

**healthwatch**  
Essex

# Insights into Hospital Discharge

A study of patient, carer and staff  
experience at Colchester Hospital



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## Abbreviations

<b>CCG</b>	Clinical Commissioning Group	<b>NHS</b>	National Health Service
<b>CHC</b>	Continuing Healthcare	<b>NRES</b>	National Research Ethics Services
<b>DST</b>	Decision Support Tool	<b>OT</b>	Occupational Therapist
<b>EoL</b>	End of Life Care	<b>PALS</b>	Patient Advice and Liaison Service
<b>HWE</b>	Healthwatch Essex	<b>SW</b>	Social Worker
<b>NEECCG</b>	North East Essex Clinical Commissioning Group	<b>TTA</b>	'To Take Away' (referring to medicinal tablets)
		<b>TTO</b>	'To Take Out' (referring to medicinal tablets)

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# 1. Insights into Hospital Discharge

In this report we present our findings from data derived from our research into hospital discharge at Colchester General Hospital in Essex. This is the second in a series of reports based on research carried out by Healthwatch Essex. Further reports for Broomfield Hospital in Chelmsford, and Princess Alexandra Hospital in Harlow, plus a final report based on our analysis of all three hospitals, will be published in July 2016. These reports will be available on the Healthwatch Essex website:

[www.healthwatchessex.org.uk/  
what-we-do/our-reports/](http://www.healthwatchessex.org.uk/what-we-do/our-reports/)

## 2. Healthwatch Essex

This research has been conducted by Healthwatch Essex (HWE), an independent organisation with responsibilities under the Health and Social Care Act (2012) to provide a voice for the people of Essex with regard to health and social care services. Our research team conducts high quality research on the 'lived experience' of patients, citizens and social care users to inform improvements in local health and social care provision.

Studying the 'lived experience' involves the detailed examination of participants' 'lifeworlds', their experiences of a particular phenomenon, how they make sense of these experiences and the meanings they attach to them.<sup>1</sup> It is premised on a philosophical understanding that a proper scientific understanding of the social world cannot be undertaken by merely collecting 'objective facts', but that research needs to engage in a deep and empathetic way with those involved in an attempt to get as close as possible to the everyday world as experienced by those individuals. It is the lived experience that reflects and determines people's confidence and trust (Brennan *et al*, 2013) in the healthcare system and undoubtedly contributes to their overall physical health and emotional wellbeing, and to their assessment of how the NHS and social care function in meeting their needs.

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<sup>1</sup> The 'lived experience' is a concept that originates from the work of the German philosopher Edmund Husserl. He proposed that a proper scientific understanding of the social world could not be undertaken by collecting 'facts' about an event, but rather the researcher needs to engage in an empathetic way with those they are studying in an attempt to get as close as possible to the world as experienced by those individuals. (Husserl, E. 1970 [1901]. *Logical investigation*. New York: Humanities Press.)

# 3. Background

## 3.1 Hospital discharge: an issue of national concern

The experiences of patients and their carers preceding and following hospital discharge are often unsatisfactory and, following a number of high profile national reports and widespread media coverage about cases of unsafe discharge, there is growing concern among the public about discharge from hospital. In some areas of the country a number of serious failings causing patient harm have been highlighted, including cases where patients had received poor care relating to hospital discharge practices (Francis, 2013). Problems such as miscommunication, incorrect diagnoses, delayed and premature discharge have been identified. Healthwatch England undertook a national enquiry of people's experiences of hospital discharge and reported that many people were experiencing delays and a lack of co-ordination between services and that patients were not sufficiently involved or informed about decisions involving their care (Healthwatch England, 2015). More recently, a report on hospital discharge published by the Parliamentary Ombudsman (Mellor, 2016) claimed that failures in communication, assessment and service coordination are compromising patient safety and dignity, causing avoidable distress and anguish for their families and carers. Nationally, problems related to hospital discharge are not new but growing emergency hospital admissions in England, an increasing ageing population, often with accompanying complex discharge needs, a reduction in social care expenditure,<sup>2</sup> and rising hospital deficits have all contributed to the challenges in achieving a timely, safe and satisfactory discharge for patients.

<sup>2</sup> This is further complicated given that in July 2015 a delay to 2020 was announced in the Government's original intention to introduce a more generous means testing process under the Health and Social Care Act 2012.

### 3.2 Continuity of care

Effective discharge planning is crucial to care continuity. The extent to which, over time, people experience care as connected, within a hospital setting and during their transfer of care in the community, is an essential component of care quality. For people leaving hospital, the discharge planning process plays a significant role in achieving this. It is evident that effective, timely, and safe discharge is important for patients and their families and that the discharge planning process plays a significant role in achieving this.

### 3.3 A growing, elderly, frail population

The growing elderly population is linked to increasing hospital admissions. The percentage of the total population who are aged over 60 has risen sharply in recent years, now accounting for almost a quarter of the population, and this number is predicted to rise further (ONS, 2015). Thirty-six per cent of people aged 65-74 and 47% of those aged 75 and over have a limiting longstanding illness (Age UK, 2015). Of the 16 million adults admitted to hospital last year, almost 8 million (47%) were aged over 65 years (Health and Social Care Information Centre, 2015).<sup>3</sup> In their report, Healthwatch England (2015), identified problems experienced by elderly patients and their families in relation to accessing continuing healthcare and in waiting for assessment before being discharged. Furthermore, according to the Alzheimer's Society (Lakey, 2009) approximately 30% of patients who occupy hospital beds have dementia.<sup>4</sup> A two-year analysis of hospital episode statistics data found that dementia

patients were 10% to 20% more likely to die in hospital than comparable patient groups, and that their lengths of hospital stay are, on average, a quarter longer than for those without dementia. Over half of all new admissions to care homes in the UK are of people transferred from general hospitals (Office of Fair Trading, 2005). For such patients, and their family members, being discharged from hospital often presents life-changing and unique, emotionally difficult decisions. This may also present accompanying financial challenges, insofar as most people being transferred to a care home will now either have to pay for all or some of their care.

### 3.4 Hospital resources

It is evident that effective, timely and safe discharge is important for patients, and it is also of key concern for acute hospitals, which are under increasing pressure to avoid 'delayed transfers of care'<sup>5</sup> and to ensure that hospital beds are available to patients requiring admission. Discharge planning is a key part of the operational management of beds (NHS, 2016). While discharging a patient from hospital inevitably involves a degree of planning, for some patients who have complex ongoing health and social care needs, this requires detailed assessments, planning and delivery by multi-agency working or multi-disciplinary teams. The majority of these more complex cases will be elderly patients who may require assistance to be discharged to their own home with continuing healthcare and/or social care provision, which may include discharge to a residential care or nursing home, a hospice, or an intermediate care or nursing home.

<sup>3</sup> While undoubtedly the increasing elderly population means an increase in demand for hospital resources and that there has been an increase in day beds for those aged 85 and over, it should be noted that the 'total number of bed days following emergency admissions of people aged 65 and over has fallen' (Wittenberg *et al.*, 2014). This was unexpected given projections based on prior use of elderly cohorts. The number of bed days fell from 22 million in 2001/02 to 20 million in 2012/13, a decline of 91% (*ibid.*).

<sup>4</sup> One reason for the longer stays is that patients with dementia are three times as likely to have a fall while in hospital as other patients (Robinson and Tyndale-Biscoe, 2014).

<sup>5</sup> A 'delayed transfer of care' occurs when an adult inpatient in hospital is ready to go home or move to a less acute stage of care but is prevented from doing so. This is sometimes referred to informally as 'bed-blocking'.

Their length of stay in hospital is often difficult to predict and such complex cases are usually managed by dedicated discharge teams working in hospitals. However, delayed transfers of care for these patients are common. Eighty per cent of all delayed discharges or transfers of care are experienced by people over the age of 70 (Royal Voluntary Service Report, 2014). Funding issues are also a consideration for such cases as, while healthcare is generally provided free by the NHS, social care is means tested and these and other assessments are carried out in hospital.

### 3.5 Hospital discharge in Essex

The people of Essex have highlighted a concern about hospital discharge and in 2013 hospital discharge was identified by the Who Will Care Commission (Hughes-Hallett and Probert, 2013) as an area requiring urgent attention by commissioners, providers and other statutory organisations.

Experience of hospital discharge has also been one of the prominent issues reported to the Information Service provided by HWE. We've received a large number of telephone calls from relatives of elderly patients who wished to complain about the discharge process and/or to request information to support and care for an elderly relative following their discharge from hospital. Concerns have also been expressed about a lack of patient and carer involvement in discharge planning and of patients being discharged prematurely with no or little support following discharge.

In 2014, in response to concerns in the county, we chose to undertake research on hospital discharge and its effect on the lived experience of patients and family members caring for patients in Essex. This was based on the assumption that to improve hospital discharge we need to understand how patients, family members and professionals experience the discharge process and how their views relate to each other. With the agreement of senior executives at the proposed hospitals, it was decided that a study would be designed to examine issues relating to hospital discharge at three acute hospitals in the county: Colchester (North East Essex), Broomfield (Mid Essex), and Princess Alexandra (West Essex).<sup>6</sup> The hope is that our findings will assist hospitals, the relevant Clinical Commissioning Groups, Essex County Council, and other organisations that provide care to patients aligned to hospital discharge, to improve the quality of hospital discharge for patients.

While we have used the same research design for all three hospitals, inevitably our findings from each site have varied. By focusing on three hospitals in Essex we aim to provide an insight into problems occurring in particular locales, as well as highlighting aspects that may facilitate effective practice across the county.

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<sup>6</sup> Initially we had planned to conduct the study in just two hospital sites, Broomfield Hospital in Chelmsford and Princess Alexandra Hospital in Harlow, chosen because we wanted our work to include citizens' voices from as wide a population across the county as possible. However, we were approached by North East Essex CCG with a request to carry out the study at Colchester Hospital as well. North East Essex CCG and Health Education East of England provided joint funding as a contribution to the cost of conducting the study at Colchester Hospital.

### 3.6 Colchester General Hospital

Colchester General Hospital is an acute hospital in North East Essex providing accident and emergency (A&E), medical care, surgery, critical care and other core services. During the months of June, July, August and September 2015, a total of 1,687 delayed transfer of care days were reported at Colchester General Hospital (NHS England, 2016). The majority of these delays were due to one of the following reasons: time taken to carry out assessments to determine patients' ongoing healthcare requirements, patients awaiting further non acute healthcare services, determining available places for patients in care homes or nursing homes, awaiting patient or family decisions about care homes or care packages, and awaiting the setting up of care packages (ibid). A small number of days' delay were due to funding delays. These numbers are not untypical when compared to other acute hospitals. A minority of patients, those with particularly complex discharge needs, contribute greatly to these figures. Such statistics illustrate the challenges and complex issues hospitals face in finding satisfactory discharge outcomes for these patients, and hint at the distress experienced by patients and their families during such lengthy and complex discharge processing.

### 3.7 Study design

One of the primary aims of Healthwatch Essex is to work with the citizens of Essex, patients and local health and social care providers to improve local health and social care delivery. Therefore, our study design was co-produced,<sup>7</sup> that is we consulted with the public, patients and local stakeholders to decide how we should plan and execute our study. To achieve this we carried out focus group meetings with various stakeholders at all three hospital sites and at North East Essex CCG. The study at Colchester General Hospital was facilitated by the Medical Director, Dr Angela Tillett, who supported the hospital's involvement in the study and helped identify suitable wards and areas for the research team to work in, and key staff to approach. Further preparation and planning meetings took place with Dr. Oonagh Corrigan and ward and discharge staff leads.



