Freedom of Information Request: Our Reference CTMUHB_222_26

You asked:

1. **In relation specifically to the Royal Glamorgan Hospital can you please provide standard operating procedures, service specifications or strategy documents that relate broadly to:**

a) **How are discharges managed from medical wards?**

b) **How medical wards coordinate discharges?**

c) **How the hospital coordinates discharge plans with other statutory providers such as the Local authority's?**

d) **That illustrate how care plans are developed to cater for an individual's needs?**

e) **That sets out the expectation of how the medical wards work with carers and families?**

2. **Again, in relation to the Royal Glamorgan Hospital can you send me standard operating procedures, clinical procedures or guidance that outline specifically:**

a) **How a patient existing and future care needs are assessed on the medical wards?**

b) **How are patient's risks assessed, and plans developed to mitigate those risks when approaching discharge from a medical ward (falls for example)?**

c) **What clinical tools are used to assess the needs of patients approaching discharge? Specifically, in relation to mobility, self-care, medical needs and social needs.**

d) **How frequently would the medical wards leadership expect that a falls risk assessment is undertaken?**

Our response:

1. Discharge Processes and Coordination

a. How are discharges managed from medical wards?

Discharge arrangements at the Royal Glamorgan Hospital are managed in line with the Health Boards Integrated Discharge Policy which follows national guidance and adopts the national Discharge to Recover then Assess (D2RA) model of care.

This involves:

- Discharge planning starting within 24hrs of admission, with and Expected Date of Discharge (EDD) and D2RA pathway recorded in this time.
- Daily board rounds to review patients' progress and identify discharge barriers
- D2RA pathways (0-3) determine the appropriate discharge route:
  - Pathway 0 – Home with no new care and support.
  - Pathway 1 – Home with support.
  - Pathway 2 – Bed based rehabilitation.
  - Pathway 3 – Bed based complex assessment.
- Completion of a proportionate assessment to determine care needs for discharge called Electronic Transfer of Care (EToC), Electronic Discharge Advice Letter (EDAL).
- Medication reconciliation.
- Patients who are as clinically optimised should be discharged within 48 hrs in line with national standards. If not discharged in this time frame they are recorded as a pathway of care delay (PoCD) and reported to Welsh Government.

b. How medical wards coordinate discharges?

Medical Wards co-ordinate discharges through:

- Daily MDT/Board Rounds, involving:
  - Doctors
  - Nurses
  - Allied Health Professionals (OT/PT/SALT)
  - Patient Flow Co-ordinators
  - Use of complex Discharge Liaison Nurses, Case Managers or Social Workers to support and oversee complex discharges.

- Support from Discharge Hub that:
  - Processes all proportionate assessments for discharge (EToC).
  - Liaises with local authorities about availability of care for pathway 1 discharges.
  - Allocates all community hospital beds for pathway 2 and 3 patients
  - Reviews all patients who are clinically optimised.
  - Escalates delays.

- Real-time patients tracking system – Electronic White Board.
- Communication with bed management teams to support patient flow (Head of Patient Flow, Clinical Site Manager, Patient Flow Co-ordinator).
- Daily conference calls pan-CTM.
- Escalation Processes for delayed discharges (for both internal and external delays) aligned with local operational policies.

c. How the hospital coordinates discharge plans with other statutory providers such as the Local authority's?

CTMUHB operates integrated discharge arrangements with:

- Rhondda Cynon Taf County Borough Council
- Merthyr Tydfil County Borough Council
- Bridgend County Borough Council

This is delivered through application of the Integrated Discharge Policy and a Memorandum of Understanding for Discharge Services, signed by statutory directors and the Chief Operating Officer of CTMUHB. The MoU sets out how partners work together to deliver safe, timely and effective hospital discharge, including joint working, escalation routes and minimum standards.

Discharge plans are co-ordinated through:

- Proportionate trusted assessment completed by the ward-based MDT.
- Daily co-ordination and liason through the discharge hub.
- Appropriate attendance at board rounds, MDT and discharge planning meetings.
- Weekly review of patients to review delays and jointly progress actions.
- Monthly review meetings of pathway of care delays.
- Site based support from Complex Discharge Liaison nurses that support co-ordination with community nursing and community hospitals.

d. That illustrate how care plans are developed to cater for an individual's needs?

