actions is communicated periodically by service leads to the corporate Risk & Assurance team and the position summarised and reported to support corporate oversight and the provision of assurance to the Quality & Safety Committee.

This report presents the status of actions agreed following HIW reviews/inspections within the health board as informed by updates received to date from service areas.

3. NEW REPORTS RECEIVED

3.1 Health Board Services – Draft HIW Reports & Immediate Improvements

<u>Dan Y Deri (HIW 21160) - Immediate Improvement Plan</u>
An unannounced inspection of the above service was undertaken on 15/03/2022. Following the inspection, HIW wrote to the health board requesting an immediate improvement plan (immediate improvement plans are requested ahead of issue of formal inspection reports where actions need to be expedited).

An immediate improvement plan was submitted on 25th March 2022, but further assurances were sought by HIW before it could be accepted. A revised improvement plan was submitted to HIW on 14th April 2022, and was accepted.

The health board is now waiting to receive the formal inspection report and details of any further improvements recommended. The report and improvement plan will be presented to the Committee when they are finalised.

Cefn Coed Hospital: Tawe Clinic – Clyne & Fendrod Wards (HIW 21193)
An embargoed draft report has been received from HIW on 6th April 2022, following an unannounced inspection of the above service undertaken between 14-16th March 2022. No immediate improvements were required, but the report made 21 recommendations for attention.

The health board improvement plan was submitted on the 6th May plan (an extended deadline agreed with HIW). The health board is waiting for confirmation that the improvement plan is accepted. A copy of the report and improvement plan will be presented to the Committee when they are finalised.

3.2 Health Board Services – Final HIW Reports & Improvement Plans

No new final reports relating to the inspection of health board managed services were issued in the period.

3.3 Primary Care Contractors – HIW Reports issued

Llansamlet Surgery
HIW inspected Llansamlet Surgery on 7th March 2022. The report was published on 11th April 2022. No areas for improvement were identified.

4. PROGRESS AGAINST ACTION PREVIOUSLY AGREED

4.1 Health Board Directly Managed Services

There are 8 inspections undertaken within services directly managed by the health board which have actions remaining to be confirmed as complete. The below table summarises the overall status of actions agreed for those services:

Number of Recommendations	Number of Actions Agreed	Number of Actions Completed	Number of Actions Ongoing
110	**185**	**142**	**43**

More detail on these is presented at **Appendix 1**. Assurance in respect of contracted services and those reviews conducted nationally or across organisational partnership boundaries are described in the later sections of this report.

The last issue remaining in relation a previous inspection of **Neath Port Talbot Birth Centre** (which was closed subsequently due to staffing issues) has been addressed. Infection control considerations in relation to the use of curtains had been raised by HIW – however, management have confirmed that curtains will not be used when the centre re-opens.

5. UPCOMING & ONGOING HIW REVIEWS WITHIN THE HEALTH BOARD

Local Review of Governance Arrangements at Swansea Bay UHB for the Provision of Healthcare services to Her Majesty's Prison Swansea

HIW has undertaken work during 2021/22 in support of the above review. The HIW lead for this review has indicated that due to unforeseen circumstances HIW has had operational issues and the timescales for distribution have been delayed. Noting the passage of time, she has provided an opportunity for the health board to provide updated information on some areas previously in transition. Details of health board quality assurance group structure developments have been shared. Further detail will be reported to the Committee when received.

6. NATIONAL & PARTNERSHIP/JOINT REVIEWS & OTHER MATTERS

National Review of Patient Flow (Stroke Pathway)

HIW is undertaking a national review of Patient Flow. In order to assess the impact of patient flow challenges on the quality and safety of patients awaiting assessment and treatment, HIW has elected to focus its review on the stroke pathway. The aim of the review is to understand what is being done to mitigate any harm to those awaiting care, as well as understand how the quality and safety of care is being maintained throughout the stroke pathway.

The review's overall focus is on patient flow concentrating on the stroke pathway, from the point of requesting an ambulance or people self-presenting at ED, through to discharge from hospital or transfer of care to other services. The main questions the review is seeking to answer are:

- How are healthcare services ensuring that timely access and treatment is provided to patients on the stroke pathway?
- What steps are healthcare services taking to ensure that safe and effective quality care is provided at each stage of care, minimising the impact of delays?
- What measures are healthcare services taking to ensure that patients are able to be discharged effectively, and safely from hospital services?

As part of the above national review, HIW conducted an onsite visit at Morriston Hospital on 26-28 April 2022. The approach included attendance at meetings, and discussions with Emergency Department staff, stroke services staff and patient flow/discharge managers. In addition, the HIW team visited staff at Singleton. It has been indicated that further interviews may take place remotely via MS Teams between the 9-20 May 2022.

No issues were raised at the time of the on-site inspection with the service lead. HIW reviewers indicated that they would write an initial letter to the Chief Executive and a final letter when their All Wales work is complete.

When writing to the health board in relation to the above review, HIW made an additional request in relation to a past one. On 8 August 2018, HIW published a report following its thematic review of *Patient Discharge from Hospital to General Practice*. The review made 13 recommendations to act upon, and HIW requested a response from all health boards in relation to their current position against the recommendations. The intention was that the responses could be used to inform the HIW Patient Flow

review, and may also be published as a national summary. The original report and health board response is attached at **Appendix 2**.

National Review of Mental Health Crisis Prevention in the Community (Mar 2022)
During 2021, HIW undertook a *National Review of Mental Health Crisis Prevention in the Community*. The review explored the experiences of people with mental health needs, and the adequacy of services available to support their mental health and well-being at the earliest opportunity.

The report was published on 10 March 2022 and made 19 recommendations for improvement. HIW wrote to health boards subsequently on 5 May 2022, requesting an update on action taken or planned response to the report recommendations by 27 May 2022**.** The Service Group Director for Mental Health & Learning Disabilities has been nominated as the senior lead for coordination of an improvement plan for Swansea Bay. A copy of the report and health board action plan will be presented to the Committee when developed.

National Review of Maternity Services (Nov 2020) – SBU Progress
In November 2020, HIW issued a national report setting out the findings from the first phase of a *National Review of Maternity Services* across Wales, which explored the extent to which health boards across Wales provide safe and effective maternity services. (Subsequently, HIW decided not to proceed with phase 2 of the review.)

The report made 32 recommendations. Against these recommendations, the health board identified 101 individual actions and submitted an action plan to HIW on 19th March 2021.

The pandemic and staff absence has impacted subsequently on progress against some of the original timescales; however, as at May 2022, of the 101 actions agreed, 86 have been confirmed as complete by the service. Target dates have been refreshed for the 15 remaining actions, indicating a further 7 will be completed by the end of September 2022; 6 more by the end of December; and all will be complete by the end of the 2022/23 financial year.

Patient Safety, Privacy, Dignity and Experience whilst Waiting in Ambulances during Delayed Handover (Oct 2021)
Following publication of the above report in October 2021, a response is being coordinated nationally, engaging the Welsh Ambulance Services Trust, health boards and Welsh Government. A national task & finish group has been established to provide advice and make recommendations to the Emergency Ambulance Services Committee Management Group, and onwards to its Joint Committee. Initial meetings are being held in April and May 2022.

Joint Inspectorate review of Child Protection Arrangements (JICPA)(Sep 2021)
The above review was undertaken jointly by the Care Inspectorate Wales (CIW), HIW, Estyn, Her Majesty's Inspectorate of Probation (HMIP) and Her Majesty's Inspectorate of Constabulary and Fire & Rescue Services in May & June 2021. The review spanned services provided by Neath Port Talbot County Borough Council, Swansea Bay University Health Board, Wales National Probation Service and South Wales Police.

Following the review, a draft letter outlining the effectiveness of partnership working and the work of individual agencies in Neath Port Talbot was issued on 10 August 2021. A final report was published on 16 September 2021.

The local authority was required to prepare a written statement of proposed action responding to the findings outlined in the letter. The statement and response was compiled on a multi-agency basis involving the National Probation Service, Youth Justice Service, Swansea Bay University Health Board and South Wales Police. A combined action plan was developed by leads from each of the partner bodies. The health board actions and the combined action plan consolidated by the local authority for submission were signed off by the Executive Director of Nursing in October 2021.

The SBU Safeguarding Committee is the group nominated within the health board to monitor progress against agreed action. The health board Head of Safeguarding has confirmed that all actions for which the health board was the nominated lead have been completed.

7. GOVERNANCE AND RISK

This report aims to provide assurance regarding action taken to address issues & risks highlighted by HIW inspections and to inform Committee memebrs and the Board of approaching and ongoing inspection activity.

8. FINANCIAL IMPLICATIONS

It is possible that actions to address some issues raised in HIW inspections may require resources. However, this report does not make any recommendations with financial implications.

9. RECOMMENDATIONS

Members are asked to:

- **NOTE** the update in relation to HIW activities and the health board responses to issues raised.

- **CONSIDER** any areas requiring further assurance.

Governance and Assurance		
Link to Enabling Objectives ***(please choose)***	**Supporting better health and wellbeing by actively promoting and empowering people to live well in resilient communities**	
	Partnerships for Improving Health and Wellbeing	☐
	Co-Production and Health Literacy	☐
	Digitally Enabled Health and Wellbeing	☐
	Deliver better care through excellent health and care services achieving the outcomes that matter most to people	
	Best Value Outcomes and High Quality Care	☒
	Partnerships for Care	☐
	Excellent Staff	☐
	Digitally Enabled Care	☐
	Outstanding Research, Innovation, Education and Learning	☐
Health and Care Standards		
(please choose)	Staying Healthy	☒
	Safe Care	☒
	Effective Care	☒
	Dignified Care	☒
	Timely Care	☒
	Individual Care	☒
	Staff and Resources	☒
Quality, Safety and Patient Experience		
HIW inspections may identify issues impacting upon the quality or safety of services, or the experiences of those affected by them. This reports aims to provide assurance on actions taken to address issues.		
Financial Implications		
It is possible that actions to address some issues raised in HIW inspections may require resources. However, this report does not make any recommendations with financial implications.		
Legal Implications (including equality and diversity assessment)		
HIW inspections may identify areas of non-compliance with legislation. This reports aims to provide assurance on actions taken to address issues.		
Staffing Implications		
HIW inspections may identify issues related to the staffing of services eg staffing numbers, or staff training/competency, or the solutions to other issues raised may have implications in terms of staff resources. This reports aims to provide assurance on actions taken to address issues.		
Long Term Implications (including the impact of the Well-being of Future Generations (Wales) Act 2015)		
The work of HIW provides an independent view of issues and risks within services. In addressing matters arising from reviews and inspections, the health aims to understand the causes of issues in order to prevent them from re-occurring.		
Report History	This is report has been prepared directly for the Committee	
Appendices	Appx 1: Progress against action previously agreed Appx 2a: HIW Thematic Report: Patient Discharge Hospital to General Practice 2017-2018 Appx 2b: SBU Action Plan: Patient Discharge Hospital to General Practice 2017-2018	

APPENDIX 1: PROGRESS AGAINST ACTION PREVIOUSLY AGREED

Date of Inspection	Inspection	HIW Ref	Nbr Report Rec'ns	Nbr Actions Agreed	Nbr Actions Complete	Nbr Actions Ongoing	Comments
August 2019	Cefn Coed Hospital	19016	33	33	31	2	Remaining actions to be confirmed are: • Closure of the smoking room • Considerations to improve clinic rooms on two wards Progress on these actions has been delayed due to the pandemic.
Jan 2020	Morriston Hospital Paediatric Services	19260	30	26	22	4	Remaining actions to be confirmed are: • Consider ward layout and dignity of patients/parents/carers • Emergency Bell needs to be heard across the ward • Provision of EPALS/PILS (life support) training • Ensure all staff have timely annual appraisals
Sep 2020	Morriston Orthopaedic Surgery (Ward B)	20028	3	12	1	11	An update has not been requested previously. The head of nursing has been contacted for details of progress.
Mar 2021	Morriston Emergency Department	20085	9	34	30	4	Remaining actions to be confirmed are: • Move from Waterlow Score to Purpose-T for assessment & management of tissue damage • Complete PADRs for all staff • Establish future process for PADR to ensure compliance • Develop workforce plan
Apr 2021	Bryn Afon (Ferndale)	20133	2	9	7	2	Remaining 2 actions to be confirmed both relate to the commencement and completion of building works which has been delayed.
Jun 2021	Morriston Acute Medical Assessment	21007	7	12	11	1	Remaining action to be confirmed is: • Architect design to be provided to HIW
Jun 2021	Morriston Childrens' Emergency Unit	21008	11	44	29	15	A more recent update has been provided and is currently being reviewed corporately by the Risk & Assurance team to support the service. Figures here include the immediate improvements and wider ones subsequently recommended, and will be updated for the next report.