<sup>7</sup> 'Co-production in research aims to put principles of empowerment into practice, working with communities and offering communities greater control over the research process and providing opportunities to learn and reflect from their experience.' Durose *et al.* (2011)

### 3.8 Previous research and views of our stakeholders

In preparation for the study we conducted a literature review of the published research literature on patient experiences of hospital discharge and this was updated on completion of the study. The aim of the review was to understand what was known about the patient, patients' families and informal carers' experiences of hospital discharge and what factors influenced that experience.

Our review of 259 published research study articles revealed that patient and carer involvement in discharge planning is crucial and that staff need to work actively to determine what patients need post-discharge and how this can be best facilitated to empower patients and their relatives/carers as 'partners in care'.<sup>8</sup> This information, alongside information gathered during focus group meetings with key stakeholders (patients, carers, hospital staff involved in discharge and hospital management), informed our study aims and design.

### 3.9 Study aims

- To develop insight into the 'lived experience' of hospital discharge processes in Colchester Hospital.
- To identify both the challenges and positive attributes that facilitate, or inhibit, an effective and safe discharge from hospital for patients.
- To engage with stakeholders throughout to maximise the impact of the research study to improve patient and carer experiences of discharge.

<sup>8</sup> A copy of our comprehensive review of the research literature on hospital discharge will be published and made available on our website [www.healthwatchessex.org.uk/what-we-do/our-reports/](http://www.healthwatchessex.org.uk/what-we-do/our-reports/)

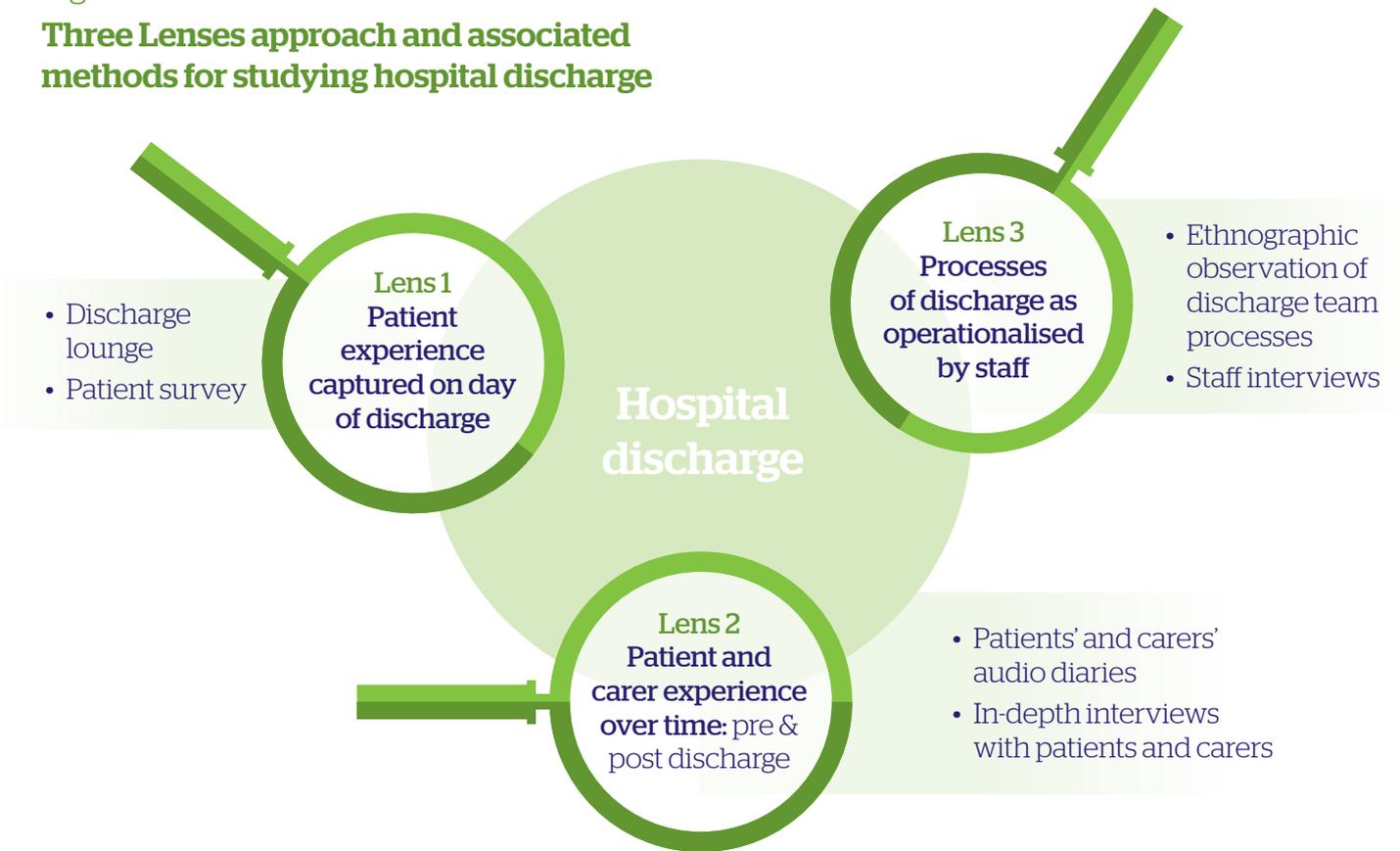
# 4. Methods

To best understand the complex factors involved in participant experiences of discharge, we adopted a mixed-methods approach (Creswell, 2003; Morgan, 2007). While largely qualitatively driven, we drew on both qualitative and quantitative research methods. This approach was designed to produce: in-depth accounts of patients' and carers' lived experiences; a rich description of both cultural practices and processes surrounding discharge; and an analysis based on statistical survey methods to suggest causal factors or correlations in patient and carer experiences of discharge.

Our design was premised on our initial understanding that hospital discharge is a fluid process that begins once a patient is admitted, and carries on throughout their stay in hospital and beyond. It is a dynamic negotiated process involving a number of key people - patients, doctors, other members of the clinical and social care teams and patients' family members and/or carers (formal and informal). We applied academic rigour with a degree of pragmatism (what is achievable, practical and ethical), thinking carefully about how best to capture this dynamic discharge process (movement over time) from the perspective of the patients, their family members (carers) and key staff involved in the process. To this end we designed a three lens framework (see Figure 1) to capture experiences of hospital discharge from different perspectives in anticipation that these perspectives, when analysed, would help present an overall picture, capturing the dynamic nature of hospital discharge, to inform a broad understanding of the issues.

Figure 1:

### Three Lenses approach and associated methods for studying hospital discharge



**For Lens 1** we developed a survey to capture patient experiences on the day of discharge, administered in the hospital's discharge lounge by a team of three trained HWE volunteers to collect answers to pre-set questions, including some free-text questions. The survey consisted of 32 questions and provided a snapshot of what the participants thought of their experience of hospital discharge while waiting in the discharge lounge. At the heart of the survey were five evaluative questions which covered: how well participants felt their discharge was going; how they rated the discharge lounge; how they rated the arrangements for leaving hospital; how well staff listened to them; and how happy they were with arrangements for their health and social care after leaving hospital. In addition, the research volunteers were asked

to complete diaries on their observations while in the discharge lounge. Quantitative survey data was analysed by an expert in statistical methods, who also designed the survey. Answers on survey forms were copied into a spreadsheet using numerical coding. This data was then analysed using the open source statistical software, R, to produce tables and graphs showing summary information about the people who took part (i.e. age, gender, whether they had a disability) and about their experiences and opinions of hospital discharge. The free-text questions served to elucidate the issues participants faced during hospital discharge. The open ended qualitative survey data and contextual notes made by the researchers who carried out the survey interviews were also transcribed and subjected to thematic analysis.

The qualitative and quantitative data set was subsequently triangulated (Patton 1999) to elucidate complementary aspects of the same phenomenon.

86 people gave their consent to participate in the survey. Seventy-five were patients who answered the questions themselves, while the remainder answered the questions with assistance from a relative or carer, or requested that a friend or family member do so on their behalf. All but 27 of the survey participants left free text comments.

**Lens 2** involved the recruitment of patients and carers from two wards who were invited to complete diaries (either using digital recorders or in written form) providing information about their experiences of hospital discharge as they occurred during their stay in hospital and following discharge, and to participate in interviews following their discharge from hospital. Our participant sample is purposive insofar as we set out to include a large proportion of elderly patients, as we know they often experience problems during and following discharge.

In conducting ethical research, a balance has to be struck between ensuring no inadvertent harm is caused to participants, while recruiting a broad spectrum of experiences, especially capturing the experiences of the most vulnerable. Researchers worked closely with staff in both the wards and the discharge lounge to identify suitable patients to approach. While wishing to ensure we were able to interview as broad a sample of patients as possible we experienced ethical challenges in recruiting those who were particularly sick and vulnerable. We also experienced challenges in recruiting carers (family members/friends) of patients in cases where patients did not have sufficient

mental capacity to consent. We found that family members were often in a hurry and too distressed or anxious about their relatives, so when we mentioned the study to them they were reluctant to participate. While our sample is not a representative one (indeed, this is not the aim for qualitative research), it provides a descriptive picture of the experiences of participants and we identify common themes across their narratives. In Lens 3 we present our analysis of our observational/ethnographic data, which includes observations of more complex discharge cases. The follow-up interviews were designed to explore in more detail patient and carer experiences during the patient's stay in hospital and post-discharge. They were conducted with participants in their place of residence to gather an in-depth account of their experiences related to their hospital discharge and transition from hospital care to care at home. Interviews and audio diaries were transcribed (verbatim) and the resulting data analysed. We applied thematic analysis, a search for themes that emerge as important to the description of the phenomenon (Daly, Kellehear and Gliksman, 1997). This involves the identification of themes through 'careful reading and re-reading of the data' (Rice and Ezzy, 1999: 258). Our first level of analysis utilised a thematic approach (looking for broad/common themes and variations); with the second level of analysis using more detailed coding, demarcating segments within the themes so that the data 'emerged' from participant experiences. It is a form of pattern recognition within the data, where emerging themes become the categories for analysis. To ensure rigour in the analysis this process was carried out by the researchers involved in the data collection, and analysis checking and discussion meetings took

place at HWE and the University of Essex with the entire research team. Any areas of contest concerning data findings and interpretation were resolved through discussion and re-analysis of the primary data.

**In Lens 3** we wanted to find out more about some of the challenges that staff face in preparing patients for discharge and, in particular, how they deal with planning for complex discharge cases. We chose to use ethnographic methods (observation and interviews) to study the processes and challenges staff face and their views of these. Ethnography is a qualitative approach that involves relative submersion in the studied setting, and is historically associated with observational work and interviews carried out in everyday settings. It has been used in healthcare research and medical settings (see Savage, 2000; Pope, 2005) and focuses on the meanings of an individual's actions and explanations, rather than their quantification. Although time consuming, it is a particularly useful method in revealing complex or unfamiliar cultural practices.