In line with national guidance CTM adopts a D2RA approach for discharge where a proportionate assessment is used to complete a delivery plan for a period of intermediate care, where the patient is given time to recover and a statutory assessment for ongoing care needs completed.

Statutory care and support plans for ongoing long-term care after discharge are completed during the period of intermediate care and ideally not in Royal Glamorgan Hospital. This only occurs when there is lack of capacity in a community hospital to complete the assessment. Guidance for completing this assessment provided in the Integrated Discharge Policy.

- For care at ward level there is an expectation that care plans are developed using a holistic, person-centred approach, consistent with prudent healthcare principles and based on holistic multi-disciplinary team (MDT) assessment including:
  - Physical health
  - Mental Health and cognition
  - Functional ability
  - Social circumstances

- Informed by MDT input, including AHP assessments (e.g. Occupational Therapist (OT), Physiotherapist (PT))

- Consideration of:
  - Patients preferences and expectations
  - Cultural needs
  - Risk Factors
- Regular review and updating of care plans throughout admission
- Focused on supporting independence and recovery

e. That sets out the expectation of how the medical wards work with carers and families?

The Health Board expects clinical teams to:

- Take reasonable steps to identify carers as early as possible during a hospital admission, including at the point discharge planning begins.
- Involve carers and families in discharge planning discussions, subject to patient consent.
- Provide clear information and communication regarding:
  - Discharge plans
  - Medication
  - Treatment plans and follow up arrangements
- Work collaboratively with carers as part of the MDT process
- Ensure communication is timely and documented.

Hospital discharge in CTM complies with the Social Services and Well-being (Wales) Act 2014 and its statutory Codes of Practice, alongside national discharge policy. The Integrated Discharge Policy outlines the legal rights that cares have that must be recognised throughout the discharge process and includes:

- A process to refer to social care for a statutory carers assessment in line with section 24 of SSWBA.
- A flag on the Electronic Whiteboards to identify the need for carers support
- Processes to ensure that carers are:
  - Involved in discussions and decisions about discharge where appropriate.
  - Treated as equal partners, not assumed providers of care able to request a combined assessment with the cared-for person (only if they consent) on the ward when a statutory assessment completed.
  - Provided with information, advice and assistance to carers from the right source.

The proportionate assessment for discharge (EToC) has questions to ensure that the discharge plan does not:

- Assume that a carer is able or willing to provide support
- Build a discharge plan that relies on unpaid care without agreement
- Substitute informal care for statutory support without assessment

It is essential to recognise that all patients are presumed to have the capacity to make independent decisions unless there is reasonable doubt to suggest otherwise. In such circumstances, the health board should determine whether the Mental Capacity Act applies and address this in collaboration with carers and families. During discharge planning, the Mental Capacity Act is adhered by assessing the patient's ability to make informed choices regarding their care. If the patient is deemed to lack capacity following appropriate assessments, families and carers are appropriately involved to support best-interest decisions, ensuring that the patient's preferences, rights, and the principle of least restriction remain at the forefront.

2. Clinical Procedures and Assessment Processes

a. How a patient existing and future care needs are assessed on the medical wards?

Assessment within CTMHB is continuous and includes:

- Initial nursing and medical assessment on admission
- Ongoing MDT review via daily board rounds

- Ongoing proportionate assessment by the MDT for discharge through the EToC
- Functional Assessments by AHPs
- Consideration of:
  - Baseline level of independence vs Current function/presentation
  - Anticipated recovery trajectory

CTM acknowledges that you cannot reliably assess future or long-term care needs on an acute hospital ward as the environment fundamentally distorts a person's true level of function, independence and recovery potential. This is grounded in national policy, evidence, and legislation.

National guidance explicitly prohibits assessment for long-term care needs in an acute hospital as they are not the best place to determine future function or care needs, because people perform differently once clinically stable and back in their own environment.