APPENDIX 1: PROGRESS AGAINST ACTION PREVIOUSLY AGREED

Date of Inspection	Inspection	HIW Ref	Nbr Report Rec'ns	Nbr Actions Agreed	Nbr Actions Complete	Nbr Actions Ongoing	Comments
28 to 29 September 2021	Hospital Onsite IR(ME)R inspection – Radiotherapy Service at Singleton.	21053	15	15	11	4	Remaining actions to be confirmed are: • Employer Procedure document review by 31/9/23 • Accidental/unintended Exposure Procedure review by 31.5.22 • Department capacity review (as part of the Programme Business case) by 31.6.22 • Additionally, working is ongoing to review the utilisation of space in the unit).

Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Patient Discharge from Hospital to General Practice: Thematic Report 2017-2018



This publication and other HIW information can be provided in alternative formats or languages on request. There will be a short delay as alternative languages and formats are produced when requested to meet individual needs. Please contact us for assistance.

Copies of all reports, when published, will be available on our website or by contacting us:

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

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Contents

Healthcare Inspectorate Wales (HIW) is the independent inspectorate and regulator of healthcare in Wales

Our purpose

To check that people in Wales are receiving good care.

Our values

- **Patient-centred: we place patients, service users and public experience at the heart of what we do.**
- **Integrity: we are open and honest in the way we operate.**
- **Independent: we act and make objective judgements based on what we see.**
- **Collaborative: we build effective partnerships internally and externally.**
- **Professional: we act efficiently, effectively and proportionately in our approach.**

Our priorities

Through our work we aim to:

Provide assurance:	**Provide an independent view on the quality of care.**
Promote improvement:	**Encourage improvement through reporting and sharing of good practice.**
Influence policy and standards:	**Use what we find to influence policy, standards and practice.**

1. Executive summary

Based on concerns identified during work inspecting General Practices during 2014-15, HIW decided to undertake a national review to evaluate the quality of patient discharge from hospitals to general practices. The review set out to understand and assess the:

- Quality and quantity of information provided by secondary healthcare to primary healthcare (general practice) and whether it can be improved.
- Timeliness and accuracy of discharge information and what the barriers to achieving best standards are.
- Impact poor discharge information has.
- Mechanisms used for information sharing and whether these can be improved.

Our review consisted of gathering information from all seven health boards and Velindre NHS Trust via the completion of self-assessment forms. Completion of this form included the provision of information and supporting documentation relating to each organisation's own discharge policies. Alongside analysis of documentary evidence, we ran an extensive campaign of public engagement and undertook a wide ranging period of fieldwork where we spoke to over 250 individuals from a range of organisations including all seven health boards, the Welsh Ambulance NHS Services Trust (WAST), Velindre NHS Trust and local representative committees of NHS GPs.

Overall, we found that the quality of discharge to be variable, which requires significant attention to ensure that safe and effective healthcare is provided across Wales. We found that whilst all health boards and Velindre NHS Trust appeared to have in place the correct policies regarding discharge, there appears to be a lack of awareness and understanding of the processes from staff on wards. There was also a lack of understanding of what information should be shared between secondary care and GPs.

We saw that good discharge relies heavily on effective planning, and that more needs to be done across Wales to ensure that health professionals work together as effectively as possible. This means that there needs to be:

- Greater clarity over the roles and responsibilities of those healthcare professionals involved in the discharge process: We found that staff did not always understand the valuable role that their colleagues play in the process.
- Increased involvement of pharmacy roles within the discharge process to aid with To Take Out (TTO)[1] medication timeliness and clarification. We found that where ward-based pharmacy staff were used more often, that discharge was more efficient.
- Improved communication with patients and families, with a need to clarify arrangements over who ensures patients and families are engaged with effectively.
- Stronger relationships between GPs and hospitals: We consistently found issues with a lack of mutual understanding of roles, impacting the quality of information being shared between hospitals and GPs.

[1] To Take Out (TTO) refers to medication that a patient is given after leaving hospital.

One of the key issues from our review is the range of mechanisms used to facilitate the sharing of discharge information, and how these methods impacted the process. We found mixed methods and systems being used, ranging from electronic and paper. We also saw that, in some cases, discharge information continues to be sent by Fax to GPs. Where paper based documentation is used, this increases risk in terms of readability and the potential loss of data due to transfer between sites and systems. We saw that in areas where electronic-discharge (e-discharge) is used as a method for recording and distributing information, this had a positive impact on both quality of information and timeliness of receipt by the GPs. For instance it has resulted in less time being used by GPs to clarify relevant, additional information from secondary care, freeing them up to provide patient care.

Whilst we have seen the positive impact that e-discharge can have, there remains a professional duty on those involved with the patient care pathway to make sure they share and communicate all the pertinent information. An e-discharge system is not the solution by itself, rather it is part of a wider range of actions that are required from all. We saw that even with e-discharge in place there are instances where sparse or incomplete information is provided. In addition, for e-discharge to work, the underpinning infrastructure needs to allow it to function as intended. We found frustration amongst healthcare staff at the inadequacies of their organisation's Information Technology (IT) systems undermining their ability to use e-discharge effectively.

We found that a number of positive and local initiatives had been developed. In particular the use of dashboards to monitor live discharge data is an example of technology working to aid the provision of an effective service. This data assists with ongoing work to address bottle necks in the system as well as overall analysis to help develop improvements.

For technology to be truly effective, IT systems across Wales need to be integrated, however it is important to reiterate that for this to happen there is a clear need to be realistic about what is required, and the timeframes needed for implementation.

What can be improved regardless of IT and e-discharge systems, is the relationship between secondary care and general practice. Bringing this relationship closer will see an improvement in understanding roles and responsibilities, as well as opening channels for ongoing dialogue to raise concerns and share best practice.

Throughout our review we've conducted an extensive number of interviews that have provided a commonly held view and understanding of the issues and challenges that prevent good discharge. Therefore it's concerning that these issues have not been overcome, instead leading to a disjointed approach across Wales with local initiatives and tools developed in the absence of the implementation of national solutions.

Poor discharge can lead to poor outcomes for patients and for their loved ones. It is essential that each professional involved in a patient's care needs to take professional responsibility and accountability in ensuring that they play their part in the patient's pathway. The challenges within this report need to be overcome in order to ensure that the necessary improvements are made across Wales.

Recommendations:

Report Finding		Recommendation
1	We identified some overlap and lack of clarity regarding some of the roles associated with the discharge process within secondary care.	NHS Wales healthcare organisations should ensure there is clarity in relation to the roles staff play in the discharge process, and to communicate this across their respective organisations therefore helping to increase staff and patient understanding of the discharge process, and improve consistency.
2	We found that NHS Wales healthcare organisations policies specify timeframes ranging between 24 and 48 hours prior to discharge, for take home medication to be confirmed. Overall we found that compliance against these timeframes was variable.	NHS Wales healthcare organisations need to audit and monitor compliance with their own policy timeframes and Health and Care Standard 2.6 regarding the provision of TTO medication.
3	There is a risk to patients of not understanding how to take their medication or of any potential side effects. Therefore it is important that the patient and/or carer understands why medication has been given, how it should be take and potential side effects.	NHS Wales healthcare organisations need to ensure that patients are provided with appropriate information about the medication they have been prescribed in a timely manner prior to discharge. Compliance against this should be audited and monitored.
4	We found that increased ward based pharmacy helped improve efficiency regarding take home medication (TTO's) and the discharge process.	NHS Wales healthcare organisations should consider introducing ward based pharmacists to help improve medication lists and the production of timely discharge summaries.
5	Pilot studies of Patients Know Best (PKB) require further evaluation in terms of outcomes. Where benefits are identified in terms of information sharing and patient engagement, these should be shared with all NHS Wales healthcare organisations.	NHS Wales should ensure that any potential benefits identified as part of PKB pilot studies, are shared across healthcare organisations.

6	The inclusion of patient, family and carers is vital given these individuals are often best placed to know how to assist with continued care post discharge.	Measures should be taken to improve inpatient, family and carer engagement to ensure people are fully consulted about their care and treatment NHS Wales healthcare organisations. This is in line with Health and Care Standard 4.2 Patient Information and Standard 5.1 Timely Access.
7	Feedback received acknowledged the improvement in quality and timeliness that electronic transmission brings.	NHS Wales should specify a target date by which discharge summaries and clinical letters issued to general practices are issued via direct electronic transmission.
8	Feedback received indicated that Physiotherapists and Occupational Therapists are under utilised within current discharge processes. The inclusion of their entries within discharge summaries would help avoid separate communication to GPs, or their counterparts in primary care, helping with efficiency. Whilst some NHS Wales healthcare organisations formally include such professionals as part of the MDT aspect of the discharge process, this approach is not consistently applied across Wales.	Where not already formally included, NHS Wales healthcare organisations to increase the inclusion of Physiotherapists and Occupational Therapists within the MDT aspect of the discharge process where relevant.
9	There has been an improvement in quality and timeliness where e-discharge is in operation. However, this is not in operation across many sites/hospitals with staff querying when rollout will be more widespread.	NHS Wales needs to clarify timeframes and next steps regarding the rollout and implementation of e-discharge across all NHS Wales healthcare organisations.
10	Feedback received acknowledged the improvement in quality and timeliness that e-discharge has brought.	NHS Wales healthcare organisations should actively pursue the implementation of e-discharge systems in support of improved quality, timeliness and sharing of discharge information. Any new e-discharge system needs to be monitored continually to measure its effectiveness.

11	The use of performance dashboards to present live discharge information data across several periods of time, wards, hospitals, etc., provides a valuable insight into discharge performance across an organisation.	NHS Wales healthcare organisations should ensure they have arrangements in place to share good practice around live dashboards.
12	A common theme during our fieldwork was the weaknesses in the relationship between general practice and secondary care, the common view being that the relationship is not close enough.	NHS Wales healthcare organisations should, where not already in place, implement mechanisms where primary and secondary healthcare interface issues can be addressed.
13	The importance of junior doctors receiving training on the discharge process and electronic discharge should not be underestimated. Discharge training should be seen as a priority and scheduled within the first week of induction.	NHS Wales healthcare organisations to ensure that junior doctors receive discharge training as part of their induction, and that compliance should be continually monitored.

2. What we did

In 2016-17 HIW committed to undertake an all Wales thematic review focusing on the quality of patient discharge from hospital to general practice. This was primarily a response to the issue of poor discharge practices being highlighted during our 2014-15 inspections of general practices.

In particular we noted a recurring theme around the quality of information and communication between hospitals and GPs. We also noted patterns and themes from concerns raised with us relating to patient discharge, which included:

- a lack of accurate and useful discharge information;
- poor quality transfer of care information;
- delays in provision and availability of discharge letters; and
- overall completion and timeliness of discharge communication.

Good discharge is important as it

> "…aims to bridge the gap between hospital and the place to which the patient is discharged, [to] reduce length of stay in hospital, and minimise unplanned readmission to hospital"[2].

Where this has not happened, poor discharge can result in a breakdown in the continuity of care, leading to detrimental outcomes such as lack of follow-up in the community or readmission to hospital.

In developing its approach to this work, HIW took account of reviews and activities completed, or planned, by other organisations. Our purpose for this was to ensure that we were not duplicating the work of others, but complementing in order it to increase overall knowledge of the topic.

Wales Audit Office

We considered the work that the Wales Audit Office (WAO) undertook in relation to discharge planning. WAO undertook audits[3] across each of the seven health boards, seeking to answer the question *'Does the organisation have sound governance and accountability arrangements in relation to discharge planning?'* We were also participants in a WAO led patient discharge seminar that took place in March 2018. The seminar asked participants to focus and share solutions for patient discharge going forward.

[2] See: www.bmj.com/content/337/bmj.a2694

[3] As of 14 February the WAO published reports for: Aneurin Bevan University Health Board, Betsi Cadwaladr University Health Board, Cardiff and Vale University Health Board, Hywel Dda University Health Board, Powys Teaching Health Board and Velindre NHS Trust. www.audit.wales/publications

The Welsh Government Quality and Safety Assurance Group/NHS Delivery Unit

The Welsh Government Quality and Safety Assurance Group (QSAG) commissioned the NHS Delivery Unit to develop standards for health boards on the provision of discharge information/transfer of care. Such standards exist in Scotland and England but not Wales. HIW was part of the Task and Finish Group formed to agree these standards for the transfer of care from secondary to primary healthcare, which led to a Welsh Health Circular communication[4] and the development of guidance on implementation.

Stakeholder Reference Group

We established a stakeholder reference group for this review which included membership from the NHS Delivery Unit, Wales Audit Office, Public Health Wales, Royal College of General Practitioners, Community Pharmacy Wales, Royal College of Emergency Medicine Wales, Board of Community Health Councils Wales, HIW GP Stakeholder Reference Group, Royal College of Nursing, Health and Social Services Group – Welsh Government; Academy of Royal College Wales, and Royal College of Physicians. The group was set up to provide guidance and scrutiny for our review where necessary and to ensure that relevant organisations were kept suitably informed with the plans and progress of the review.