The ethnographic observation of the discharge team was carried out during August and September 2015. This involved shadowing the discharge team during week-days and week-ends. Our researcher shadowed different members of the discharge team (both health and social care) during their day-to-day clinical work (i.e. board rounds, interactions with patients and ward staff, decision support tool [DST] meetings). The health and social care sections of the discharge team were located in the same office location although in the past they had occupied two different offices. In cases where a member of the discharge team had to interact with a patient, verbal consent from the patient was obtained. If patients were not able to provide verbal consent

(i.e. they lacked mental capacity) the researcher stayed in the nursing station until the discharge member of staff had finished talking with the patient. When a member of the discharge team being shadowed interacted with other healthcare staff, the researcher's role was described to the healthcare staff. The researcher also attended board rounds in a number of different wards in the hospital (i.e. surgical, medical, care of the elderly, oncology and orthopaedics). The discharge member of staff introduced the researcher and explained the reasons for their presence at the board round. The researcher recorded field-notes during fieldwork and at the end of the fieldwork day to capture the overall experience of spending the day with the discharge team.

In addition, semi-structured interviews with members of the discharge team and senior ward staff involved in discharging patients were carried out. The interviews were primarily reflexive and focused on how staff experienced the overall discharge process and their collaboration with other colleagues and agencies based in or outside the acute care setting. The interviews lasted approximately 20-30 minutes and were carried out in private rooms. Each lens data set was analysed separately before the entire data set was triangulated and overall findings produced.

#### **4.1 Ethics**

Ethical approval for the study was granted by the NHS National Research Ethics Services, (NRES Committee East Midlands - Nottingham 1) in March 2015. Following submission for NHS site approval from the Research & Development (R & D) department at Colchester Hospital, who acted as Lead R & D site for all three hospitals,

permission was granted to start the study in May 2015. Written informed consent was obtained from all study participants and, in the case of the observational work with the discharge team, we obtained verbal consent from patients where interaction between patients and discharge team staff being observed took place. In addition to the provision of relevant information to facilitate participant's informed consent, the protocol was also designed to ensure that, as far as possible, awareness of the study was raised in advance, alerting staff, patients and carers that they may be approached.

## 4.2 What data did we collect?

Data collection began in June and was completed in December 2015. In total we gathered the following data:

### Lens 1

- Survey interviews with 86 patients (some with relatives/carers) in the discharge lounge<sup>9</sup>

### Lens 2

- Six interviews with patients.
- Four patient diary recordings.

### Lens 3

- 11 in-depth interviews with clinical staff involved in discharge planning activities (eight staff from discharge team and three ward staff).
- 65 hours of observation shadowing discharge team staff.

<sup>9</sup> Although 86 people consented to take the survey, a few people did not complete all of the questions and so for some questions the data presented will reflect this.

# 5. Lens 1

## Patient survey in discharge lounge

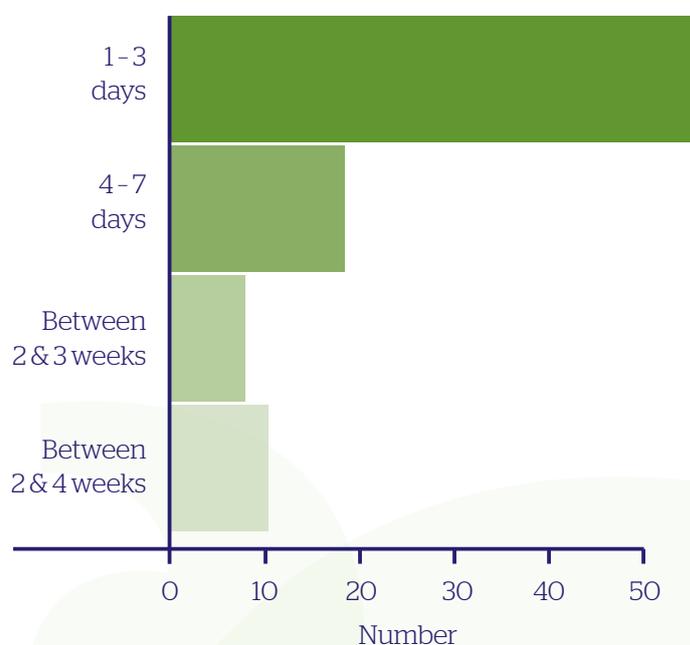
Eighty-six people gave their consent to participate in the survey. Patients' median age was 80 years. Fifty-five percent of the sample were female, and 45% male. The majority of patients reported their ethnicity as white British (92%).

### 5.1 Length of stay and type of admission

The majority of patients (64%) who had been discharged and were waiting in the lounge, had a relatively short hospital stay of 1 - 3 days. 21% had a slightly longer stay, and 15% stayed for 1 - 4 weeks.

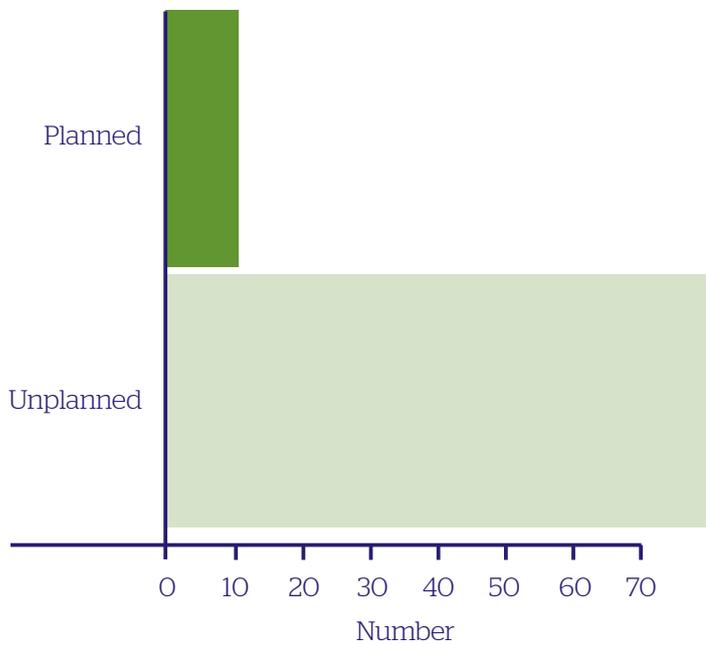
Figure 2:

#### How long in hospital?



For the vast majority (90%) of survey participants their admission was unplanned.

Figure 3:  
**Was admission planned or unexpected?**



### 5.2 Discharge destination

The majority of the sample (79%) reported that they were being discharged to their own home; a few participants reported that they were being discharged to a friend or relative's home (12%), and others to a residential care or nursing home (7%).

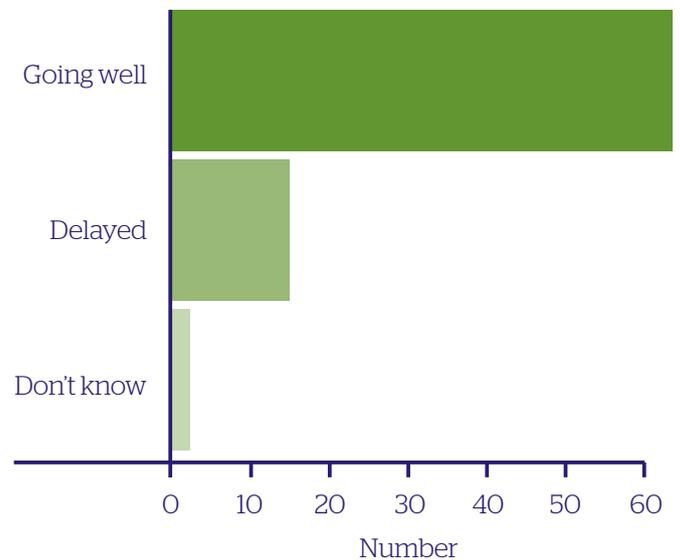
### 5.3 Discharge lounge use

We found that the discharge lounge was not in frequent use; our research ambassadors, who administered the survey, were informed that many wards choose not to send patients to wait there. In particular, they noted that very few patients were being sent from the wards situated some distance away from the discharge lounge area.

### 5.4 Delays

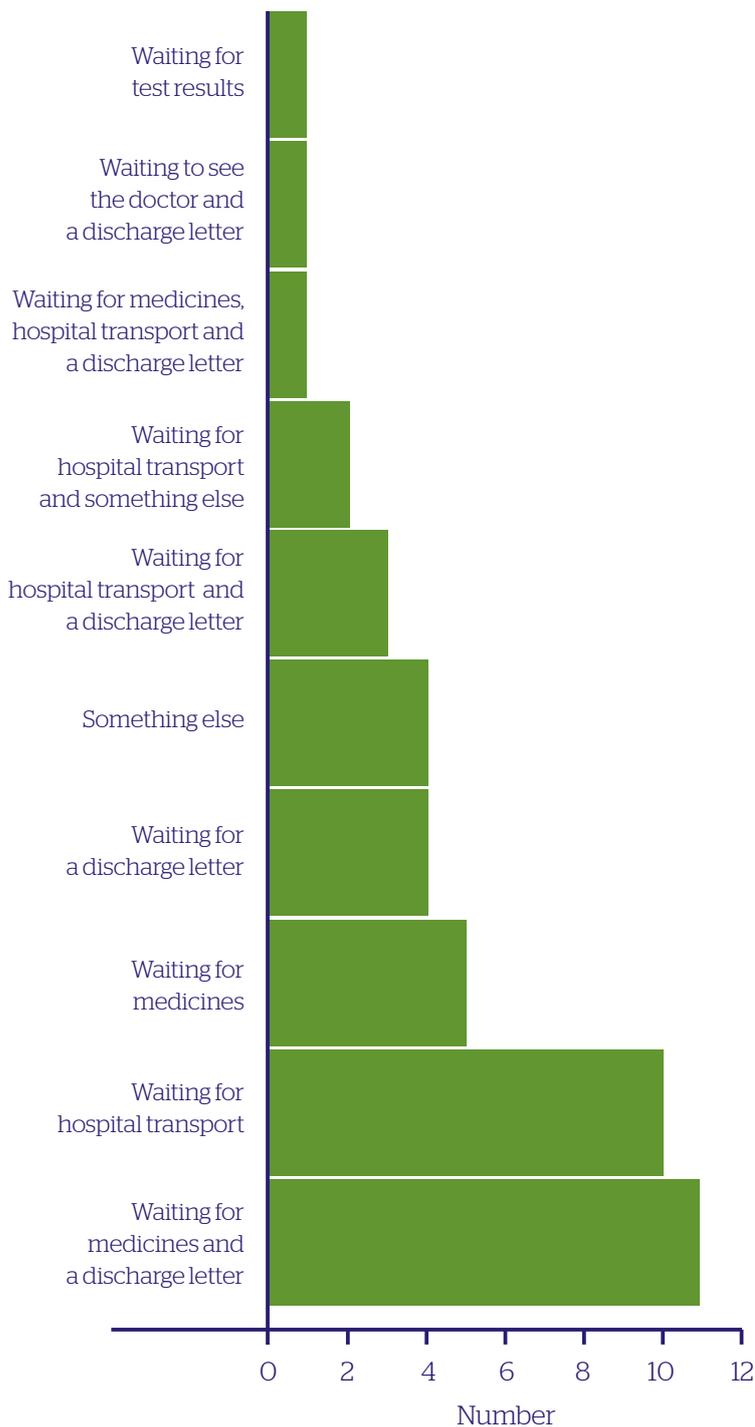
The majority of respondents reported that their discharge was going well (79%). However, many of those who were approached to take part did so soon after they had arrived in the lounge. Given that after completing the survey patients often spent a considerable time waiting before finally leaving the hospital, it seems that this response would inevitably have been different had they been interviewed later. See Figure 4.

Figure 4:  
**Would you say that your discharge is going well or that it is delayed?**



Most of those who described their discharge as delayed reported the main reason for this delay as being either that they were waiting for medication and/or a discharge letter (26%). See Figure 5.