Evidence from D2A evaluations shows that when assessment occurs in a person's own home or in community step-down beds there is:
- Reduced long-term care placement
- Higher levels of regained independence
- Better alignment between need and provision
- Improved patient and family satisfaction

b. How are patients' risks assessed and plans developed to mitigate those risks when approaching discharge from a medical ward (falls for example)?

CTMHB risk assessments are undertaken in line with NHS Wales Patient Safety frameworks, including:
- Falls risk assessment (multifactorial)
- Pressure Damage risk assessment (Purpose T)
- Nutritional Screening
- Cognitive

- Risk mitigation plans may include:
  - Mobility support and supervision
  - Medication review
  - Environmental adjustments
  - Therapy input
  - Equipment
  - Individualised care planning

c. What clinical tools are used to assess the needs of patients approaching discharge? Specifically, in relation to mobility, self-care, medical needs and social needs.

Clinical tools used to assess discharge needs may include:
- Mobility Assessment
- Functional Assessment
- Medical Review – (e.g. National Early Warning Score (NEWS), clinical review and documented discharge management plan

- Cognitive Assessment – in instances where there is a capacity concern (e.g. Moca score, Mental Capacity assessment)
- EToC proportionate assessment which incorporates assessment questions under the 5 elements of assessment required by SSWA and domains of a Decision Support Tool.
- Statutory Social Care Assessment and Nursing Needs Assessment if supported on D2RA pathway 3.
- Decision Support Tool – assessment for continuing healthcare if the patient has a primary health need.

These tools inform:

- Discharge pathway allocation (D2RA)
- Level of support required
- Mitigation required
- Rehabilitation and reablement needs

d. How frequently would the medical wards leadership expect that a falls risk assessment is undertaken?

Within CTMHB, falls risk assessments are expected to be:

- Completed on admission, within 6 hours
- Reassessed:
  - Following any fall
  - If clinical condition changes that may affect risk (e.g. acute infection or illness, deterioration in mobility or strength, changes in medication, onset of delirium or cognitive decline, post-operative status)
  - As part of routine ongoing inpatient care (reviewed regularly and at MDT discussions)

Ward level leadership would expect consistent reassessment, robust documentation, and escalation of identified risks inline with local CTMHB Falls policy.

Clinical Governance Summary

Within Royal Glamorgan Hospital and the wider Cwm Taf Morgannwg University Health Board, the management of patient discharge, assessment processes, and risk management is expected to operate as an integrated, continuous, and multidisciplinary system of care, aligned with Welsh Government policy and NHS Wales standards.

Discharge planning is embedded from the point of admission and progresses through daily multidisciplinary team (MDT) review, supported by structured processes such as board rounds, discharge coordination, and the Transfer of Care Hub. This ensures that patients are identified as medically optimised in a timely manner and discharged safely using "Home First" and Discharge to Recover then Assess (D2RA) pathways, in collaboration with Local Authority partners and community services.

Patient assessment is similarly dynamic and ongoing, incorporating medical, nursing, and allied health professional input. Clinical teams utilise a range of recognised assessment tools and professional judgement to evaluate patients' physical, cognitive, and functional needs. These assessments inform both

immediate care delivery and longer-term discharge planning, ensuring that decisions are person-centred, proportionate, and responsive to change.

Risk management, including but not limited to falls prevention, is expected to be proactive and continuously reviewed throughout the patient's admission. Risks are identified on admission, reassessed at regular intervals, and updated in response to any change in clinical condition or following an incident. Effective practice requires that identified risks are clearly documented and linked to individualised care plans with appropriate mitigation measures.

Across all areas, the Health Board would expect:

- Clear and contemporaneous documentation of assessments, decisions, and care plans
- Evidence of regular MDT review and coordinated discharge planning
- Demonstrable integration with Local Authority and community partners
- A consistent focus on supporting patient independence and safe discharge
- Compliance with relevant Welsh legislation, including the Social Services and Well-being (Wales) Act 2014

Overall, these processes are intended to ensure that care delivery within CTMUHB is safe, effective, and person-centred, while supporting timely discharge and minimising avoidable delays or harm.