The Review Team

To support our work we established a review team that comprised relevant expertise. Members of this team included a:

- retired General Practitioner
- Consultant Physician
- Nurse/Safeguarding Lead
- Lay Reviewer.

Methodology

The methodology for our review initially consisted of an information gathering exercise whereby we gathered information from NHS Wales healthcare organisations via completion of a self assessment form. These organisations included:

- Abertawe Bro Morgannwg University Health Board (ABMUHB)
- Aneurin Bevan University Health Board (ABUHB)
- Betsi Cadwaladr University Health Board (BCUHB)
- Cardiff and Vale University Health Board (C&VUHB)
- Cwm Taf University Health Board (CTUHB)
- Hywel Dda University Health Board (HDUHB)
- Powys Teaching Health Board (PTHB)
- Velindre NHS Trust.

[4] See: http://gov.wales/docs/dhss/publications/whc2018-014en.pdf

The self assessment form requested responses to a series of questions relating to:

- their discharge policies
- e-discharge
- shared learning
- communication with general practice
- communication with patients/family/carers.

Where appropriate we requested that organisations also provide supporting documentation. The information received enabled us to understand the current intended discharge processes in each area.

We then analysed the documentary evidence[5] obtained from all stakeholders and ran an extensive campaign of public engagement that included:

- an online survey
- a social media campaign
- an electronic communication with local authorities and health board A&E's.

Furthermore, we interviewed over 250 individuals[6] from:

- All seven health boards
- Welsh Ambulance NHS Services Trust
- Velindre NHS Trust
- and attended and gained feedback from Local Medical Committees (LMC).[7]

Scope

The focus of this review was to look at the approaches adopted by each of the seven health boards and Velindre NHS Trust using Welsh Government Health and Care Standards (2015) to assist with the evaluation of the:

- Quality and quantity of information provided by secondary healthcare to primary healthcare (general practice) and whether it can be improved
- Timeliness and accuracy of discharge information and what the barriers to achieving best standards are
- Impact poor discharge information has
- Mechanisms used for information sharing and whether these can be improved.

[5] Documentary evidence included NHS Wales healthcare organisation discharge policies, various professional guidance and self assessment forms.

[6] Not including the numerous GP's spoken to as part of our LMC meetings, the review team interviewed: 43 Nursing staff; 23 Pharmacy staff, 22 Consultants; 21 Directors of Departments; 18 Managers of Departments/Wards; 12 Discharge Liaison Nurses; 10 Members of staff from Therapy Departments; 8 Members of staff from Patient Flow/Discharge Team; 6 Junior Doctors; 6 Heads of Department; 5 GP's and 3 Registrars. In addition there were 20 members of staff from various departments not placed within the categories mentioned.

[7] https://www.bma.org.uk/about-us/how-we-work/local-representation/local-medical-committees/lmc-wales

Terminology

NHS Wales Data Dictionary clarifies that *"Discharge is the end of the patient's continuous spell using a bed(s) in one hospital site"*.[8] Transfer of Care is when an inpatient is ready to move to the next stage of care and a Delay Transfer of Care (DToC) is when they are prevented from doing so for one or more reasons.[9]

The principle of transfer of care is a helpful one, implicitly acknowledging the importance of continuity in the process whereby a patient leaves hospital. For the purpose of our report, we have chosen to use the term 'discharge' as we believe that the public and patients will more clearly understand this terminology. However, the concept of Transfer of Care is an important one for healthcare professionals and organisations to understand and work towards.

The structure of our report is a reflection of where poor discharge can have a negative impact upon patient care and the continuity of that care. Subsequent sections of the report are a description of our findings and are presented in an order that reflects the discharge process from admission to discharge. We have sought to measured our findings against the Health and Care Standards in order to ascertain whether good discharge has been achieved. We deem good discharge to be well planned; well informed by professionals, patients and families; and well communicated to those continuing the care following discharge from hospital.

[8] See: www.datadictionary.wales.nhs.uk/#!WordDocuments/discharge.htm

[9] See: www.wales.nhs.uk/document/176141

3. What we found

The impact of poor discharge

The impact of poor discharge has been well researched and documented. Two key pieces of work relating to this were published by Healthwatch England[10]; and the Parliamentary and Health Service Ombudsman[11]. Healthwatch England identifies several basic failings that contribute to poor discharge. These included *"…hospitals not routinely asking patients if they have a home or safe place to be discharged to, details of medications not being passed on to GPs and carers, and families not being notified when loved ones are discharged."* Some of the feedback Healthwatch England reported from patients highlights the distress patients and their families can experience when discharge is poor:

> *"I rang shortly after lunch to be told [mum] had been discharged. I was shocked. She lived alone and was still delusional. A neighbour rang to say mum had been brought home by ambulance in her nightgown and left at the cold house after the driver got a key from the neighbour. The elderly neighbour stayed with her all night. She was readmitted the next morning."*

> *"Staff on the ward are really supportive but the process of discharge is confusing at best and damaging to wellbeing at worst. It's the communication and expectations that is very hard to keep track of: decisions reversed with no notice, no clear guidance to the family of who makes the decision."*

Healthwatch England's report concluded that following certain procedures[12] recommended by the National Institute for Health and Care Excellence (NICE)[13] can help prevent poor hospital discharge. Whilst these specific NICE procedures are related to service user experience in adult mental health services, some remain pertinent to this review. Specifically: *"Before discharge… discuss arrangements with any involved family or carers…"* and *"Give service users clear information about all possible support options available to them after discharge."*

Information we have gathered from our engagement with the public via an online survey[14], alongside data provided by the Board of Community Health Councils in Wales[15], further illustrates the impact poor discharge has on patient care.

[10] Healthwatch England: Safely Home: What happens when people leave hospital and care settings. https://www.healthwatch.co.uk/sites/healthwatch.co.uk/files/final_report_healthwatch_special_inquiry_2015_1.pdf

[11] Parliamentary and Health Service Ombudsman (PHSO): A report of investigations into unsafe discharge from hospital. The report selects 9 of the PHSO'S most serious cases to illustrate the gap between established good practice and people's actual experience of leaving hospital. https://www.ombudsman.org.uk/sites/default/files/page/A%20report%20of%20investigations%20into%20unsafe%20discharge%20from%20hospital.pdf

[12] See: https://www.nice.org.uk/guidance/CG136/chapter/1-Guidance#discharge-and-transfer-of-care

[13] See: https://www.nice.org.uk/

[14] HIW public engagement included an online survey, promotion at public events, social media campaign, news item on http://hiw.org.uk/?lang=en, e-comms with local health boards and local authorities and a poster campaign at GP's, libraries, leisure centres and health board A&E departments.

[15] See: www.wales.nhs.uk/sitesplus/899/home

The full results from our survey can be found in Annex B. Specific feedback we received about how poor discharge had affected people include:

"…pharmacy prescriptions…the carbon copy discharge summary form is too brief and illegible"

"if it had not been for my wife I would have dreaded to think what would have happened…I found it particularly distressing [seeing a person on a packed ward who suffered from dementia and was ready to go]…his daughter arrived and had a total melt down because she could not cope with him being discharged in such a way without being prepared and this affected me…all I kept think was how lucky I was to have someone to care for me and keep me safe"

"Delay in being discharged is a common experience, having to wait hours for discharge even after being assessed as ready to leave…this time period can be extremely stressful and anxious and being unnecessarily separated from family"

Findings from public/patient engagement

Some of the key results to note from our survey were that only:

- some patients felt that their family or home situation was taken into account when planning for discharge
- roughly half of patients received a copy of their discharge letter before being discharged[16]
- roughly half of patients felt they were not given enough notice they were going to be discharged
- and most patients had to be re-admitted to hospital in relation to the same medical problem.

As the survey results show, there is room for improvement regarding patient involvement in their own discharge, receipt of their Discharge Advice Letter and engagement with the patient in terms of discharge date. The Academy of Medical Royal Colleges Wales (AMRCW) Report into the Primary and Secondary Care Interface (2017) includes the following relevant principle: *'Give clear guidance to the patient as to what is the problem, what has been done so far and what it is intended to do. The patient should have an appreciation of what they themselves need to do. Do not commit other teams to any particular action or timescale without checking that is reasonable and practicable.'*

Linking the findings from our patient engagement exercises together with intelligence provided by the Board of Community Health Councils (CHCs) in Wales has yielded similar results. Abertawe Bro Morgannwg Community Health Council undertook a survey[17] of patients who were the recipient of stroke services in the ABMUHB area.

[16] When a patient leaves hospital they should be given a letter for their GP, providing information about their treatment and future care needs. See: www.nhsdirect.wales.nhs.uk/encyclopaedia/h/article/hospitalappointments,admissionanddischarge/

[17] www.wales.nhs.uk/sitesplus/902/opendoc/329276

It found that 52% of people went home without a care plan in place; 51% did not feel safe and confident about leaving hospital; and 46% felt they did not feel there was enough help or support for families/carers.

Supporting data

In terms of the potential harm that poor discharge can result in, data on patient safety incidents[18] in Wales[19] and England for the period April 2016 – March 2017 showed that 11% of total patient safety incidents related, in part, to discharge[20]. This is not inconsequential as a figure given that a patient safety incident is defined as *'any unintended or unexpected incident which could have or did lead to harm for one or more patients received NHS care'*[21].

NHS Wales healthcare organisations collect and report data relating to the NHS Wales complaints process known as *Putting Things Right*[22]. However, each NHS Wales healthcare organisation uses different systems to collect information, using different categorisation and classification. Therefore comparison of complaints involving discharge across NHS Wales healthcare organisations is difficult within the current system. To address this Welsh Government is currently attempting to standardise how data is captured to help provide clarity and consistency, and allow for the introduction of a new standard to collect information raised through *Putting Things Right*.

Public Services Ombudsman for Wales findings

Over the period February 2015 to October 2017 the Public Services Ombudsman for Wales (PSOW) conducted fifteen investigations[23] where patient discharge was referenced in a significant way. Some examples of this are:

> *'No discharge information (e.g. communication with her GP) was contained within the records…'* [24]

> *'The discharge lacked effective communication…and raised serious concerns surrounding controlled medication'* [25]

[18] Patient safety incidents are reported via the National Reporting and Learning System (NRLS). The NRLS collects data on patient safety incidents in Wales and England. In Wales this data is published monthly by the Welsh Government. The data is used alongside other local patient safety intelligence and expertise to support the NHS to deliver improvements in patient safety.

[19] See: http://gov.wales/statistics-and-research/patient-safety/?lang=en

[20] Data relevant to discharge, categorised as Access, Admission, Transfer, Discharge (including missing patient), showed reported incidents for the period April 2016 – March 2017 totalled 9,421, 11% of total incidents for the same period. Incidents categorised as: Patient accident; Implementation of care and ongoing monitoring/review; Access, admission, transfer, discharge (including missing patient); Treatment, procedure; Medication; Clinical assessment (including diagnosis, scans, tests, assessments); Documentation (including staffing, facilities, environment); Self-harming behaviour; Consent, communication, confidentiality; Infection control incident; Medical device/equipment; Disruptive, aggressive behaviour (includes patient-to-patient); Patient abuse (by staff/third party); and Other.

[21] See: www.npsa.nhs.uk/nrls/reporting/what-is-a-patient-safety-incident/

[22] See: www.wales.nhs.uk/sites3/Documents/932/Healthcare%20Quality%20-%2030166_Putting%20Things%20Right_a5%20leaflet_English_WEB%20VERSION%20-%20FINAL%20-%202017%2003%2001.pdf

[23] Out of all the fifteen PSOW investigation reports it was not found in any case that discharge, and the concerns substantiated regarding this, had a significant impact on the complaints specific concern.

[24] See: www.ombudsman-wales.org.uk/en/Investigations/investigation-reports-other-20152016.aspx

[25] See: www.ombudsman-wales.org.uk/~/media/Files/Cases_en/201405067%20Final%20Report.ashx

'…no evidence in the records that the discharge had been appropriately planned' [26]

'Mr B's discharge from hospital was not properly planned…' [27]

'…the electronic discharge notification form [sent to the GP] was incomplete and therefore inadequate'. [28]

The Healthwatch England and Parliamentary and Health Services Ombudsman reports, as well as HIW's survey results and findings associated with work carried out by the Board of Community Health Councils Wales and PSOW, are just some of the evidence sources available that highlight widespread issues that are occurring in relation to patient discharge across England and Wales.

Discharge Planning

Effective planning is one of the most fundamental activities necessary to support and enable good discharge. It can also have the impact of reducing length of stays as effective planning can enable *"…early safe discharge following unscheduled admissions. The intended outcome is that patients have appropriate length of stay and are discharged in a planned co-ordinated way…".* [29]

One of the key elements of effective discharge planning is the assignment of an estimated discharge date upon admission to hospital. The Multi Disciplinary Team[30] (MDT) has an important role in relation to the whole discharge process creating the opportunity to increase ownership, provide uniform messages and ultimately help inform and support patients.