Figure 5:  
Reasons for delay



For example, a 95-year-old participant reported that he had been in the lounge for four hours. He had arrived in there at 11am with medication but had not been given a discharge letter. When the discharge letter finally arrived the medication was altered and had to be sourced again. He was finally taken home by his daughter at 3pm.

### 5.5 Medication

Almost 81% of our sample reported that they had been prescribed take-home medication. A large proportion of them (24%) reported that they had waited 'too long' to receive their medication. While the majority of participants (94%) reported that they knew how to use and when to take their medication, a fifth (20%) reported that they were not aware of its side effects.

### 5.6 Involvement in decision to discharge

Seventy-two percent of respondents felt that they had been involved in their discharge. However, those patients who felt they had not been involved in the decision making process described their discharge experience unfavourably. For example, an 80-year-old patient reported that she had not been involved in decisions about leaving hospital, nor had her family or home situation been taken into account. When asked how well she thought doctors, nurses and other care staff had listened to her, she ticked 'badly'. The participant expressed concerns about being discharged: 'I would have preferred to be kept in but was told that there were no beds. I am worried about losing my breath. I wanted to have stayed in hospital for the night'. Another patient, an 85-year-old woman, said she told the doctors that she didn't feel ready to go home but that staff hadn't listened to her. She went on to say, 'I have already been admitted twice in the last five days. I am wobbly and dizzy.'

## 5.7 Post discharge care planning

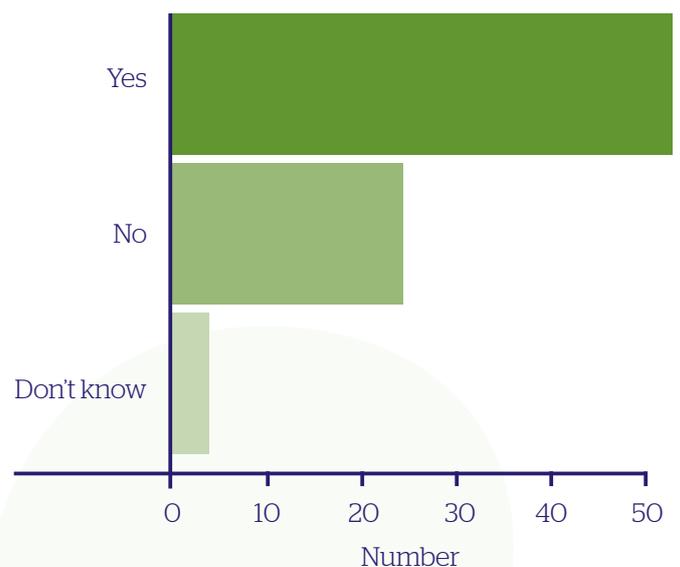
Twenty-three percent of our respondents reported that the hospital staff had not told them who to contact if they had any worries or questions about their condition after leaving the hospital. A further 30% of the sample responded that they had not been told about any danger signs to watch out for when they left the hospital. While the majority of the sample (90%) reported that their home situation had been taken into account when the healthcare team was developing plans for their discharge, a few participants reported that this had not been taken into account in their discharge plan. These participants reported several concerns regarding their health and ability to cope and function when partaking in everyday tasks. For example, the 85-year-old patient who reported that she had told the doctors that she was not ready to go home, said that, during the discharge planning process, the hospital staff did not discuss with her how she might manage to take care of her health and social care needs. She also reported that she felt the hospital staff had not listened to her post-discharge care worries. Another patient, who reported multiple conditions, said he did not feel confident about how he was going to look after himself once home and that the healthcare team had not taken into account his home situation when they were preparing him to be discharged. In addition, the carer of an 80-year-old reported that they had not received any information about his medication, they did not understand the purpose of each tablet, they did not know how and when his medication should be taken, and nor were they made aware of its side effects. When asked whether the doctors or nurses had given a family member or a close friend all the information needed to help care for them after discharge, less than half of the sample reported

that they had. Our survey also revealed that the majority of patients (70%) were being discharged with no further formal support, and that they would look to a family member or friend in the first instance if they need advice or support once home (70%). While 80% of those interviewed reported that they were confident about looking after themselves when discharged from hospital, they still relied on some additional help to do so. These combined results suggest that those patients may have been less anxious if their family or friend had been given information to help support them once home.

As we have already seen, the vast majority of survey participants had undergone an emergency/unexpected hospital admission and, furthermore, most were living with multiple comorbidities (see figure 6) and as such were likely to be concerned about their ongoing health problems.

Figure 6:

### Do you have more than one health condition or problem?



## 5.8 Summary of Lens 1 survey findings

The majority of patients and carers who participated in our study were elderly (44% of participants were in their 80s) and could be classified as having undergone a relatively simple discharge process from hospital, insofar as most had not been referred to the complex discharge team and were being discharged with little or no additional support or care. Most spoke well of staff, praising their efficiency, and felt that they were doing their best given that they were very busy and at times appeared to be short-staffed. Indeed, in response to our survey, the vast majority rated their overall experience of discharge as good or excellent. Nevertheless, some participants experienced discharge as something that had been arranged for them, rather than with them. Although these participants did not report high levels of dependency, their lack of involvement in discharge planning contributed to post-discharge care related worries and in some cases it was evident that a lack of information was likely to have an adverse effect on their wellbeing once home.

While the survey data collected in the discharge lounge gave some insight into the experiences of discharge on the day of discharge, in the following section we explore in more depth the patient journey before and after discharge. As we shall see, many of the above issues were recurring themes.

# 6. Lens 2

## Patients recruited from wards

The main themes to emerge from our audio-diary data and interviews with patients following discharge relate participants' (i.e. patients and their carers) experience of discharge planning and care after discharge.

### **6.1 Communication and discharge planning**

Participants talked about a lack of communication regarding the sequencing of their care and a lack of personal involvement in discharge related processes. Communication problems spanned across the discharge planning process within the hospital, appearing to influence how much control and involvement participants had over their discharge planning activities. Such miscommunication involved both interaction between hospital staff and departments, as well as interaction between ward staff and patients and carers. These problems contributed to participants experiencing their discharge planning as uncoordinated, as they were not involved and they had little or no control over the decision-making processes. For example, communication between hospital departments and staff produced confusion and delays for patients on their day of discharge. In particular, miscommunication (or delayed communication) between the ward staff and the hospital pharmacists contributed to delayed discharges, and the situation often arose in which participants reported that they had to wait for several hours, frequently with limited updates, until they could receive their medication and were ready to be discharged.

Table 1:

## Patient profiles

Patient	Age	Home town and living situation	Condition	Ward recruited	Length of stay
David (male)	70s	Lives with wife	Urinary tract infection	EAU	2 days
Eric (male)	70s	Lives with wife	Chest infection and shortness of breath	EAU, Layer Marney and Dedham	27 days
Hilary (female)	60s	Lives alone, in town 15 miles from hospital	Fell - broken ankle and damaged hip	Aldham Ward	7 days
John (male)	50s	Lives alone	Knee - thought it was a dvt, actually cysts	Aldam Ward	5 days
Kathleen (female)	90s	Lives alone	Fell - banged her head	D'Arcy Ward	7 days
Anastasia (female)	80s	Lives alone	Obstructed bowel following dramatic weight loss	D'Arcy Ward	6 days

*It is now 3:21. I was told at 9:30 this morning I was being discharged today. A letter for discharge has been done on time. I just happened to see a lady I know who does the pharmacy and I asked her how long she would be before my medication is sorted out. She said, "I don't know anything about it. No one has told me." She checked. She said, "Oh you are due for discharge now." She said with my medication there is a lot to be ordered so another long wait... One person doesn't tell the other person what is happening... Still here now. It is 4:08 and found out that there has been a mix up with my discharge medication. One is saying they have just ordered it so it is going to be a couple of hours before that will come up which takes it to eight hours. (Eric, audio diary)*

One person doesn't tell the other person what is happening.



These pharmacy-induced delayed discharges were particularly problematic for those participants who were reliant on external support to leave the hospital (by way of family, friends or taxis) as they did not have access personally to any means of transport.

*Interviewer: On the day you left, were all your tablets ready to go home?*

*Participant: With a little bit of wait, about three hours... My daughter had arrived by then so we just sat and talked for about three hours."*

*(Kathleen, interview)*

Participants also talked about the limited information they had received from the ward staff regarding the discharge. When faced with an unexpected discharge, some participants reported that they felt scared and surprised, as they felt they were not ready to leave the hospital.

*Interviewer: Okay. Were you involved in the decision making about your going home?*

*Eric: No, no. Just told, "You're going home today," and that's it.*

*Eric's Wife: He was a bit frightened, because he thought it was a bit soon.*

*Interviewer: The first time, or second time?*

*Eric's Wife: Both.*

*Interviewer: Both?*

*Eric: Both, yes. The second time... I mean, everyone wants to go home. You don't want to be stuck in hospital. But I didn't feel safe, because I was poorly. And I mean, I was poorly. "Well, I'm going home now," I said, "I know if anything is going to happen, I'm going to be back in here within a few days. I know what's going to happen, because it's happened so many times before. (Eric, interview)*

Many participants reported that, even though they were told that they were ready to be discharged, the healthcare staff provided them with little information about the status/ progression of their illness, treatments and the impact of both on their daily activities. These participants commented on the fact that as soon as they were deemed ready to be discharged, the healthcare staff were mainly focused on carrying out the process of discharge quickly, rather than spending time with them and explaining what would happen next. As a result, these participants reported that they left the hospital with a partial or limited understanding of the impact of their illness and medication on their daily activities once discharged.

The doctor said, "Oh, you can go home," never really gave me any clue as to what I had to do, whether I had to go back to my doctor, or whether I just carry on taking the tablets which they gave me.



*The only thing about it was they said, "You can go." The doctor said, "Oh, you can go home," never really gave me any clue as to what I had to do, whether I had to go back to my doctor, or whether I just carry on taking the tablets which they gave me. They didn't actually tell me, "Oh, well, you'll be better in a week. You'll be better in a fortnight. You need to do this and do that." I thought it would have better to have given me a bit more of an idea as to how I would go, but they didn't. (David, interview)*

This indicates that, had the healthcare staff provided this patient with more information about the progression of his illness, along with the signs that he and his wife should look for in case something went wrong, then both might have had a more positive experience of their discharge and subsequent care and support once home. The importance of good communication and its positive contribution to the coordination of care becomes starker when the quote presented above is contrasted with a quote taken from the interview of another participant, in which a positive discharge experience is described:

*A thorough consultation took place prior to discharge regarding medication, all of which was listed and administered for use at home, i.e. existing pills that I'd taken in and am on... I was encouraged to ask questions, given details of follow-up visits and general idea of length of treatment. You weren't kept in the dark. (Hilary, interview)*

Some participants talked about their unfruitful efforts to get involved in their discharge planning; these participants tried to explain to their care professionals, as Eric did, that they did not feel they were ready to be discharged, but their pleas were not heard. A few participants reported that they were readmitted soon after they had been discharged.