We found that in general the MDT processes across all health boards included appropriate diversity of representation. For example, whilst each health board has its own variations on MDT membership, almost all include Allied Health Professionals, Pharmacists, Dieticians, Social Workers, Consultants, District Nurses, Occupational Therapists and Physiotherapists. As a result we were content that in general, care and treatment for patients was considered by professionals with appropriate knowledge and skills across relevant aspects of care.

Documentation within several NHS Wales healthcare organisations, specifically set out the need to include patient families with discharge planning. In terms of ensuring patient centred care, several health boards were specific in their mention of including a patient's family in the MDT process, with many including this as a requirement within their discharge policies. We were reassured to find that this was substantiated by what we were told during interviews.

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[26] See: www.ombudsman-wales.org.uk/en/Investigations/investigation-reports-other-20162017.aspx

[27] See: www.ombudsman-wales.org.uk/en/Investigations/investigation-reports-other-20162017.aspx / www.ombudsman-wales.org.uk/en/Investigations/investigation-reports-other-20162017.aspx

[28] www.ombudsman-wales.org.uk/en/Investigations/investigation-reports-other-20162017.aspx

[29] NHS Wales: Health in Wales – Discharge Planning. See: www.wales.nhs.uk/ourservices/unscheduledcareimprovement/dischargeplanning

[30] A Multidisciplinary Team Meeting is a meeting of the group of professionals from one or more clinical disciplines who together make decisions regarding recommended treatment of individual PATIENTS. Multidisciplinary Teams may specialise in certain conditions, such as Cancer. See: www.datadictionary.nhs.uk/data_dictionary/nhs_business_definitions/m/multidisciplinary_team_meeting_de.asp?shownav=1

We were told that inviting their involvement had proven to work well, encouraging more engagement and fostering a greater understanding of the discharge process for families. All NHS Wales healthcare organisations should ensure that they adopt this approach.

It was overwhelmingly clear that individuals across all specialities cared about trying to take make affective discharge work. Having documented procedures helps provide clarity and direction, however, they do not automatically ensure effective implementation of ownership, and the communication of accurate and uniform messages with staff and patients.

Roles within secondary care

Patient discharge can be a complex activity and it is important that roles within the process are clear. Passing the Baton guidance[31] states *"The patient's experience is partly determined by the quality of the coordination of their care…This journey needs to be coordinated by a named individual to ensure the continuum of care is effectively provided by the appropriate professionals and multi agency teams. This requires whole system approach will require clear definition of roles and responsibilities."*

We identified some overlap and lack of clarity around some of the roles associated with the discharge process within hospitals. For instance at some health boards we saw numerous roles in use including Discharge Liaison Nurse, Nurse Liaison and Patient Flow Co-ordinator roles. We found that there was some confusion from staff of what these roles are and their responsibility in terms of discharge. These roles are crucial in helping staff and patients navigate their way through the discharge process. They help patients to be aware of options available to them, as well as playing a key part in reducing waiting times by facilitating the link between health and social care. This would also include attending ward rounds and meetings, contributing to discussions regarding when a patient is medically fit for discharge. The person should also have knowledge of community services that can support a patient at home. However, we found there to be inconsistency in application of these roles with little standardisation of the roles either within, or across health boards, meaning that they aren't operating as effectively as they could.

The importance of the Discharge Liaison Nurse for instance was highlighted on numerous occasions during our interviews. Feedback included:

> *"Discharge Liaison Nurse is an asset as it provides a more rounded approach to care and they are able to build a rapport with the patient and their families"*

> *"Discharge Liaison Nurses know patients, with them throughout, their attendance on ward rounds is crucial"*

Clarity of staff roles in relation to discharge is important to both patients and staff. It allows for a clearer understanding of roles and responsibilities and provides a link to post discharge arrangements, ensuring patients continue to receive the correct care.

[31] Passing the Baton is designed to provide Practitioners with the basic knowledge and information they need to play a greater role in managing the patient discharge. See: www.nliah.wales.nhs.uk

Junior Doctors

Junior doctors and consultants play a crucial role in the discharge planning process. Particular roles within this process include:

- The provision and regular review of the predicted patient discharge date
- The supervision of regular medical input
- Involvement with the MDT
- Discharge summary completion and sign-off prior to issue to general practice.

However, feedback from our interviews indicated that junior doctors are not seen to 'own' the patient journey, from admission to discharge. This was explained as a consequence of their shift-based work patterns not allowing them to follow the patient journey. Additionally we were informed that this may also be the case with nursing staff and locum doctors both in hospital and GP surgeries. This serves to highlight the importance of accurate and timely records in supporting staff to perform their roles in delivering appropriate patient care.

Whilst it may prove unrealistic to change agreed work patterns to allow staff greater exposure to the patient journey, and thus a more rounded picture and greater understanding of patient care, it is not unrealistic is to ensure that staff have access to timely and accurate information about patients. Health and Care Standard 3.5 Record Keeping states that records should be *"…accurate, up-to-date, complete, understandable and contemporaneous in accordance with professional standards and guidance…"* and *"care, treatment and decision making is supported by structured, accurate and accessible patient records…"* The maintenance of timely and accurate records could help mitigate against work patterns that do not expose staff to the complete patient journey.

Recommendation 1

NHS Wales healthcare organisations should ensure there is clarity in relation to the roles staff play in the discharge process, and to communicate this across their respective organisations therefore helping to increase staff and patient understanding of the discharge process, and improve consistency.

Medication and Prescribing

Standard 2.6 of the Health and Care Standards on Medicines Management states that people should: *'receive medication for the correct reason, the right medication at the right dose and at the right time.'*

Accurate and timely recording of a patient's medication requirements is an important part of discharge, and where medication is not accurately recorded there can be an adverse impact. Furthermore when a patient leaves hospital there is a risk that they may not take their medication or understand the side effects. Therefore it is important that the patient and/or carer understands why medication has been given, how it should be taken and potential side effects.

We evaluated compliance with this standard, focusing upon the *'prescription upon discharge'* process, otherwise known as To Take Out (TTO)[32]. We found that policies across NHS Wales healthcare organisations specify timeframes[33] ranging between 24 and 48 hours prior to discharge, for take home medication to be confirmed. Overall we found that compliance against these timeframes was variable. Our evidence suggests that in many cases confirmation of TTO requirements take place closer to discharge, in some cases on the day of discharge, primarily as a result of last minute changes to medication. There appear to be multiple reasons regarding last minute changes. These include poor communication between consultant/junior doctor and pharmacy, last minute consultant changes and staffing resources and pressures. For example, we spoke to a number of pharmacists and some of the feedback included:

> *"The approach to discharge is often reactive rather than proactive, and staff just have to go with it. It is common to find out about discharges for that day during ward rounds."*

> *"Delays can be caused by late notification of discharge."*

> *"Pharmacies are under pressure from hospitals as they do not give the pharmacy enough time to complete medication orders…expect pharmacy to complete blister packs for medication within a couple of hours even though policy states 48 hours notice to be given."*

Last minute changes lessen the opportunities for dialogue between patients and doctors and between professionals. Health and Care Standard 2.6 confirms the importance of this, stating that *"[t]here is timely, accessible and appropriate medicines advice and information for patients, carers and staff. Patients are provided with sufficient information to meet their needs regarding the purpose and correct use of their medication and alternate treatment options. All patients have an opportunity to discuss and agree their treatment plan"*.

When we spoke to GPs and GP representative bodies, and analysed supporting evidence[34], it was clear that in multiple cases the reasoning behind changes to medication was either not clear or not detailed enough to provide sufficient clarity and understanding for GPs.

[32] To Take Out (TTO) is a form that should be complete for all patients being discharged from hospital. It summaries the patient's hospital stay for their GP and acts as a prescription to order the drugs they need to take home with them.

[33] Aneurin Bevan UHB: requested 24hrs prior to discharge (Discharge Policy, pg12)
Abertawe Bro Morgannwg UHB: 24-48hrs prior to discharge (Discharge Policy, pg9)
Betsi Cadwaladr UHB: 24 or 48hrs if medication in blister pack (Discharge Protocol, pg14)
Cardiff & Vale UHB: 24-48hrs prior to discharge (Discharge Policy, pg9)
Cwm Taf UHB: 24hrs in advance of discharge date (Discharge Policy, pg9)
Hywel Dda UHB: Timely manner/48hrs for Dosette/Nomad Cassettes (Discharge Policy, pg13)
Powys Teaching HB: 24-48hrs before actual date of discharge (Community Hospital Discharge Policy & Procedures, Pg9)
Velindre NHS Trust: 24hrs prior to discharge (Self Assessment form – Medicines Management Policy (under review))

[34] Evidence included Discharge Letters with no/minimal clinical information; lack of reasoning behind new medication; concerns over discharge letters not being provided to patients; delayed discharged letters and incomplete discharge forms.

NHS Wales healthcare organisations' own guidance is varied in terms of highlighting the importance of including the reasoning behind medication changes, with CVUHB being the only organisation that makes specific mention of the importance of medication, and in particular any changes in medication, in order to support effective discharge.

It was reported to us by staff in BCUHB that there was an increase in the volume of calls from GPs to hospitals requesting further information; with readmissions occurring due to not having discharge summaries and explanation of TTO medication. The ramifications of this include unnecessary time taken by the GP to chase up additional information and an inability to form a complete picture and treat patients appropriately.

Whilst the issues we have highlighted in relation to TTO medication show flaws in discharge planning, we also identified some good practice, examples of which include:

- HDUHB – Pharmacist Technicians and Pharmacists have their own portable devices that allow access to e-discharge systems which helps facilitate timely discharge.
- ABUHB – Pharmacists have started to attend the bed management meetings; this allows for the TTO to be completed efficiently.
- ABUHB – Following a pilot conducted where pharmacy staff attended ward rounds, there was improvement in compliance with the TTO and the discharge process.
- ABUHB – Has an ongoing project to try and get the TTO documentation completed earlier. The health board has started to use pharmacy technicians to populate the TTO documentation and to relieve pressure on doctors.

The role of staff in prescribing varies across NHS Wales healthcare organisations. In the majority of cases, the responsibility falls upon the nurse in charge, consultants and pharmacy. Trainee doctors also play an important role in prescribing; however, they need a supportive MDT and clear support network, especially from senior doctors, to help ensure safe prescribing. The Royal College of Physicians (RCP) guide *'Supporting junior doctors in safe prescribing'*[35] outlines how health boards/trusts can support safe prescribing among trainee doctors. Key amongst this guidance is the vital role the MDT[36] has in supporting junior doctors with safe prescribing. The role of nurses and prescribers, as well as other MDT members, should also not be underestimated. However, the guidance is clear that whilst it is important to seek advice from the MDT, responsibility for the prescriptions ultimately lies with the prescriber.

We saw evidence that increased involvement of pharmacy in attending ward rounds and use of an MDT approach had the effect of improving TTO efficiency, especially when a ward based pharmacist was in place. We also found that having advanced nurse practitioners and pharmacists placed on wards improved prescribed medication lists and the production of timely discharge summaries. A strong theme that emerged from our discussions with staff across a range of disciplines and specialities was that increased ward-based pharmacy support helped the discharge process. An example of some of the feedback included:

[35] See: https://www.rcplondon.ac.uk/projects/outputs/supporting-junior-doctors-safe-prescribing

[36] MDT in the context of the RCP's 'Supporting junior doctors safe prescribing' guidance in particular includes nurses, pharmacists and senior doctors.

"From a pilot conducted of the pharmacy attending ward rounds, this improved the TTO and discharge process"

"Pharmacy on ward…helps with sign-offs and timeframes"

"Increase in Pharmacy presence on ward has seen a decrease in issues regarding medication"

"In terms of [pharmacist] technical support…if no technicians available this holds up the process"

The aim of the discharge process is to ensure the patient is safely discharged, ensuring continuity of care. A question raised during our review was whether a risk adverse culture has set in, with a fear about sending patients home. This despite it being acknowledged by a high number of people spoken to during our interviews, that home is often the best place for a patient's wellbeing and recovery.

An example of how the enablement of patient care at home works, and can ease bed pressures, is demonstrated by Powys Teaching Health Board (PTHB). PTHB has a virtual ward[37] where people are admitted and discharge from the virtual ward whilst they are at home. The virtual ward operates in the same manner as a normal hospital ward, however, the key difference is the patient stays safely in their own home. Patients who can access this service are those who are at risk of emergency hospitalisation which can be avoided through a co-ordinated and collaborative case management approach. This management approach involves a patient's GP, District Nurse, Social Services, the third sector, therapists and specialist nurses. PTHB won two awards[38] in 2015 for the virtual ward.

Recommendation 2

NHS Wales healthcare organisations need to audit and monitor compliance with their own policy timeframes and Health and Care Standard 2.6 regarding the provision of TTO medication.

Recommendation 3

NHS Wales healthcare organisations need to ensure that patients are provided with appropriate information about the medication they have been prescribed in a timely manner prior to discharge. Compliance against this should be audited and monitored.

[37] See: www.powysthb.wales.nhs.uk/virtual-ward

[38] See: www.nhswalesawards.wales.nhs.uk/2015-finalist-virtual-ward

Recommendation 4

NHS Wales healthcare organisations should consider introducing ward based pharmacists to help improve medication lists and the production of timely discharge summaries.

Patient and family/carer engagement

Health and Care Standard 4.2 (Patient Information) states *'People must receive full information about their care which is accessible, understandable and in a language and manner sensitive to their needs to enable and support them to make an informed decision about their care as an equal partner'*. In meeting this standard NHS Wales healthcare organisations need to ensure *"people are consulted about any treatment and care they are to receive and opportunities provided to discuss and agree options"*. Furthermore, Health and Care Standard 5.1 (Timely Access) sets an expectation that *"Accessible information and support is given to ensure people are actively involved in decisions about their care"*.

Patient engagement

Clarity around responsibility for communication with the patient throughout the discharge process may lead to a reduction in patient misunderstanding and confusion. We saw that all NHS Wales healthcare organisations have procedures in place to ensure patients understand:

- medication prescribed
- importance of the medication being taken
- potential side effects.

Furthermore, the procedures outline who is responsible for discussing these matters with patients. Most are broad in the sense that they state that the *'nurse in charge'*, *'named responsible nurse'* or *'medical staff'* should ensure appropriate communication with the patient in terms of involvement and provision of information. We found it unclear who is responsible, in practice, for communicating and ensuring engagement with the patient. The importance of ensuring there is clarity of responsibility, not only for staff but also for patients, is supported by the General Medical Council's (GMC) Good Medical Practice[39] guidance. It states that doctors registered with the GMC must communicate effectively, specifically:

> 'You must give patients the information they want or need to know in a way they can understand. You should make sure that arrangements are made, wherever possible, to meet patients' language and communication needs'.

Where NHS Wales healthcare organisations commission contracts for healthcare services, NHS Wales' framework agreement provides stipulations regarding responsibility for patient engagement, specifically that the provider must ensure that:

- Patients and carers have clear and accessible information regarding the process for making suggestions, complaints and comments about care and treatment.

[39] See: https://www.gmc-uk.org/guidance/good_medical_practice.asp

- The patient is given information on their diagnosis or the assessment process if diagnosis has not been determined.
- All information given to the patient is in clear and accessible language and, if necessary, that patients are given assistance by staff to help them understand the information.

We learnt about a pilot scheme being tested at the Princess of Wales Hospital (ABMUHB) known as *'Patients Know Best (PKB)'*[40]. This pilot scheme is described as operating to ensure patients are shown their discharge summaries and documentation, with an opportunity to provide comment. From June 2017 individuals between the ages of 16 and 24 years of age living with diabetes were able to register for a PKB record. PKB states that it is the world's only fully patient-controlled online medical records system. The primary focus being to provide better, more consistent services to patients going through big changes in their lives, the result being improved clinical outcomes. The intention is that PKB will work across all seven health board and within every clinical team providing young adult care services in Wales. However, at the time of writing this was not the case. The pilot scheme goes on to show how the sharing of information across health boards could possibly be achieved. A case study[41] relating to this scheme found that instead of taking paperwork to each hospital for them to photocopy for their records, it's available electronically. This allows for easier communication, the option to send non urgent messages to consultants being an example of this.

The scheme is at a pilot stage at ABMUHB and requires further evaluation in terms of outcomes. However, where benefits are identified in terms of information sharing and patient engagement, these should be shared with all NHS Wales healthcare organisations.

Recommendation 5

NHS Wales should ensure that any potential benefits identified as part of PKB pilot studies, are shared across healthcare organisations.

Family and Carer engagement

Family and carers are often the individuals who know the patient best and who assist with continued care post discharge. Therefore their inclusion is vital in ensuring greater understanding and management of care. Some health boards actively engage with families as part of the discharge process. For example, at ABMUHB, families attend ward rounds to ensure that information is clear and concise. Furthermore, some NHS Wales healthcare organisations meet the family within one week of admission, meet half way and then at the discharge planning meeting at the end of the a patient stay.

During our PTHB fieldwork we were informed that the health board utilises a service provided by Powys Association of Voluntary Organisations (PAVO).

[40] See: https://www.patientsknowbest.com/wales.html

[41] See: https://www.patientsknowbest.com/wales-diabetes.html

The service known as Community Connectors, helps people, their families and carers, to *"access community-level services and activities…which help prevent their circumstances deteriorating to a point where they might need higher level health or social care services"*.[42] Feedback we received was positive overall, especially regarding increased involvement from the third sector regarding patient flow and discharge. However, we were unable to ascertain whether the Community Connectors service has been evaluated in order to formally assess what difference it has made in helping discharge.

Good Practice

We saw an example of efforts made at Singleton Hospital (ABMUHB) to improve the patient discharge process following an internal audit. These efforts included work across a range of areas to improve discharge practices[43], specifically:

- within 24 hours of admission
- within 48 hours of admission
- over 48 hours after admission
- the day of patient discharge
- communication
- the knowledge and skillset of staff involved in patient discharge.

Outcomes from this audit continue to be monitored and actioned and include ensuring:

- simple/complex discharge is identified on, or shortly after admission
- contact details of named discharge co-ordinator given to patient/relative/carer
- the communication of the discharge action plan to all levels of staff.

In terms of improved communication, ABMUHB's *'What we will do – What we expect of you!'* is a patient/carer leaflet that has been produced which provides clear information on all aspects of the discharge process, which is not only useful for patients but for families. This is a good example of patient engagement which strives to clarify responsibilities.

In spite of the positive examples outlined above, our review found that informing family and carer expectations in relation to discharge remains an issue. Our patient survey results found that 31% of patients felt that they were not involved in decisions about their discharge from hospital. Furthermore, 50% of respondents felt that they were not given enough notice about when they were going to be discharged. The Board of Community Health Councils in Wales (CHC) shared intelligence with HIW regarding patient/public feedback; one example we saw taken from CTUHB demonstrated a clear lack of patient/family engagement, with the family assured that they would be invited to a discharge planning meeting, to be informed two days later that the family member had been discharged.

[42] See: www.pavo.org.uk/policy-and-partnerships/partnerships/health-social-care-and-wellbeing/community-connectors.html

[43] Improvements within these actions include: information documented on patient/relative/carer support/requirements needed on discharge; and checklist available for all discharges and completed 48 hours before discharge indicating all actions completed for safe and timely discharge.

Delays with discharge can occur when a patient's family have set views on a particular care home they want their family member discharged to. Where it is not possible to discharge a patient to a preferred care home, delays may occur. One possible solution to this is through greater engagement between NHS Wales organisations and care homes, local authorities and social services. Whilst not a particular focus of this review, we were informed that a lack of social workers or the changing of social workers can hinder the discharge process, in some cases requiring the process to start from the beginning. Furthermore, there is a negative impact on the timeliness of discharge where there are delays in acquiring care home places or social care. In addition, further delays can occur due to the differing processes in operation across health and social care, making it difficult to share information efficiently and to understand responsibilities.

Further information relating to social care can be found in the 'Issues for Further Consideration' section of this report.

The importance of good patient and family engagement cannot be underestimated, as highlighted by some of the poor communication and engagement we've drawn attention to within this section. Addressing these issues can help alleviate delayed discharge[44] and improve patient experience.

Recommendation 6

Measures should be taken to improve inpatient, family and carer engagement to ensure people are fully consulted about their care and treatment NHS Wales healthcare organisations. This is in line with Health and Care Standard 4.2 Patient Information and Standard 5.1 Timely Access.

Discharge Processes and Record Keeping

We found discharge processes that involved crossover between electronic (e-discharge) and paper discharge, across sites and across health boards, to be muddled and cumbersome. By way of example our fieldwork identified that some staff[45] revert back to using paper based discharge documentation due to a lack of access to the electronic discharge system used by their organisation. The primary reason that this occurs is due to poor or limited access to information technology when using out of hours.

Whilst each health board has a discharge policy in place, it was less clear whether each health board understood whether the policy was effective and adhered to consistently. Many of those that we spoke to over the course of the review felt that their organisation's own discharge processes were unclear. In the case of Velindre NHS Trust, at the time of our work, there was no current discharge policy[46] in place, albeit one was being developed.

[44] Main reasons observed for delayed discharges (Glasby, Littlechild, et al 2004): i) poor communication; ii) lack of assessment and planning for discharge; iii) inadequate notice of discharge; iv) inadequate consultation with patients and their carers.

[45] Identified with interviewees at ABMUHB, ABUHB, C&CUHB, CTUHB and HDUHB.

[46] Following the departure of the Discharge Liaison Nurse in 2015, a post not currently filled/in place, Velindre has been developing its approach towards discharge planning/process. At the time of fieldwork (October 2017) Velindre were developing their draft policy. During our fieldwork we were made aware that Velindre's admission policy includes a section relating to discharge.

We found that one of the main issues undermining consistency was the mixed methods and systems used to facilitate discharge, ranging from electronic systems, usage of paper based documentation, and use of old technology such as fax machines[47]. With the availability of information technology to support patient discharge, the use of fax machines to share crucial clinical information between healthcare professionals, should be phased out. Fax machines present increased risks when transferring information, such as security, proof of transfer and legibility, therefore ideally should not be used.

In health boards where e-discharge systems have not been rolled out across all wards/ specialties and therefore paper discharge documentation is in use, there are significant challenges in ensuring consistency of information input. Usage of paper based documentation increases the potential for loss of documentation and can lead to issues of readability. For instance we encountered a problem trying to read one example of paper discharge documentation which was poorly completed prior to being sent to a GP for scanning onto their system. The result of the scanning process and poor quality rendered the information unreadable. Furthermore, over time, paper notes can be increasingly difficult for junior doctors to trace and access due to the transfer of information between sites and the incremental volume. The risks associated with presenting discharge information in hard copy form have been identified and addressed as part of the NHS England Standard Contract[48]. Service condition 11.5 which states: *"from 1 October 2018, transmission of both discharge summaries and clinical letters to general practices must be via direct electronic transmission, not via email"*.

The Framework Agreements currently in use in Wales do not include specific mention of the need to share information via direct electronic transmission. Instead Section 13.5 of Schedule 2 states: *"a written comprehensive summary of care and treatment undertaken is produced and distributed to all relevant parties within 10 working days of discharge"*.

MDT within the discharge process

From our interviews we found that discharge processes do not always make use of an MDT approach. Physiotherapists and Occupational Therapists are under utilised within the current discharge processes in place. The inclusion of their entries within discharge summaries would help avoid separate communication to GPs, or their counterparts in primary care. Whilst some health boards formally include such professionals as part of the MDT aspect of the discharge process, this approach is not consistently applied across Wales. Where possible the increased inclusion of these professions could help provide a more rounded understanding of patient care. For example they could provide assistance with planning, future care arrangements, and help provide more efficient and patient centred care.

[47] In use by some ABMUHB, ABUHB, BCUHB, C&VUHB and HDUHB staff.

[48] The NHS Standard Contract is mandated by NHS England for use by commissioners for all contracts for healthcare services other than primary care. See: https://www.england.nhs.uk/nhs-standard-contract/

Recommendation 7

NHS Wales should specify a target date by which discharge summaries and clinical letters issued to general practices are issued via direct electronic transmission.

Recommendation 8

Where not already formally included, NHS Wales healthcare organisations to increase the inclusion of Physiotherapists and Occupational Therapists within the MDT aspect of the discharge process where relevant.

Information to General Practice

When patients are discharged from hospital, they are discharged back into the care of their registered General Practitioner (GP). Information about a patient's stay in hospital is sent to their GP to allow the GP to manage ongoing care.

Our work has found that the methods used to convey this information to GPs varied considerably. In some instances we found variance in usage of both electronic and paper systems, not only across organisations in Wales, but within those organisations. Where a mix of electronic and paper patient discharge records are in use, it was necessary for hospital staff to transfer information from one record to the other, which is not efficient. Furthermore, transferring information from one record and system to another increases the risk of errors and this may be amplified where the transfer is across healthcare organisations and staff are not familiar with the way information is presented.

It is also important to remember that the discharge process does not necessarily end when the hospital decides a patient is ready for discharge. In some instances it is necessary to transport a patient to their next place of care. This transportation in the majority of cases[49] is provided by the Welsh Ambulance Service NHS Trust (WAST). WAST told us during interviews that discharge documentation they received lacked information and approximately 40% of the time it is necessary for them to request further information from a ward or hospital. Where WAST staff are required to request further information, this may delay the provision of safe and effective transport for patients being discharged from hospital.