*Interviewer: What discussion did you have with staff about how you were feeling?*

*Eric: I just turned around and told them. I said to the consultant, "I don't feel as if I'm right for going home." He said, "I think we can judge that you're all right." That was their decision. They knew best, kind of thing, so I had to go along with it.*

*Interviewer: And how do you feel about that?*

*Eric: I was annoyed, because I ended up having to go back in for another two weeks. If they'd have done with me the treatment that I should have had, I wouldn't have been in so long and I would have been more on the road to recovery than I am now. (Eric, interview)*

If the healthcare staff had listened, and were more attuned to the health and care needs of the participant, Eric's readmission might have been avoided. However, despite the challenges relating to the lack of coordination of their care in the discharge planning process, the majority of participants praised the ward staff and, in particular, the permanent nursing staff, for the support and care they received from them during their hospital stay.

*Colchester Hospital, honestly, I know it's got a bad reputation but wow, I thought the nurses, they couldn't do enough for you and they are, "Are you in pain?" And they'd bend over backwards for you. The food was great, it was very clean, they would talk to you, they would explain things to you which to me was fantastic, honestly. Really, really fantastic. (John, interview)*

## 6.2 Transitional care

Despite the complexity of their conditions, some participants reported that they had to leave the hospital without having the chance to discuss their care needs, or without having any indication of how to organise their care in order to meet their healthcare needs in the community. Relatives or carers not being involved in discharge planning was often a cause of anxiety and sometimes lead to poor care and support post-discharge. Eric's wife, who was present when Eric was interviewed at home, told us:

*They sent the medication and the bag that was for a rescue pack, but didn't explain to me. I didn't see a doctor at all. They didn't explain to me how to use it. They did to [my husband], but he wasn't very well. There were no follow-ups. (Eric's wife)*

Colchester Hospital, honestly, I know it's got a bad reputation but wow, I thought the nurses, they couldn't do enough for you and they are, "Are you in pain?" And they'd bend over backwards for you.



Similarly, Anastasia, a patient in her 80s, expressed concern over the information given to her friends. Anastasia lives alone, and is heavily reliant on friends and neighbours to provide informal care, making the discharge information supplied to them extremely important.

Some participants left hospital without having their home healthcare needs assessed while they were in the hospital. This meant they often experienced difficulties once they had returned, due to a lack of appropriate care support to deal with their limited physical functionality. Without prearranged social care or community healthcare, the safety of these participants was compromised and they had an increased chances of harm from a fall or in over-exerting themselves. John told us of the difficulties he faced in his recovery due to the lack of support he received at home and how he felt he could not ask his friends and neighbours to meet all his support needs:

***I really struggled the first time, you know, like getting up and down those stairs, need to go to the shop. There's only so much you can phone people and say, "Alright mate, are you going to come up and going to go shopping for me?" (John, interview)***

John also told us how, on the first occasion he was discharged it was 10.30pm, he had 36 stairs to climb to his flat and no one had asked if he needed help. He had been admitted by ambulance but was sent home wearing only a tee-shirt, shorts and flip-flop sandals, with no money.

***When I came home, they'd not even put me down for any physio. Never asked me who'd be at home, would I be alright, can I cook? (John, interview)***

John, in common with other participants, reported that the lack of extra support once home coupled with what he perceived to be a premature discharge contributed to his readmission to hospital and the deterioration of his condition.

When I came home, they'd not even put me down for any physio. Never asked me who'd be at home, would I be alright, can I cook?



***I'm sitting there going- my knee like this, mega agony, "What am I going to do when I get home? I can't go to work. How am I going to pay my bills, my rent? How am I going to get in and out? How am I going to go and get food?" They just didn't... to me, it was just, "Right away you go. You've been in six days, go away, you're fine." Then to come back in again to me is...something's not getting done right. I don't think I should have been in twice within the same couple of days, you know? Which I think is really wrong. (John, interview)***

Some participants described their transitional care as uncoordinated. These participants mainly talked about their problems with receiving updates about their follow-up appointments either with primary or secondary care services. For example, despite being told by the ward staff that their follow-up appointments with primary and secondary care services had already been scheduled and planned, some participants reported that they had not heard back from any service regarding their follow-up appointments.

***Interviewer: Did you see a physiotherapist?***

***Eric: I saw a physiotherapist in there, only on a daily basis. When they did their job in there, just on a daily basis. They turned around and said they would come and visit me in the home shortly after being released from hospital, and I've heard nothing. (Eric interview)***



If the ward staff had provided Eric with more information about when to expect his home visit and/or the physiotherapist had been in contact (i.e. phone call, letter) with him to discuss his care needs in the community, then he might have felt that his care planning was more coordinated and tailored to meet his care needs. Other participants corroborated Eric's experience talking about how the fragmented interface between secondary and primary care services contributed to them experiencing their transitional care as uncoordinated.

*Interviewer: Did they give you any written information when you left, about what you needed to do?*

*Anastasia: No, because when the medication came round, on the top of it was written 'A nurse will be calling in to see you on the Saturday morning' and I was quite pleased. Although I was a bit cocky, "Oh I'm going to be alright" you know, I was pleased but she never came. So if it hadn't been for [Name of relative/carer], I wouldn't have known what these tablets were, because they're all different. (Anastasia, Interview)*

### 6.3 Experiences of uncoordinated care

Participants who reported being involved in planning their discharge and transitional care described both aspects as coordinated. In contrast, participants who reported that they were uninvolved in planning their discharge described these processes as uncoordinated. Poor communication among care professionals and between patients (and their carers) and care professionals (based either in the community or in the hospital) contributed to participants experiencing their discharge planning and transitional care as uncoordinated. Despite negative depictions of discharge, participants talked favorably about the ward staff, commenting on the care and support they received during their hospital stay.

### 6.4 Lens 2 summary of patient diaries and interviews

To summarise, the main issues identified in this section are as follows:

- Communication was often poor between both departments and hospital staff, as well as between staff and participants (patients and carers).
- Poor communication and lack of involvement in discharge planning led to patients experiencing uncoordinated care, both during their hospital stay and once home (transitional care).
- These problems sometimes resulted in raised anxiety among patients and carers and in patients being readmitted to hospital soon after discharge.

# 7.

## Lens 3

### Staff

In this part of our report we present the findings of our analysis of interview data with ward staff, as well as our ethnographic data based on our interviews and observation of staff in the discharge team. A total of 11 in-depth interviews were carried out with senior staff involved in the discharge process. In section 7.1 we present our analysis of the ward staff interviews and in section 7.2 we present our analysis of our ethnographic observation and interviews with the discharge team. Pseudonyms have been used throughout to protect the identity of participants.

#### 7.1 Ward staff

##### 7.1.1 Staff shortages

On a day-to-day level hospital discharge is discussed at the morning board round. The ward staff we interviewed told us that these were important occasions for the facilitation of patient discharge. Ideally, for this process to be effective, it should involve the whole multi-disciplinary team, including the hospital discharge team, social workers, or someone from the hospital assessment team (a nurse assessor), physiotherapy, pharmacy, occupational therapy etc. However, ward staff indicated that representatives from these groups were often not present. The presence of social care staff was seen to be particularly important and our interviewees felt that their absence was mostly due to staff shortages.

*The amount of staff they have it's not their fault; it's not that they don't want to come. It's just that they don't have the staff. And we've really noticed that, I'd say, in the past few months. (Francis)*

The same member of staff also noted that staff responsible for reablement<sup>10</sup> were not at the morning meetings. She stated:

***We use the reablement service quite a lot for the patients who have come in with no care, who just need a bit of rehab to get, you know, back to used to living in their own home ... it would be really handy if they were present at board rounding. But again, they don't have the staff for that. (Francis)***

They also reported that staff shortages made it more difficult to deliver a timely and effective service. As one ward nurse manager told us:

***The workload is really high at the moment. The OT service is actually on the 'At Risk' register for lack of staff at the moment. We, as of last month, were running on about 33% of vacancies, with three people off on long-term sick. Fortunately, we've just recruited two new assistants. Two people are returning off long-term sick, so it is easing off now. (Alex)***

Some ward staff we spoke to were keen to tell us that despite nurse shortages on the wards and the pressure they felt to free up beds, they would not allow this to cause the premature discharge of a patient:

***...I'm not going to just pass people through and say, "Yes, you're fine to go home," if they're not, because, ultimately, that comes back on me. (Alex)***

Nevertheless, it was clear that some staff did feel under pressure:

***I'm quite happy to speak up. I think there's a lot of people who maybe aren't. But there are some patients who I think are just being discharged quite unsafely, it happens far too quick. ...And I think it's because of bed pressures. (Francis)***

Francis also reported the contrary situation; 'And

then again, you then have the opposite side, where there's patients who should have gone home.'

Discharging patients on a Friday was reported to be a particular problem:

***Fridays are really busy, and... I think if people are discharging on a Friday, they get very panicked, because we have had experiences with reablement where they've said they can go home, they'll be in on Saturday morning. So we've discharged them Friday evening, and then they've said, "No, that's not correct."***

*Interviewer: Do you feel pressured to discharge, even though?*

***Oh yes, absolutely, from the site team. Not from our bosses. ... Not from my direct line managers, or my line manager's line manager, it's from the site team at the weekend, because the bed pressure is always, obviously, continual. People continue to come through, but less people go out. So yes, the pressures are quite high at the weekend. (Francis)***

## **7.1.2 Assessment delays**

Ward staff felt that delays in carrying out assessments contributed to patients' stays being overly long and that this created further problems insofar as elderly frail patients in particular were prone to picking up further infections:

***...where there's patients who should have gone home. It's taken so long for their care to be organised, they've then developed another acute condition while they've been here, like a UTI, and they've stayed in. I've got a man who was meant to be discharged last week, and he developed a UTI, and he's still here now. So this is nine days later. (Francis)***

<sup>10</sup> Reablement refers to services funded by social care to work with individuals who have support needs to rebuild their confidence, and to support the development of daily living skills. The service is time-limited and the overall goal is to help people back into their own home or community.

Staff reported problems in accessing NHS Continuing Healthcare funding for patients who were at 'end of life'. There are National Framework guidelines (NHS 2012) for patients with a rapidly deteriorating condition potentially entering a terminal phase, so that their assessments for continued healthcare can be carried out quickly. This is designed to ensure that appropriate care is provided for patients in their preferred location for dying. However, ward staff identified that this protocol was not always followed. Our interviewees reported that due to changes in assessment criteria patients were unable to access NHS Continuing Healthcare funding and that these delays were distressing for patients, their families and staff.

*The fast-track all changed ... And I think, since that happened, I know of three patients that died here when their wish was to die at home. ... It's quite heart breaking and soul-destroying, to know that you're not- that's all they want. They want to die at home, their family want them to die at home, and you can't do that for them, because of, you know, the time constraints and stuff. ...A lot of the time they'll say they need a checklist, and I'll say, "But hang on a minute, they're not going to be around for your checklist. They need to get out." ...By the time they do the checklist, they're either not going to make it out of hospital, or they don't get here in time, and they've already died. (Francis)*

As we shall see when we present the discharge team staff data issues relating to fast-track for 'end of life' patients were seen as a considerable problem during the period in which we conducted our study.