Record Keeping

Health and Care Standard 3.5 Record Keeping states' *"Good record keeping is essential to ensure that people receive effective and safe care. Health services must ensure that all records are maintained in accordance with legislation and clinical standards guidance"*.

[49] On day discharge services is commissioned from WAST by only three of the seven Health Boards. Any additional capacity required is commissioned by Health Boards from other providers, primarily St John Ambulance, British Red Cross and ad-hoc private providers.

During our review we saw examples of paper based discharge summaries that were poor both in terms of quality of information and in timeliness of receipt. Of the numerous examples we were provided with, the most common issues of concern were as follows:

- Illegible comments left for the GP
- Patient's name/details not included on form
- Discharging hospital not specified
- No reason provided for admission
- No diagnosis provided
- Doctor's signature missing
- The only information provided was from a pharmacist
- Medication information incomplete, with reasoning for changes not specified.

Whilst discharge documentation is not always poor in the ways described above, overall, there is significant room for improvement. It is evident that the use of paper based records continues to generate problems relating to accurate, up-to-date and understandable information. It appears logical therefore, that e-discharge and a single approach to discharge documentation should be utilised, at the very least within NHS Wales healthcare organisations.

Electronic Records

Health and Care Standard 3.4 (Information Governance and Communications Technology), states that *"Processes exist to operate and manage information and data effectively, to maintain business continuity and support and facilitate patient care and delivery"*.

E-discharge is an electronic method of recording and distributing information about the care received by a patient. This includes details about prescribed medication, diagnosis, medical progress, test results, follow-up actions and advice for the GP. This information is contained within an electronic Discharge Advice Letter[50] (eDAL) and sent to the patient's GP following their discharge.

The Medicines Transcribing and e-discharge (MTeD)[51] system supports e-discharge and enables clinicians to record details regarding a patient's stay in hospital, which is then sent electronically to the GP. The NHS Wales Informatics Service (NWIS)[52] is overseeing the development of MTeD and states the aim as being *"…to establish a consistency in discharge communication from secondary care (hospitals) to primary care (GPs) speeding up the current paper process, and improving patient safety"*.[53] During our review we were informed that Welsh Government requested the rollout of MTeD across Wales by the end of 2017/18.

[50] Regarding the content of the EDAL, the NHS Delivery Unit at the time of writing this report, were developing standards for the transfer of care from secondary to primary care. The development of these standards will lead to a patient safety alert and the development of guidance on implementation. For further information on NHS Delivery Unit see: www.wales.nhs.uk/ourservices/directory/nationalprogrammesandservices/478

[51] See: www.wales.nhs.uk/sitesplus/956/page/62570

[52] See: www.wales.nhs.uk/sitesplus/956/home

[53] See: www.wales.nhs.uk/sitesplus/956/page/62570

Given that this has not occurred, we question the feasibility of this aim and any future rollout dates given the concerns raised by staff about the limited rollout and compatibility with existing systems.

Some health boards had already taken the initiative to design and implement their own systems to facilitate discharge before MTeD. Systems in operation by health boards and Velindre NHS Trust include:

- ABMUHB: Electronic Transfer of Care (EToC)[54]
- ABUHB: Clinical Workstation (CWS)
- BCUHB: MTeD/paper TTO prescription/EPOC[55]
- C&VUB: MTeD
- CTUHB: MTeD (95% of wards whilst in final stages of rollout)
- HDUHB: MTeD/Paper
- PTHB: Paper/MTeD (used for discharge on 4 wards)
- Velindre NHS Trust: CANISC (e-patient administrative system)/Paper.

Staff working in NHS Wales healthcare organisations with established e-discharge alternatives to MTeD (ABMUHB with EToC and ABUHB with CWS) were positive about these solutions, with GPs also supportive of these systems. We heard positive feedback about CWS in particular, with staff informing us that the system had been updated continually over time to fit the needs of the user. ABUHB LMC feedback was also supportive with over 90% of discharge summaries promptly and properly completed as a result of proper discharge planning and use of e-discharge.

Where e-discharge is in use, whether MTeD or a health board's own solution, GPs/GP representative bodies informed us that both the quality and timeliness of discharge documentation had improved. Feedback included:

> "…quality of letters has improved and overall feedback is that as a result the discharge process is a lot smoother and more efficient"

> "MTeD has provided GP's with better information and has made it easier and quicker to access"

> "MTeD has a clear list when it comes to medication so you can see the history from the beginning".

[54] See: www.wales.nhs.uk/sitesplus/956/page/52547

[55] EPOC is used for discharge summaries, clinical letters and for doctor handover requests (in Paediatrics and the Medical CPG).

Overall feedback regarding eDAL[56] was also positive and that the use of eDAL allowed for:

- the quicker transfer of information
- the reduction in GP requests for further information
- the reduction of complaints that health boards received regarding discharge summaries.

A specific example of this positive feedback included:

> "…if the eDAL's were populated on a day to day/decision to decision basis, then there will be less work at the point of discharge resulting in quicker, safer and more efficient discharge for patients and staff."

> "Being able to e-discharge has improved safety and timeliness and nine out of ten GP's receive the eDAL within a couple of hours."

However, usage of eDAL is not without its challenges. Some of the negative feedback we received regarding it included:

> "eDALs have improved the discharge summary but has not changed the culture and the way staff work. Population of the discharge summary is left until the last moment leading to delays in it reaching pharmacy to populate the medication. It also means that the summaries can be rushed, leading to mistakes and also leads to junior doctors stating that they prefer paper discharge as it's quicker and easier."

> "There are a lack of IT systems available on wards meaning that it can be an issue to get junior doctors to complete EDALs."

> "Lack of time and IT systems cause junior doctors to rush the EDALs, leaving the quality of the information to be poor. Even though the GPs receive the information quicker, the information can sometimes be minimal meaning that the GP still has to call up the hospital to gather more information."

Whilst feedback and evidence suggests that e-discharge has brought about improvements, the system has not proved infallible. The quality of information is dependent upon the quality, accuracy and veracity of the user's input. Whilst electronic systems can aid efficiency, they are not the solution by themselves.

[56] eDAL is the term used in Cwm Taf for an MTED Discharge Advice Letter (DAL).

The general principle of good record keeping still applies and is key to ensuring good clinical care. The GMC Good medical practice (2013) guidance specifies that in providing clinical care a doctor must provide clear, accurate and legible records that detail relevant findings, decisions made and actions agreed, information given to patients, and any drugs prescribed or other investigation or treatment.

We identified that contemporaneous entry into the eDAL does not always happen. For the e-discharge process to work effectively information needs to input in a timely manner. This then allows the presentation of an accurate record that allows professionals access to the most relevant and recent information.

During our fieldwork at ABMUHB we were informed that the health board was considering whether a *'no ETOC*[57] *no discharge'* policy should be implemented. There are potential issues that could arise with such a policy, for example if a patient isn't discharged it can cause knock on delays due to a lack of available beds. However, we were informed that ABMUHB had considered this and used improvement methodology to test its impact on a single bay, then by ward prior to evaluation and rollout across the site. The health board goes on to state that if the summary is completed ahead of discharge, then there is no delay in discharge as a result.

Whilst acknowledging the improvement in quality and timeliness that e-discharge has brought, our work has found that electronic documentation received by GPs can still be incomplete or sparse in detail. For instance we saw documentation where:

- No discharge summary had been received
- The discharge summary provided no details regarding diagnosis
- No information regarding medication was provided and therefore it was not possible to determine whether the lack of information was appropriate or whether it was missing through error
- There was insufficient evidence in support of diagnosis
- Post discharge care/management information was not always provided.

However, where e-discharge is used, we were informed that the number of discharges sent and received without any information had fallen. This had resulted in less time spent by GPs contacting secondary care to request further information, which allowed them to spend more time to assess and treat patients.

Whilst we have seen the benefits that can be gained by e-discharge, its usage can still be undermined by poor infrastructure, specifically a lack of adequate IT hardware and a lack of access (for instance number of IT terminals available in some sites). We saw that a lack of access to computers in order to use e-discharge systems meant that for some staff it was more timely and convenient to convert back to paper documentation. Staff told us:

> "Financial investment in IT needed, complicated by a poor phone network in Pembrokeshire"

> "Out of Hours (OoH) don't have access to IT systems"

[57] Electronic Transfer of Care.

"Timely discharge letters is a serious issue and the [MTeD] trial on ward seven was good, however, there has been a hindrance due to [poor] IT support"

"Information Technology within the Health Board is in the stone age, with systems still not talking to each other and not sharing information"

"Doctors struggle to enter data as they go along as only one computer to share with no alternative portable devices"

"Access to IT equipment is an issue, [those computers on the ward] are quite slow which is a reflection of IT equipment across the Health Board"

"MTeD whilst good, a lack of access via IT is a hindrance"

If e-discharge is to be truly effective in terms of improving the quality and timeliness of discharge information, the infrastructure underpinning it needs to be appropriate and accessible. There needs to be a common system and way of working in NHS Wales before real improvements and efficiencies can be made. There is a need to be realistic about what is required and the timeframes needed for implementation. Currently no health board in Wales operates a principally electronic system for discharge. Effective data entry is the key to e-discharge arrangements being compliant with Health and Care Standard 3.4, specifically that *"data and information are accurate, valid, reliable, timely, relevant, comprehensive and complete"*. It is important for staff to be fully trained and supported in using the system, whatever form of e-discharge system is in operation, in order to make sure it is used properly.

The content of discharge documentation is equally, if not more important, than the system or format used. This was an issue that was raised frequently with us during the course of our review. In particular we heard that there is a need for clarification regarding what information should be included on discharge documentation. GPs and GP representative bodies informed us that the information GPs identified as most important, was:

- the inclusion of reasoning behind medication changes
- the monitoring that is required
- the diagnosis and summary information covering the time the patient was in acute care.

In view of the risks and inefficiencies inherent in paper based discharge documentation, we believe that the implementation of an electronic discharge (e-discharge) process should be the aim for all NHS Wales healthcare organisations.

Recommendation 9

NHS Wales needs to clarify timeframes and next steps regarding the rollout and implementation of e-discharge across all NHS Wales healthcare organisations.

Recommendation 10

NHS Wales healthcare organisations should actively pursue the implementation of e-discharge systems in support of improved quality, timeliness and sharing of discharge information. Any new e-discharge system needs to be monitored continually to measure its effectiveness.

Other technology

Separate to e-discharge and MTeD, we saw examples of other solutions being used in some areas to aid efficiency in relation to patient care and discharge. For example, the Radiology directorate at one health board uses electronic Dragon Dictate voice recognition/dictation software to dictate patient record entries. This had the benefit of improving productivity and efficiency due to dictation proving quicker than manual input. Whilst use of voice recognition software has the potential to help efficiency regarding time and resources, any implementation would require careful consideration, and rely upon professional responsibility and mechanisms in place to ensure the veracity of records.

A further example we saw of technology being used to assist with discharge, was the use of dashboards to monitor discharge data. Several health boards have these in place, however, the approach taken by ABMUHB was notable. The ABMUHB EToC Performance dashboard presents live discharge data across several periods of time, across all hospitals, wards, consultants, specialities and sub specialities. At the time of our fieldwork[58] we were able to interrogate the system to see live data regarding discharge performance. For example, at Morriston Hospital 46% of discharges had been approved and sent within 5 working days, whilst mental health discharges stood at 70%. Dashboards such as this are extremely valuable and provide excellent insight into performance in relation to discharge across the organisation. The availability of such data assists with ongoing work to address bottle necks in the system as well as overall analysis to help develop improvements.

Recommendation 11

NHS Wales healthcare organisations should ensure they have arrangements in place to share good practice around live dashboards.

[58] Fieldwork date in which we saw the live dashboard data was 9 September 2017.

Professional Responsibility

Accountability

Whilst e-discharge can be beneficial in enabling and supporting effective discharge, it is not the solution by itself. As important is the quality of the information being captured. This links directly to the professional responsibility of all those involved in a patient's care to provide adequate information to ensure standards of and continuity of care is maintained.