### 7.1.3 Family involvement in discharge planning

Research on hospital discharge tells us that involving families in discharge planning consistently leads to better outcomes for patients, and that the presence or absence of a family carer can have implications for delayed discharge, as family and friends often provide support in maintaining older people in the community (Victor, Healy, and Thomas, et al., 2000). While NHS guidance recommends that family carers are kept informed and given the opportunity to contribute, many of the ward staff we spoke to felt that families could be 'difficult', delaying patient discharge by raising unnecessary concerns about their relative's living situation. As one member of staff described:

*Generally, most patients want to get home as soon as possible. Families can be difficult because they'll have their own opinion, their house is a mess or they've got beer cans all over the house but they forget that if the patient's got capacity and that's the way they want to live, and that can be difficult because they'll say, "How can you send them back?" That's the way they want to live and as long as they're safe and the place is safe. (Alex)*

Another member of staff on the same ward also felt that some families did not want to facilitate hospital discharge; she reflected:

*I think some relatives, kind of feel that their relatives are in hospital for a certain amount of time, that's therefore a given, and they can be quite obstructive in helping out. It's not an urgency to get people discharged, I think that's a bit unfair. But they don't, I don't think they appreciate the need for the bed. (Francis)*

### 7.1.4 Continuity of care

All of the staff we interviewed commented that local systems often lack the capacity to assist patients in need of support following hospital discharge:

*...it's so fragmented, that's the right word, because there are so many ... systems that we use, like reablement, that have had no capacity. Then you think, "Why are we using something that has no capacity?" (Alex)*

*There's not enough beds. You can't push a person out of a residential home. It's not their fault, it's just that maybe we need more. (Kim)*

All of the ward staff who were interviewed identified that there were both internal causes of discharge delays and causes related to the influence of external/other agencies. Financial challenges on primary care community services were seen as having a negative impact on patients' continuity of care-after needs.

*I think the district nurses, obviously things, I know, changed for them- I don't know how long ago it was, but they used to have a lot more teams. So they were a lot more supportive, I think, when we had patients going home who were struggling a bit. Now they have to be housebound. ... Well, a lot of our patients aren't housebound, but they struggle, they're old. And it's just the two of them, like a wife and a husband, and they're still expected to go to the practice nurse, to have clips out of their wound, or catheters looked- you know, things like that. Or blood taken, they've got to go to their GP's surgery now. (Francis)*

### 7.1.5 Communication

Ward nurse participants commented that they spent a long time on administrative processes in order to facilitate a patient's discharge. Often this work was done by senior nursing staff. In common with the other hospitals in this study, the ward staff commented on how clumsy the fax machines were in imparting information. As one nurse reflected:

*I just think social stuff could be done quicker like that, because we fax things and they say, "We didn't get it" but the fax report that we've got is saying that it's gone through. So that delays it again, because they don't tell us they haven't got it. We assume they've got it, because it says that it's gone through. So I don't think the fax is the way to go. (Kim)*

## 7.2 Discharge team staff

The work of the discharge team is complex and involves working both with others within the team, and with those involved in the care of patients referred to the team - in both the hospital and the community - and communicating with patients and family members to ensure a smooth, safe and timely discharge and transfer of care from the acute hospital. This work involves gathering information, and arranging and carrying out various assessments on patients to see whether they fulfil certain criteria for continuing health or social care provision. We present our analysis of our ethnographic observation and interviews carried out with some members of the discharge team.

*I just think social stuff could be done quicker like that, because we fax things and they say, "We didn't get it" but the fax report that we've got is saying that it's gone through... So I don't think the fax is the way to go.*



## 7.2.1 Limited resources

Discharging with limited resources was one of the key themes relating to discharge planning in participants' talk and our researcher's field notes. The limited resources, both within the hospital and in the community, presented several challenges for the discharge team and hence had a negative impact on discharge planning. As was previously gleaned from the ward staff we interviewed, the discharge team staff reported that resources such as staff shortages in both the discharge team and wards (i.e. nurses, pharmacists, doctors, OTs and physios) had a detrimental impact on discharging patients. More specifically, many participants reported that there were often delays in patients being discharged because the social care team was short staffed and as such they could not keep pace with the high volumes of discharge notifications that were received. There were not enough staff members to cover all the wards, including attendance of the board rounds, which were important times to capture discharge related information and communicate with other staff. The situation became more acute in instances where the delegated social worker for the ward was on leave, as the ward was then left without any social care cover. There were many instances in which social workers had to 'jump' between cases, which contributed to facilitating some discharges but delaying many others. Although they tried to catch up with their caseload once they were back from their leave, this did not prevent delays in carrying out necessary patient discharge related assessments and the writing up of reports, which would enable families to determine the cost of their relative's social care and choose accordingly:

*I know I'm not going to be here until next Tuesday and there isn't anybody to cover ... it's just me ... So it's challenging because I know today I'm trying to take measures to ensure everything is as up to date as it can be ... so usually if I come back after having time off, there's been a problem or there's been an inappropriate referral, so it is problematic when you're not there. (Social care team, Cassie)*

Similarly, the health care team had a staff shortage (two discharge facilitators gave in their notice during the study). The remaining staff faced significant challenges in covering all the wards and dealing with the workload involved with the increasing number of 'continuing healthcare assessments'. Discharge planning, however, was not only impeded by staff shortages in the discharge team; staff shortages at the ward level also played a central role. Participants particularly commented on the very limited number of therapists and doctors available on the wards and the increasing recruitment rates of agency/bank nurses due to staff shortages. The limited number of therapists and doctors were seen to cause delays because, despite being medically fit, some patients could not be discharged as therapists had not managed to finish their interventions or order equipment, and doctors did not have time to review patients' discharge summaries. Our discharge team staff participants reported that agency/bank nurses, recruited to cover staff shortages, were not familiar with the needs of individual patients and provided limited or no input to the health and social care assessments. As one member of the discharge team informed us:

*At any one time on any ward there are, you know I would say up to 50% or more patients who may be medically fit for discharge.*

*Interviewer: Up to 50%?*

*Yes, yes, easily, easily. Because we have on the board you could look at the numbers and... But as I said, things are better but it could be even better if we had more resources to get these patients seen and get them out. (Healthcare team, Bill)*

In addition to the limited resources within the hospital, resource limitations outside the hospital contributed to delayed discharge and hindered discharge planning processes. Residential care/nursing homes and care agencies, as well as the high threshold criteria for accessing services and difficulties with community care services, appeared to have a negative influence on discharge planning. Firstly, participants reported that care homes varied in their response to patient referrals, and while some care/nursing homes would trust the assessments carried out by the hospital team, others would not. In the latter case it could take several days until the home carried out their assessments, an issue that further delayed patients' discharge. Also, the shortage of home care providers coupled with the complexity of patients' needs posed significant challenges to the discharge team in sourcing care for some patients, and often caused delays. Secondly, for patients who needed a mental health assessment, the high threshold criteria for accessing mental health services coupled with the long waiting list of the local mental health team to carry out assessments, resulted in additional delays in discharge planning. Further, the lack of a care pathway for patients with bone fractures, resulted in increasing the hospital's bed

I suspect at the heart of all this is finance. I think that is what is dictating this...I think there is a tussle; people trying to decide who should be funding this and in the process the patient may suffer.



occupancy as, despite being medically fit, these patients often had to remain in hospital until their plasters were removed.

Problems with community care services, and in particular with patients' eligibility to receive an NHS funded care package (i.e. for patients with complex care needs or whose illness had reached a terminal phase), had a considerable negative impact on discharge planning. Noticeably, participants' difficulties in accessing care packages appeared to contribute to their experience of moral distress.<sup>11</sup> Firstly, participants reported that, although the discharge team worked on a seven-day pattern, primary care (and other social care agencies) did not follow the same work pattern. Patients could not be discharged during weekends as GPs and district nurses were not available to monitor patients' health once discharged in the community and this was the same for patients being discharged to care/nursing homes as many operated with limited staff during weekends. However, one of the main challenges that participants reported was the increasing number of patients that were deferred for NHS continuing health care (CHC) and end of life care (EoL). Participants reported that their daily clinical work was challenged because of inconsistencies surrounding the ways that the North East Essex CCG applied the CHC and EoL criteria to assess patients' eligibility for either of the care packages.

<sup>11</sup> Moral distress occurs when one knows the right thing to do, but institutional constraints make it nearly impossible to pursue the right course of action'. (Jameton, 1984)

For instance, there was a view that, for patients with certain care needs, clinical presentation and prognosis would not get funded even though in the past other patients with similar care needs and prognosis had received a funded care package:

***On our way back to the office, [Sophie] and I discussed the increasing number of patients whose CHC applications are rejected. [Sophie] commented that she is unable to predict anymore if an application is going to be accepted or not as there are massive variations to the types of patients whose applications for CHC are accepted. (Researcher field notes, June 2015)***

The split budgets and decreasing financial support from the central government, led the local CCG and authorities to battle over who was not going to assume the responsibility of covering the care costs of the patient. This was another issue that participants linked with the increasing number of patients rejected for complex care packages and the rising number of disputes between health and social care services:

***I don't know, I don't know the reasons. I suspect at the heart of all this is finance. I think that is what is dictating this...I think there is a tussle; people trying to decide who should be funding this and in the process the patient may suffer, the patient and the family. (Healthcare team, Bill)***

Tensions between the social and health care team were reported. Participants working within the social care team reported that they were unfairly criticised for delayed discharges by the senior management team, family members and their health care colleagues. The small size of the team coupled with their already high caseloads, which were further increased as they had to

source care for the deferred patients, resulted in delayed discharges.

***I think the biggest reason for those tensions is that...if somebody should be entitled to continuing healthcare, by law they shouldn't be providing the social care...I think, obviously, being very conscientious, the social workers and social work assistants are all very tense about that and there are high intensities around that in this office. I think that does bring some problems. (Healthcare team, Sophie)***

Many participants appeared distraught due to the inability of staff to change the CCG's decisions, and hence at the high number of patients who, against their own wishes, died in the hospital. Not being able to deliver the type and level of care that these patients needed appeared to trigger a range of emotional reactions in both the discharge team and ward staff. This experience of 'moral distress' was also reported by the ward staff we interviewed. In general staff morale in the discharge team appeared to be low as a result of their perceived inability to improve a process that they described as unfair.

A small proportion of participants commented that the current performance targets imposed by the central government added an extra pressure to the discharge team, as the targets did not necessarily mean that they worked in favour of improving patients' experience of discharge:

***That is a challenge because you are trying to do what is best for the patient, you are trying to do it as quickly and as safely as you can for the patient; but always at the back of it is Government targets and you have to do this, you have to do that. Whether it is good for the patient or not. (Healthcare team, Taylor)***

The processes presented above had a significant influence on the type and quality of care that patients received. Many patients, despite their complex needs, ended up receiving care packages that did not meet their needs adequately and others preferred to be discharged with no or limited care provision in the community, rather than wait until their assessments were carried out and their care packages were sourced from either the health or social care authorities. Both outcomes had a negative impact on patients' experience of discharge and hospital staffs' experience of discharge planning and consequently job satisfaction.

### **7.2.2 Variations in knowledge sharing and communication**

Another key theme in participants' talk around discharge planning was the variation in the ways that knowledge was shared within the discharge team and between the discharge team and the hospital wards. Despite the initial challenges, many participants reported that the recent changes to co-locate the health and social care teams strengthened collaborative work and knowledge sharing. In contrast, some participants reported that the health and social care divide influenced the ways that they communicated and collaborated with each other. Despite the spatial integration, the health and social care teams described each other as distinct organisations that worked under completely different rules and regulations. The underlying fragmentation of the discharge team appeared to contribute to differences on how each team viewed the needs of the patient:

*At our level here, the team interact very, very well. Moving into the office was a very difficult way forward because obviously we were very segregated. Even just a move into an office was fraught with its own complexities, which you would expect sometimes. For me, it's been a positive experience, but we have a long way to go to develop. We are integrated in a sense of in the office and there is a lot of joint work going on, but we are still very fragmented.*

*(Social care team, Judy)*

Participants appeared concerned about how the underlying fragmentation of the discharge team influenced the way that ward staff viewed their roles in the hospital. Knowledge sharing and communication was also problematic between the discharge team and ward staff and posed several challenges to discharge planning. Processes that had been established to facilitate knowledge sharing did not work, or only partially worked, and communication on discharge planning processes was frequently ruptured. Both issues had a direct and an indirect impact on patients and their families' experience of discharge. For instance, despite the fact that a proportion of participants described the ward board rounds as a good opportunity to exchange and share information (which indeed it was), our researcher noted variations between wards concerning how well focused their board rounds were on discharge planning. Whereas some wards used the board round as an opportunity to share knowledge and facilitate discharge planning, other wards did not appear so much involved in the process. Instead these wards used the board round primarily as an opportunity to exchange information on patients' health needs rather than to plan ahead for patients' care needs upon discharge.

We went through a spate where all the doctors were going, “This person’s palliative, this person’s for fast track, this person” and they were telling families and telling the patients that they would get full funding, but then the fast track was getting rejected and they were going via social care.



Further, knowledge sharing and communication between the discharge team and ward staff was also variable. Whereas some ward staff were aware of discharge planning processes and facilitated the discharge team, in many of the wards staff were rarely willing to get involved, and when they did, their involvement had frequently adverse effects. Instances of ward staff sending inappropriate discharge notifications and providing patients and their families with incorrect information about discharge planning are examples that discharge team staff used to illustrate communication ruptures and problems with knowledge sharing between the discharge team and ward staff. Many participants highlighted the fact that patients often received contradictory information on their discharge planning from a range of different sources. Despite the fact that ward staff had met with the discharge facilitator on the board round, our researcher noted that ward staff provided information to patients without any prior consultation with the members of the discharge team (either health or social care):

*Doctors will say one thing. We went through a spate where all the doctors were going, “This person’s palliative, this person’s for fast track, this person” and they were telling families and telling the patients that they would get full funding, but then the fast track was getting rejected and they were going via social care. That was causing a few complaints and a few problems from our point of view because we’re the discharge team, we’re the ones that make that recommendation, not the consultants. (Social care, Judy)*

On other occasions, our researcher noted that ward staff raised the expectations so high that it was difficult even for the patients and their relatives to accept what they had been promised:

*Sophie and I visited a patient on [name of hospital ward]. The husband of the patient told us that one of the doctors told his wife that an ambulance would pick her up every day from the nursing home and transfer her to her home to visit her friends and husband. Sophie said to the husband that this was very unlikely to happen as the hospital does not have such capacity. Luckily the husband of the patient thought the same thing and hence tried to control the expectations of his wife upon discharge. (Researcher field notes, June 2015)*

In both cases the challenge for the discharge team revolved around how to handle the increased expectations of patients and their families, since both appeared to trust doctors' opinion more than the opinion of the discharge facilitator. It appeared that ward staff's limited knowledge of discharge planning and the lack of a discharge facilitator able to be continuously present in the wards, contributed to problematic knowledge sharing and communication in the majority of wards. Noticeably though, knowledge sharing and communication between the discharge team and some ward staff worked better in certain instances. This was not because the latter had more knowledge on discharge planning or because they had a dedicated discharge facilitator based on their wards, but because these ward staff viewed the discharge team as a 'tool' that they could use to facilitate the smooth running and management of the ward. Our researcher observed that productivity was improved greatly where professionals recognised the role of other professionals and established boundaries to facilitate knowledge sharing and communication accordingly. Finally, a small proportion of participants reported that they felt excluded from the decision making processes. For instance, when disputes between the discharge team and staff in certain wards were observed, it appeared that these disputes were partially as a result of the limited amount of information that both the discharge facilitators and ward staff had received from the managerial level regarding their collaboration and knowledge sharing, on many occasions these miscommunications within the discharge team, and between the ward staff and the discharge team, resulted in delayed discharges, as each had a different opinion regarding the patients' needs. Hence, there was a disjoint between the hospital departments.

Whoever has done that assessment should be able to then commission and source the care with a funding stream that is pulled together.



### 7.2.3 Finding solutions to complex processes

Another theme in participants' talk related to the complexity of discharge planning and participants' efforts to simplify the process and make it more accessible, with regard to knowledge and processes, to both patients and ward staff. Participants identified a range of aspects in discharge planning that could either be simplified or streamlined. For example, some participants reported that the creation of a discharge booklet and drop-in centre would resolve many of the communication problems among the discharge team, families and ward staff. Other participants described the discharge process as particularly complex and strenuous; more specifically these participants reported that they frequently carried out unnecessary assessments, the majority of which were particularly lengthy, and hence they were spending much time duplicating and re-writing assessments. These participants reported that health and social care IT systems needed to be integrated, and assessments, carried out either by the health or social care team, should be shared and not considered invalid if they were not carried out by the agency in charge of patients' care in the community:



*At the end of the day, what we do is we duplicate a lot of assessments, and that's not good for the patient. As you know, we've got the CHC side, so if somebody might be looking as if they might meet the CHC, then it will go down that route. They'll do their assessments, full assessment, very comprehensive, even a support plan. It isn't agreed. It then comes to us. We have then to do another assessment. ... If we've got a comprehensive assessment, why? The integration, to me, should be that whoever has done that assessment should be able to then commission and source the care with a funding stream that is pulled together. (Social care team, Judy)*

A small proportion of participants noted that the hospital may not be the appropriate place for assessments, and in particular for patients with

diminishing cognitive abilities (i.e. patients with dementia or delirium). Instead these participants suggested that assessments should be carried out in patients' homes as they were more likely to provide a better picture of patients' needs. Finally, some participants suggested setting up a liaison housing officer for patients who were admitted to hospital with no fixed abode. Participants reported that these patients overstayed in hospitals as they did not have a discharge destination and at times, their discharge was further delayed because they did not have, and the hospital could not provide, any new clothes to wear upon discharge. As a result, a proportion of these patients experienced delayed and undignified discharges (i.e. they were discharged wearing gowns).

### 7.3 Lens 3 summary

Our findings indicate that a range of factors influence the work of healthcare professionals involved in (complex) discharge planning. Political and structural (macro), organizational (meso) and individual (micro) factors affect the discharge planning process. For instance, staff shortages influenced the level and quality of discharge related care that participants could deliver; similarly, communication problems among staff and limited knowledge of discharge planning procedures contributed to delayed discharges. Positive patient experience was often the exception rather than the rule in our participants' talk. Organising (complex) discharges does not occur in a vacuum; internal and external forces influence the type, level and quality of discharge planning that healthcare professionals are able to provide to their patients and families. Service delivery needs to listen to the stories of health and social care professionals, understand how they experience delivering discharge-related care to patients and configure services in a way that meet both patients' and healthcare professionals' values, goals, and preferences.

# 8.

## Conclusion and Recommendations

### 8.1 Summary findings

Our study has generated a multi-lens perspective on the lived experience of hospital discharge at Colchester General Hospital, allowing us to make links between the experiences of: patients (and relatives/carers) who were waiting in the discharge lounge on the day of discharge; patients whose experiences were captured from the time of their admission to hospital to their return home; and staff involved in facilitating the discharge of patients on a daily basis. One of the benefits of our three lens approach is that it has allowed us to see common problems identified by the various parties involved, at different points in time (day of discharge) and over the full duration of a patient's journey throughout their stay in hospital and following discharge. While most of the patients interviewed were not assessed as having complex discharge needs, the majority were quite elderly, living with a number of ongoing health conditions, and had come to be in hospital due to an emergency admission. Our analysis of the staff observation combined with our interview data illustrates challenges involved in more complex discharge cases. However, we found that many of the same underlying issues were common to both complex discharge cases and the more common discharge cases. We identified a number of challenges deriving from the patients' lived experiences of hospital discharge. We suggest these are caused by factors at the micro level (between individuals, such as small-scale interaction), at the meso level (action by and between groups, including on the ward level and intermediate protocols and processes) and at the macro level (wider social, political and economic factors affecting resources).

In this report we will concentrate our recommendations on issues pertaining to the meso and micro levels only. We will address all three levels in fuller detail in our forthcoming report *Insights into Hospital Discharge: A study of patient, carer and staff experience in Essex*, which combines our research on hospital discharge across all three hospitals (Colchester General, Broomfield, and Princess Alexandra).

## 8.2 Communication and information

The key issue, which emerged repeatedly across the entire data set, was the problem of poor communication. Communication problems in particular spanned across the entirety of the discharge planning process in the hospital, appearing to influence how much control and involvement patients had over their discharge planning activities. We revealed how poor communication and/or miscommunication occurred between hospital staff and departments, as well as between ward staff and patients and their families/carers. Patients were often not kept well informed about the sequencing of their care during their stay in hospital and were given insufficient opportunity to be involved in discharge planning and decisions relating to their discharge. As a result, patients' journeys were sometimes experienced as disjointed.

Staff trying to arrange discharge for those patients with ongoing care needs were frequently hampered in their work by having to use outmoded means of communication, such as fax machines. Further changes to assessment for NHS Continuing Healthcare funding criteria, especially for those patients who were told by doctors they were at the 'end of life' stage of care, resulted in confusion about who would be entitled to receive such care, which upset patients, their families and nursing staff alike.

Processes that had been established to facilitate knowledge sharing did not or only partially worked, and communication regarding discharge planning processes was frequently ruptured. Both issues had a direct and an indirect impact on patients and their families' experience of discharge. For instance, despite the fact that a proportion of participants described the ward board rounds as a good opportunity to exchange and share information our researcher noted variations between wards about how well focused their board rounds were on the issue of discharge planning. Whereas some wards used the board round as an opportunity to share knowledge and facilitate discharge planning, other wards did not appear as involved in the process. Instead these wards used the board round primarily as an opportunity to exchange information on patients' health needs, rather than using them to plan ahead for patients' care needs upon discharge.

Communication problems between hospital departments and staff presented further confusion and delays for patients on their day of discharge. In particular, miscommunication (or delayed communication) between the ward staff and hospital pharmacists contributed to patients experiencing delays and this resulted in them having to wait for several hours, frequently with limited updates, until they were able to receive their medications and be discharged.

### 8.3 Continuity of care

Poor communication coupled with a lack of involvement in discharge planning led patients to experience uncoordinated care, both during their hospital stay and once home (transitional care). These problems sometimes resulted in raised anxiety among patients (and their carers) before leaving hospital and further, in patients' being readmitted to hospital soon after discharge. Many participants reported that, though they were told that they were ready to be discharged, health care staff provided them with little information about the status/progression of their illness, the treatments for their illness, and the impact of both on their daily activities. These participants commented on the fact that as soon as they were deemed to be ready for discharge, the health care staff's main focus was carrying it out quickly, rather than spending time with them and explaining what would happen next. As a result, these participants reported that they left the hospital with a partial or limited understanding of the impact of their illness and medication on their daily activities once discharged. A few patients revealed how the fragmented interface between secondary and primary care services contributed to them experiencing their transitional care as uncoordinated.

Patients who reported being involved in planning their discharge and transitional care described their care as coordinated. In contrast, participants who reported that they were uninvolved in planning their discharge described these processes as uncoordinated.