In terms of accountability, junior doctors in the vast majority of cases, are responsible for the completion of discharge documentation/eDAL, with the consultant bearing ultimate accountability for sign off. The recurring theme that all NHS Wales healthcare organisations reported to us was that junior doctors have limited capacity when it comes to completion of discharge documentation. Some examples of what we were told include:

> "…junior doctors don't have the time or resource to complete the summaries"

> "…a major fact that effects the quality of the summary is the fact that juniors are rushed to complete them and given too many [other] tasks to complete at the same time. Time pressures are always something we talk about when on shift or on break, if we are lucky enough to have a break"

> "…the whole culture around discharging patients needs to be changed and consultants need to be more proactive in assisting and guiding junior doctors in completing summaries"

We were told during our engagement with GPs and GP representative bodies that they would like to have clarity over whose responsibility it was to inform the GP that a patient has been admitted into and discharged from a hospital. Electronic discharge systems such as MTeD do provide this notification to the GP Surgery. This is done when the eDAL is sent to the GP Surgery and the system notifies the relevant users that it's ready to access. Clearly however, this only applies to organisations that have adopted electronic systems. A GP requires appropriate discharge documentation and handover in order to take forward patient care. However, where nothing has been received, the question is raised as to who is clinically responsible for the patient. This becomes an important issue especially when there is follow-up treatment is required. GMC Good Medical Practice (2013) guidance states the following regarding the continuity of care: *'You must contribute to the safe transfer of patients between healthcare provides and between health and social care providers. This means you must: share all relevant information with colleagues involved in your patients' care within and outside the team, including when you hand over care as you go off duty, and when you delegate care or refer patients to other health or social care providers'*.

The AMRCW Report *'Professional behaviours and communication across the Primary and Secondary Care Interface*[59]', whilst not including specific mention of responsibility of care, does provide the following guidance that *'when transferring a patient to the care of another colleague (or seeking an opinion) ensure that all the information that colleague may need is sent to them in a clear format, preferably electronic if available'*.

It is important that professionals take appropriate steps in transferring patient care, adhering to their professional responsibility.

General Practice and secondary care relationship

One of the themes arising from our work relates to weaknesses in the relationship between general practice and secondary care, with a common view that the relationships are not close enough. In terms of the reasons for this, we were told by a mix of GPs and hospital staff that work patterns were not conducive to the building of these relationships, and that the effect of this has been the blur the boundaries or responsibility, for example the responsibility for taking forward and following-up on outstanding investigations or treatments. The AMRCW Primary and Secondary Care Interface (2017) Report[60] offers guidance regarding where responsibility could lie: *'The individual who orders a test is responsible for reviewing the result and taking appropriate action. If not able to review the result the individual should check another person will take on the responsibility in their team'*.

As mentioned previously, we were told that the rotation of staff (junior doctors) limited the development of the general practice/hospital relationship and impacted team working. The rotation of staff make it difficult for GPs to form relationships with staff as rotation means different staff are available at different times. We also heard how GPs found it difficult to ascertain whom to contact should they have any queries. This difficulty was due to discharge documentation either not clearly stating the responsible clinician, or as a result of shift patterns making it difficult to speak to an appropriate person in lieu of the responsible consultant. However, it should be acknowledged that GPs fed back that they have encountered these difficulties on far fewer occasions where the hospital has use of e-discharge.

Whilst there are areas for improvement in terms of strengthening the GP/hospital relationship, there are also examples where this has improved. In addition to e-discharge, we were provided with examples of meetings and forums existing with the intention of developing and maintaining this relationship. An example of this are cluster groups[61] whereby staff such as clinical directors, pharmacists, and GP cluster leads will meet with primary care (GPs). These forums should allow for open discussion about how to improve joint working, integration and allocation of resources.

[59] See: http://interface.amrcw.org.uk

[60] Professional behaviours and communication across the Primary and Secondary interface Report (2017).

[61] See: www.primarycareone.wales.nhs.uk/primary-care-clusters

We saw an example at ABMUHB where the Medical Director holds bi-monthly meetings with GPs to discuss any issues and areas for improvement. This provides direct access to GPs so that clearer messages can be conveyed regarding aspects of both secondary and primary healthcare. Furthermore it also provides the opportunity for GPs to comment on existing good and bad practice they've encountered.

Recommendation 12

NHS Wales healthcare organisations should, where not already in place, implement mechanisms where primary and secondary healthcare interface issues can be addressed.

Training

Staff training is an essential part of improving discharge. We found across many health boards that some junior doctors had either not been afforded the opportunity or had missed (as part of their induction) discharge training. Health and Care Standard 7.1 (Workforce) states that *"Health services should ensure there are enough staff with the right knowledge and skills available at the right time to meet need"* and that *"the workforce attend induction and mandatory training programmes"*. Given that some junior doctors had missed discharge training as part of their induction, it is questionable whether this standard is being met consistently across Wales.

It is important that junior doctors receive training on what information to input onto discharge summaries as part of the discharge process, for example diagnosis, summary of care whilst at hospital and reasoning for medication changes. The importance of junior doctors receiving training on the discharge process and electronic discharge should not be underestimated. Discharge training should be seen as a priority and scheduled within the first weeks of induction. This training should emphasise the importance of timeliness and quality of discharge information.

Whilst training for the completion of discharge documentation is undertaken by junior doctors as part of induction, post induction there is reliance upon ongoing support from more senior colleagues. Unfortunately, our fieldwork identified that this support, specifically from consultants, is not always felt to be forthcoming. As mentioned earlier in the report, we also found that some staff were not aware of their own health board or trust's policy regarding the discharge process. At Velindre NHS Trust we told by separate consultants that there was either no formal agreed discharge policy, and that one was being created and would be a first of its kind, or that there was indeed a discharge policy in place. The reality is that Velindre are currently in the process of finalising their discharge policy. However, this is an indication that better communication is required by NHS Wales healthcare organisations to ensure staff are fully aware of what is in place.

Recommendation 13

NHS Wales healthcare organisations to ensure that junior doctors receive discharge training as part of their induction, and that compliance should be continually monitored.

Issues for further consideration

This section contains issues that whilst outside the scope of our review, emerged as recurring themes. We will consider how best to take these issues forward, either by ourselves, or whether they are matters more suitable to be considered by other organisations.

Social Care

- Lack of social workers/changing of social workers hindered the discharge process and in some cases required the process to start again. Feedback from our interviews was positive when it came to wards where a social worker was in place. A social worker being attached to a ward helped increase understanding of requirements for discharge into community/ social care and helped communication with local authorities, improving overall discharge efficiency.
- Delays in acquiring social care have a negative impact on acute discharge. The availability of resources to support complex care packages impacts negatively on discharge. Lack of available care home places/beds/EMI beds impacts negatively on hospital discharge.
- There needs to be further understanding of how the Welsh Community Care Information System (WCCIS)[62], a health and social care system, will integrate with other systems, such as MTeD in order to ensure it is utilised correctly and that confidentiality issues are addressed.

[62] See: www.wales.nhs.uk/nwis/page/66175

4. Conclusion

The aim of this review was to evaluate the quality of patient discharge from hospital to general practice. Throughout our review and across the extensive number of interviews there was a commonly held view and understanding of the issues and challenges that prevent good discharge. This makes it more concerning that these issues have not been overcome, leading to a fragmented approach being taken across Wales with local initiatives and tools being developed in the absence of national solutions being implemented. Poor discharge can lead to poor outcomes for patients.

While we have concluded that e-discharge appears to be one of the key mechanisms that can enable and support better discharge, certainly in terms of efficiency, it is not the answer by itself. Regardless of what electronic solution is identified as being the most suitable and efficient, a key element to the success of any system will be ensuring that the information being input is accurate, timely and informative. This requires each professional involved in a patient's care taking professional responsibility and accountability in ensuring that they play their part in the patient's pathway.

Several other enablers are also required to ensure the discharge process operates as intended. These include adequate IT infrastructure, and effective communication, both between professionals, across primary and secondary care, and crucially with patients and carers.

We have identified several areas of good practice, many developed locally, throughout our review. We were also pleased to encounter universal enthusiasm and commitment from all staff regarding the need for better patient discharge. A contemporaneous electronic record system is essential and whilst there cannot be rapid implementation of this, there should be a planning process in place for all health boards to support implementation. This would require NWIS to address and avoid incompatibility issues.

IT systems across Wales need to be integrated before real improvements and efficiency can be achieved. There is a need to be realistic about what is required and the timeframes needed for implementation.

Regardless of electronic discharge systems, the relationship between secondary and general practice needs to be closer. This will help foster improved understanding regarding roles and responsibilities, and afford the chance to raise concerns more efficiently.

Following on from this review, HIW will be undertaking follow-up activity on recommendations made. This is to ensure that health boards and Velindre NHS Trust are being vigilant in addressing these matters and taking all necessary action to improve the issues highlighted in our review.

Appendix A – Recommendations

As a result of the findings from our review, we have included the following overarching recommendations for health boards, trusts and Welsh Government to consider:

Report Finding		Recommendation
1	We identified some overlap and lack of clarity regarding some of the roles associated with the discharge process within secondary care.	NHS Wales healthcare organisations should ensure there is clarity in relation to the roles staff play in the discharge process, and to communicate this across their respective organisations therefore helping to increase staff and patient understanding of the discharge process, and improve consistency.
2	We found that NHS Wales healthcare organisations policies specify timeframes ranging between 24 and 48 hours prior to discharge, for take home medication to be confirmed. Overall we found that compliance against these timeframes was variable.	NHS Wales healthcare organisations need to audit and monitor compliance with their own policy timeframes and Health and Care Standard 2.6 regarding the provision of TTO medication.
3	There is a risk to patients of not understanding how to take their medication or of any potential side effects. Therefore it is important that the patient and/or carer understands why medication has been given, how it should be take and potential side effects.	NHS Wales healthcare organisations need to ensure that patients are provided with appropriate information about the medication they have been prescribed in a timely manner prior to discharge. Compliance against this should be audited and monitored.
4	We found that increased ward based pharmacy helped improve efficiency regarding take home medication (TTO's) and the discharge process.	NHS Wales healthcare organisations should consider introducing ward based pharmacists to help improve medication lists and the production of timely discharge summaries.
5	Pilot studies of Patients Know Best (PKB) require further evaluation in terms of outcomes. Where benefits are identified in terms of information sharing and patient engagement, these should be shared with all NHS Wales healthcare organisations.	NHS Wales should ensure that any potential benefits identified as part of PKB pilot studies, are shared across healthcare organisations.

6	The inclusion of patient, family and carers is vital given these individuals are often best placed to know how to assist with continued care post discharge.	Measures should be taken to improve inpatient, family and carer engagement to ensure people are fully consulted about their care and treatment NHS Wales healthcare organisations. This is in line with Health and Care Standard 4.2 Patient Information and Standard 5.1 Timely Access.
7	Feedback received acknowledged the improvement in quality and timeliness that electronic transmission brings.	NHS Wales should specify a target date by which discharge summaries and clinical letters issued to general practices are issued via direct electronic transmission.
8	Feedback received indicated that Physiotherapists and Occupational Therapists are under utilised within current discharge processes. The inclusion of their entries within discharge summaries would help avoid separate communication to GPs, or their counterparts in primary care, helping with efficiency. Whilst some NHS Wales healthcare organisations formally include such professionals as part of the MDT aspect of the discharge process, this approach is not consistently applied across Wales.	Where not already formally included, NHS Wales healthcare organisations to increase the inclusion of Physiotherapists and Occupational Therapists within the MDT aspect of the discharge process where relevant.
9	There has been an improvement in quality and timeliness where e-discharge is in operation. However, this is not in operation across many sites/hospitals with staff querying when rollout will be more widespread.	NHS Wales needs to clarify timeframes and next steps regarding the rollout and implementation of e-discharge across all NHS Wales healthcare organisations.
10	Feedback received acknowledged the improvement in quality and timeliness that e-discharge has brought.	NHS Wales healthcare organisations should actively pursue the implementation of e-discharge systems in support of improved quality, timeliness and sharing of discharge information. Any new e-discharge system needs to be monitored continually to measure its effectiveness.

11	The use of performance dashboards to present live discharge information data across several periods of time, wards, hospitals, etc., provides a valuable insight into discharge performance across an organisation.	NHS Wales healthcare organisations should ensure they have arrangements in place to share good practice around live dashboards.
12	A common theme during our fieldwork was the weaknesses in the relationship between general practice and secondary care, the common view being that the relationship is not close enough.	NHS Wales healthcare organisations should, where not already in place, implement mechanisms where primary and secondary healthcare interface issues can be addressed.
13	The importance of junior doctors receiving training on the discharge process and electronic discharge should not be underestimated. Discharge training should be seen as a priority and scheduled within the first week of induction.	NHS Wales healthcare organisations to ensure that junior doctors receive discharge training as part of their induction, and that compliance should be continually monitored.

Appendix B – Survey Results

Intelligence we've gathered from our own engagement with patients, the public.
A summary of key results from our online survey are as follows:

Did you feel you were involved in decisions about your discharge from hospital?

	%
Yes, definitely	44
Yes, to some extent	19
No	31
Did not want to be involved	6
Don't know/can't remember	0

Did hospital staff take your family or home situation into account when planning your discharge?

	%
Yes, definitely	44
Yes, to some extent	12
No	25
Did not want to be involved	19
Don't know/can't remember	0

Were you given a copy of your Discharge Advice Letter before being discharged? A discharge advice letter may contain information such as your diagnosis, advice to GP, follow-up action and test results

	%
Yes	50
No	31
Don't know/can't remember	19

Do you feel you were given enough notice about when you were going to be discharged?

	%
Yes, definitely	31
Yes, to some extent	19
No	50
Don't know/can't remember	0

Did you have to go back to hospital in relation to the same medical problem you were previously in hospital for?

	%
Yes	62
No	38

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No.	Recommendation	Action	Responsible Person(s)	Timeframe
1	**NHS Wales healthcare organisations should ensure there is clarity in relation to the roles staff play in the discharge process, and to communicate this across their respective organisations therefore helping to increase staff and patient understanding of the discharge process, and improve consistency.**	The Health Board's SAFER Discharge Policy was reviewed in December 2019 and is published on the Health Board Intranet, accessible to staff. The policy puts the patient and family/carers at the heart of decision-making and has a section detailing the responsibilities of key roles/staff groups: • Unit/Service Group Directors • Heads of Nursing • Senior Matron • Matrons • Ward Manager / Sister / Charge Nurse • Nurse in Charge / Coordinator • Consultants (supported by their medical team) • Discharge Liaison Nurse Team • Other Clinical Staff Additionally, discharge pathways have been clarified and documented for staff.	Unscheduled & Emergency Care Delivery Board	Policy & plans in place & the latter are progressing. Plans will be subject to review in Q1 of 2022.

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		During 2021, the health board has developed length of stay action plans. These contain a number of initiatives & activities to improve to promote timely discharge. Implementation is being monitored by the Urgent & Emergency Care Board. Audits have been undertaken which review compliance with principles of the SAFER bundle.		
2	**NHS Wales healthcare organisations need to audit and monitor compliance with their own policy timeframes and Health and Care Standard 2.6 regarding the provision of to take out (TTO) medication.**	The SAFER Discharge Policy indicates that Take Home Medication should be reviewed & requested when the decision is concluded for discharge – 24 hours prior to discharge (with provision to expedite the same day for unexpected discharges). Discharge should be anticipated in advance – this is especially important for those patients requiring packages of care where medication is required to be supplied in dosette boxes. This allows time to ensure that arrangements are in place with the GP and community pharmacy. For non-complex discharges the target for turnaround is two hours from the pharmacy being informed.	Head of Pharmacy (Acute Services)	Rollout of tracker commenced – anticipated for completion end of Quarter 2, 2022/23.

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		Meeting the two-hour target has been challenging due to staff vacancies and absences due to COVID. In stroke patients the discharge is normally more complex and the time frame will be longer. The Health Board is now utilizing and rolling out a prescription tracker system that can be used to record and monitor discharge turnaround times that are processed in the dispensary on an ongoing basis. The tracker is in the process of being rolled out across Morriston Hospital with future phases involving Singleton and NPT hospitals. The tracker currently monitors dispensary workflow and will be rolled out to wards in Quarter 1 of 2022/23. The tracker system will allow generation of reports – these are currently being designed in partnership with the supplier.		

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		As part of the rollout the system will be made available for nursing staff. It is anticipated that this will be delivered during Quarter 2 of 2022/23.		
3	**NHS Wales healthcare organisations need to ensure that patients are provided with appropriate information about the medication they have been prescribed in a timely manner prior to discharge. Compliance against this should be audited and monitored.**	The medicines management team aim to complete medicines reconciliation within 24 hours of admission in line with NICE recommendations. Pharmacy technicians and pharmacists ensure that the correct medication and doses are documented and any issues are communicated to the ward team as early as possible in the admission process. This early intervention has been shown to reduce length of stay. Throughout the patient's stay, on their daily rounds the pharmacy team discuss medication issues with the patient and explain any new or changes to the medication prescription. The information is provided both verbally and by use of patient information leaflets. Where patients require additional	Head of Pharmacy (Acute Services)	Resuming Q1/2 2022/23.

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		assistance in taking their medicines correctly, medicines administration charts (MAR charts) or dosette boxes can be supplied. The pharmacy team also provide detailed patient counselling in regard to high risk anticoagulant medication prescribed in stroke on discharge. Patient satisfaction surveys have previously been completed but this has not taken place during the last two years during the COVID pandemic. The pharmacy completes point prevalence audits on all contributions of care that pharmacy provides. The audits include recording of information on patient counselling issues. The audits are undertaken annually. They paused during Covid but are resuming shortly – the next audit will be undertaken in Q1/2 2022/23. The outcomes will be received by Pharmacy senior management team, Medicines Management Board, and Neath Port Talbot Singleton Service Group Board. They are shared		

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		with Executive Directors and other stakeholders where relevant.		
4	**NHS Wales healthcare organisations should consider introducing ward based pharmacists to help improve medication lists and the production of timely discharge summaries.**	Pharmacy services are provided to the majority of ward areas. However, the establishment required to provide pharmacy cover to each ward is not funded and with the addition of increased activity and acuity this reduces the ability of the team to attend board and ward rounds. The result is that cover is frequently provided by pharmacists and technicians who are covering multiple ward areas and therefore opportunities for an optimal level of input at this stage are not always available. The team's role includes prompting the early prescribing of TTO's for discharge and provide a fully integrated pharmacy service to patients to facilitate a safe and timely discharge for the patient. The pharmacy service is provided by pharmacists and technicians who contribute to improving the	Head of Pharmacy (Acute Services)	Complete (and improvements continuing)

		quality of medication regimens and the information provided on discharge medication. In addition to ward based activities, SBU the health board has other initiatives that have promoted improvements in medication lists at discharge: The electronic discharge communications process implemented in SBU health board, requires that all medication lists included within the information transferred to primary care are signed-off by pharmacists. The health board has implemented HEPMA (Electronic Prescribing and Medicines Administration) in Singleton Hospital and has plans to roll it out into other sites. This means that where implemented, discharge medications prescribed electronically are seamlessly transferred onto patients' discharge advice letters in WCP (Welsh Clinical Portal), minimising the risk of transcription error. Additionally, e-prescribing has a number of		

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		safeguards to direct prescribers to the most appropriate prescription e.g. highlighting interaction between medications and contraindications due to allergies.		
5	**NHS Wales should ensure that any potential benefits identified as part of PKB pilot studies, are shared across healthcare organisations.**	PKB pilot results have been presented across the units. They were presented in the Grand Rounds and Clinical Outcomes Group. Additionally, the health board has been feeding in the learning to the national Digital solutions for Patients and Public Programme as we are a pathfinder project for this. The Swansea Bay Patient Portal (PKB) is being implemented further, providing an online record to help patients better manage their overall care and help make them feel more in control of their health and wellbeing. It allows patients access to an electronic copy of their Swansea Bay blood results and clinical documents. It also allows patients to	Senior Project Manager (Digital Services)	Complete (Review & discussion of benefits) Rollout continues.

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		upload any information they want relating to their health for their own records. Whilst this is only currently available to certain services, the Health Board is currently accelerating the rollout with the intention of making the portal widely available by the end of 22/23. Once a patient has signed up to the Swansea Bay Patient Portal they will have access to a wide range of clinical information and resources to help support their health and wellbeing.		
6	**Measures should be taken to improve inpatient, family and carer engagement to ensure people are fully consulted about their care and treatment NHS Wales healthcare organisations. This is in line with Health and Care Standard 4.2 Patient Information and Standard 5.1 Timely Access.**	Patient wishes must be paramount to treatment plans and discharge processes. This is set out in the principles of the SAFER Discharge Policy. Engagement with patients is supported by the use of EIDO leaflets. From a patient perspective, these are designed to cover the clinical procedure, the main risks and benefits in a patient friendly format.	Service Group Directors	Complete for 2021/22, and will be repeated.

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		The health board is currently implementing Length of Stay improvement plans. Compliance with key elements of the SAFER Discharge Policy have been undertaken in service groups as part of that work programme. The SAFER audits have explored patients' understanding the care and using the following questions: 1. *What is wrong with me or what are you trying to exclude?* 2. *What have we agreed that will be done and when to 'sort me out'?* 3. *What do I need to achieve to get me home?* 4. *Assuming my recovery is 'ideal' and there is no unnecessary waiting, when should I expect to go home?*		
7	**NHS Wales should specify a target date by which discharge summaries and clinical letters issued to general practices are issued**	A health board *Policy on improving communication between secondary care and primary care at the point of discharge/transfer* was endorsed by COEG in September 2021. It indicates that a *"no discharge summary, no discharge"* policy should operate on all	Executive Medical Director	Complete

	via direct electronic transmission.	wards in the Health Board, except in exceptional circumstances where an admitted patient would be put at risk. The policy requires that written communication should be passed from secondary care to primary care no later than 24 hours after discharge. Where available, the written communication is via the electronic transfer of care (ETOC) or discharge advice letter (DAL). Responsibility for ensuring performance issues are addressed sits with Service Group Medical Directors. The Swansea Bay University Health Board dashboard supports review of the timeliness and completeness of written communication. This performance data is received at the Clinical Outcomes and Effectiveness Group (COEG) meetings. Additionally, Service group discharge summary communications are monitored as part of		

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		the Executive performance management arrangements.		
8	**Where not already formally included, NHS Wales healthcare organisations to increase the inclusion of Physiotherapists and Occupational Therapists within the MDT aspect of the discharge process where relevant.**	Therapies are already included within the discharge process, actively contributing to board rounds within acute wards, and the health board has progressed and is progressing further improvement activities – some of these are indicated below: Improvement work on Length of Stay has included the undertaking of SAFER audits – reviewing the effectiveness of the SAFER Discharge Policy implementation. The audits include a Board Round Assessment tool which includes review of the attendance levels of each expected member of the Multi-Disciplinary Team, including physiotherapists and occupational therapists.	Service Groups, Head of Occupational Therapy, Head of Physiotherapy	Complete (and improvements continuing)

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		Additional funding has been made into community therapies teams to support Hospital to Home initiatives, supporting facilitate early discharges. Early supported discharge team is in place consisting of both nursing & therapies to support respiratory patients. Discharge to Recover & Assess (D2RA) is a model implemented in the integrated community teams to support safe and timely discharges from hospital. The community teams work closely with secondary care teams to share information for seamless transfer of care and ongoing therapy needs. During 2021, seven day working has been piloted for therapies working in key specialties (General Medicine, Orthopaedics and Emergency Care). This facilitates discharge during weekends, and also support admission avoidance. Action is being		

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		progressed currently to make this arrangements substantive. Consideration of therapies provision is being included in the planning of Acute Medicine service re-design underway currently.		
9	**NHS Wales needs to clarify timeframes and next steps regarding the rollout and implementation of e-discharge across all NHS Wales healthcare organisations.**	Complete. The DAL (Discharge Advice Letter) system within the WCP clinical system provides this. This solution has now been rolled out across the Health Board.	SBUHB Digital Services	Complete
10	**NHS Wales healthcare organisations should actively pursue the implementation of e-discharge systems in support of improved quality,**	There is a bimonthly meeting with the Executive Medical Director (EMD) and Group Medical Directors (GMDs) and a DATIX report pertaining to incomplete / unsatisfactory / delayed ETOC (electronic transfers of care) from secondary to primary care is a standing item of this meeting. The	Executive Medical Director	Complete

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	timeliness and sharing of discharge information. Any new e-discharge system needs to be monitored continually to measure its effectiveness.	meeting is chaired by the Executive Medical Director. A DATIX report is shared by GMDs with relevant specialities within their Service Group clinical cabinets to undertake a review and provide a response/reflection to ensure learning/improvement. This is also a standing items in COEG.		
11	**NHS Wales healthcare organisations should ensure they have arrangements in place to share good practice around live dashboards.**	As recognised by the HIW Report, SBU has developed dashboards presenting live discharge data in a number of useful ways. Local live dashboards such as 'SIGNAL' were completed in 2019/20. This displays next steps for patients as to their discharge plan.	SBUHB Digital Services	Complete
12	**NHS Wales healthcare organisations should, where not already in place, implement mechanisms where primary and secondary healthcare**	SBU health board continues to hold bi-monthly meetings with Local Medical Committee to discuss issues and areas for improvement. As reported, the meetings provides direct access to GPs so that clearer messages can be conveyed regarding aspects of both secondary and primary healthcare and opportunities for GPs to comment on	Medical Director (Primary Community & Therapies Service Group)	Complete

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	interface issues can be addressed.	existing good and bad practice they've encountered. The meetings are chaired by the Medical Director (Primary Community & Therapies Service Group). There are also monthly meetings with cluster leads. Cluster leads have been appointed to lead / support clinical pathway development working with secondary care colleagues eg diabetes, respiratory pathways.		
13	**NHS Wales healthcare organisations to ensure that junior doctors receive discharge training as part of their induction, and that compliance should be continually monitored.**	Video training on the completion of the Discharge Advice Letters using the module within WCP is included as part of junior doctors' mandatory induction.	AMD (Education & Training)	Complete