### 8.4 Staff and resource issues

Communication problems were exasperated by other issues such as staff shortages, and additional resource issues relating to care packages. Staff were largely highly praised by patients but our data revealed that staff shortages resulted in staff feeling under pressure, at times, to discharge patients too quickly, while simultaneously experiencing a backlog of assessments meaning that patients were unnecessarily delayed. Tensions between the social and health care teams were reported. Participants working within the social care team reported that they were unfairly criticised for delayed discharges by the senior management team, family members and their health care colleagues. A combination of the small size of the team and their already high caseloads, which were further increased as they had to source care for deferred patients, resulted in delayed discharges. Many patients, despite their complex needs, ended up receiving care packages that did not meet their needs adequately and others preferred to be discharged with no or limited care provision in the community, rather than wait until their assessments were carried out and their care packages were sourced from either the health or social care authorities. Both outcomes had a negative impact on patients' experience of discharge and hospital staffs' experience of discharge planning.





## 8.5 Recommendations

### 8.5.1 Information and communication: patient, carer and hospital staff

- I. Upon admission to a hospital ward, patients and their relatives or carers should be provided with simple and easy-to-read information about the discharge planning process. This should include information relating to short hospital stays typically provided by acute hospitals and general advice about post-discharge support and care.
- II. In addition to the collection of medical information, healthcare professionals should be involved in the collection of information relevant to a patient's social situation (i.e. whether they live alone, proximity to relatives or networks of support). This should include information about a patient's relatives and carers.
- III. The development and establishment of a rigorous system (i.e. forms) that will facilitate professionals to systematically collect and continuously update the above information.
- IV. Upon discharge ensure that all patients' questions regarding diagnosis, medication, follow-up care and post-discharge care are answered and communicated in verbal and written forms (i.e. discharge letter).
- V. Healthcare professionals should replace outmoded means of communication (i.e. faxes) with more advanced means that could facilitate their work and improve their performance.

### 8.5.2 Provision of integrated care

- I. Having identified the medical and social care needs of the patients upon admission, care professionals should examine how these care needs may affect a patient's discharge. Hospital based health and social care services should work together to continue developing systems of care that put patients' needs and values at their core.
- II. Health and social care teams need to build a stronger interface to avoid silo work. Patients' health and social care needs are interrelated and therefore services need to develop in a way that reflects this.
- III. At some point patients will experience discontinuity of care (transition from generalist to hospitalist care and vice versa). It is important for primary and secondary care services to strengthen their interface to provide better continuity of care. This is particularly important for the elderly population, who experience frequent care transitions.

### **8.5.3 Education and training**

- I. Provide Continuous Professional Development (CPD) training for ward staff about hospital discharge processes and teach them how to engage with patients and their carers as partners in care.

### **8.5.4 Pharmacy and transport**

- I. Delays on day of discharge due to problems with transport service arrangements and pharmacy holdups need to be addressed. We shared this information with hospital managers at our stakeholder meetings and managers responded that they were aware of such delays and had taken measures to address them.

While the recommendations in this report are aimed specifically at hospital management and staff, and North East Essex CCG, we believe that there is also a role for HWE to engage with the public and our other statutory partners so that all can be better informed and prepared for the particular challenges identified in this report. As such, we will be offering to work with Colchester General Hospital staff and the CCG to assist with the design of written information for patients and carers. Finally, we will engage with local citizens to raise awareness of ways to be better prepared for hospital discharge more generally, through public and social media discussions about advance planning for elderly frail patients and those with long-term co-morbidities and longstanding chronic conditions.

# 9.

## Bibliography

Age UK (2015) *Later Life in the United Kingdom*, [http://www.ageuk.org.uk/Documents/EN-GB/Factsheets/Later\\_Life\\_UK\\_factsheet.pdf](http://www.ageuk.org.uk/Documents/EN-GB/Factsheets/Later_Life_UK_factsheet.pdf) (accessed 15 January 2016)

Baillie, L., Gallini, A., Corses, R., Elworthy, G., Scothcer, A. and Barrand, A. (2014) 'Care transitions for frail, older people from acute hospital wards within an integrated healthcare system in England: a qualitative case study', *International Journal of Integrated Care*, 14:1-11.

Brennan, N., Barnes, R., Calnan, M., Corrigan, O., Dieppe, P., and Entwistle, V. (2013) 'Trust in the health care provider-patient relationship: A systematic mapping review of the evidence base'. *International Journal of Quality in Health Care* 25: (6)

Centre for Longitudinal Research (2015) *1958 National Child Development Study*, *United Kingdom Data Service*, NCDS webpages, <https://discoverukdataservice.ac.uk/series/?sn=2000032> (accessed 6 June 2015)

Coleman, E. A and Boulton, C. E. (2003) 'Improving the quality of transitional care for persons with complex care needs', *Journal of the American Geriatrics Society*, 51:556-557.

Community Care Act (2003) [http://www.legislation.gov.uk/ukpga/2003/5/pdfs/ukpga\\_20030005\\_en.pdf](http://www.legislation.gov.uk/ukpga/2003/5/pdfs/ukpga_20030005_en.pdf) (Accessed on 19/04/2016)

Creswell, J. W. (2003) *Research Design: Qualitative, Quantitative, and Mixed Methods Approaches*, Second Edition, University of Nebraska, Lincoln

Daly, J., Kellehear, A. and Gliksman, M. (1998) *The Public Health Researcher: A Methodological Guide*, Oxford: Oxford University Press.

Department of Health, (2006) *Our health, our care, our say: a new direction for community services*, London: The Stationery Office.

- Department of Health, (2009) *Transforming community services: enabling new patterns of provision*, London: The Stationery Office
- Department of Health, (2012) *Decision support tool for NHS continuing healthcare (revised)*, London: Department of Health.
- Durose, C., Beebeejaun, Y., Rees, J., Richardson, J. and Richardson, L. (2011) *Towards Co-production in research with communities*, Durham University: Connected Communities
- Essex County Council, *Essex Joint Strategic Needs Assessment*, 2013
- Francis, R. (2013) *Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry*, London, UK: The Stationery Office
- Haggerty, J. L., Reid, R. J., Freeman, G. K., Starfield, B. H., Adair, C. E. and McKendry, R. (2003) 'Continuity of care: a multi-disciplinary review', *The British Medical Journal*, 327: 1219-1221.
- Health and Social Care Act (2012), c.7. <http://www.legislation.gov.uk/ukpga/2012/7/contents/enacted> (Accessed: 27 November 2015).
- Healthwatch England (2015) *Safely home: What happens when people leave hospital and care settings?* Healthwatch England Special Inquiry, [http://www.healthwatch.co.uk/sites/healthwatch.co.uk/files/170715\\_healthwatch\\_special\\_inquiry\\_2015\\_1.pdf](http://www.healthwatch.co.uk/sites/healthwatch.co.uk/files/170715_healthwatch_special_inquiry_2015_1.pdf) (accessed 15 January 2016)
- Healthwatch Essex (2015) 'You really do give up your own life, once you become a full-time carer': *Exploring the lived experience of carers in South Essex*, <http://www.healthwatchessex.org.uk/what-we-do/topics/carers/>
- Holland, D. E and Harris, R. M. (2007), *Discharge planning, transitional care, coordination of care, and continuity of care: clarifying concepts and terms from the hospital perspective*, *Home Health Care Services Quarterly*, 26(4): 3-19.
- Huby, G., Brook, J. H., Thompson, A. and Tierney, A. (2007) 'Capturing the concealed Interprofessional practice and older patients' participation in decision-making about discharge after acute hospitalization', *Journal of Interprofessional Care*, 21(1), 55-67.
- Huby, G., Stewart, J., Tierney, A. and Rogers, W. (2004) 'Planning older people's discharge from acute hospital care: linking risk management and patient participation in decision-making', *Health, risk & society*, 6(2), 115-132.
- Hughes-Hallett, T. and Probert, P. (2013) *'Who will care?': Five high-impact solutions to prevent a future crisis in health and social care in Essex*, Chelmsford, UK: Essex County Council.
- Husserl, E. 1970 [1901]. *Logical investigation*. New York: Humanities Press
- Lakey, L. (2009) *Counting the Cost Caring for People with Dementia on Hospital Wards*, London: Alzheimer's Society.
- Mellor, J. (2016) Hospitals still fail to send patients home safely, *Resolve: News from the Ombudsman Service*, May 2016. <http://phsoext.newsweaver.com/Newsletter/qvsc6s81t6dajixonhfxwu?a=1&p=970846&t=191122>
- Michie, S., Miles, J. and Weinman, J. (2003) 'Patient-centredness in chronic illness: what is it and does it matter?' *Patient Education and Counselling*, 51, 197-206.
- Milne, E., Corrigan, O. and Haines, S. (2016) 'Improving Hospital Discharge Experience by Empowering Patients and Caring for Carers', *Healthwatch Essex*, Forthcoming at [www.healthwatchessex.org.uk/what-we-do/our-reports/](http://www.healthwatchessex.org.uk/what-we-do/our-reports/)

- Morgan, D. L. (2007) *Paradigms lost and pragmatism regained. Methodological implications of combining qualitative and quantitative methods*, Journal of Mixed Methods Research, 1, 48-76
- NHS (2012) National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care. [https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/213137/National-Framework-for-NHS-CHC-NHS-FNC-Nov-2012.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213137/National-Framework-for-NHS-CHC-NHS-FNC-Nov-2012.pdf)
- Office of Fair Trading (2005) *Care Homes for Older People and the UK: A market study*, London: OFT
- ONS (2015) *National population projections for the UK, 2014-based*, Office for National Statistics
- NHS (2016) *Quality and Service Improvement Tools, Discharge Planning*, [http://www.institute.nhs.uk/quality\\_and\\_service\\_improvement\\_tools/quality\\_and\\_service\\_improvement\\_tools/discharge\\_planning.html](http://www.institute.nhs.uk/quality_and_service_improvement_tools/quality_and_service_improvement_tools/discharge_planning.html) (accessed 14 January 2016)
- NHS England (2016) *Delayed Transfers of Care Data 2015-16*, <http://www.england.nhs.uk/statistics/statistical-work-areas/delayed-transfers-of-care/delayed-transfers-of-care-data-2015-16/> (accessed 14 March 2016)
- Patton, M. Q. (1999) *Enhancing the quality and credibility of qualitative analysis*, HSR: Health Services Research, 34 (5) Part II, pp.1189-1208.
- Pope C. (2005) *Conducting ethnography in medical settings*, Medical Education, 39:1180-1187
- Rice, P. L. and Ezzy, D. (1999) *Qualitative Research Methods: a health focus*, Oxford: Oxford University Press.
- Roberts, K. (2002) *Exploring participation: older people on discharge from hospital*, Journal of Advanced Nursing, 40(4), 413-420.
- Robinson, P. and Tyndale-Biscoe, J. (2014) *What makes a top hospital? Dementia Care Report*, CHKS, [http://www.chks.co.uk/userfiles/files/CHKS\\_2014\\_WMATH\\_7\(1\).pdf](http://www.chks.co.uk/userfiles/files/CHKS_2014_WMATH_7(1).pdf) (accessed 14 March 2016)
- Royal Voluntary Service (2014) *Going Home Alone: Counting the cost to older people and the NHS*, <http://www.royalvoluntaryservice.org.uk/our-impact/reports-and-reviews/going-home-alone>
- Savage J. (2000) *Ethnography and health care*, BMJ, 321:1400-1402
- Shepperd, S., Parkes, J., McClaren, J. and Phillips, C. (2004) *Discharge planning from hospital to home*, *Cochrane Database System Review*, doi: 10.1002/14651858.CD000313.pub2
- The King's Fund, (2014) *A new settlement for health and social care*, London: The King's Fund
- Victor, C. R., Healy, J., Thomas, A., and Seargeant, J. (2000) *Older patients and delayed discharge from hospital*. Social Care in the Community. 8 (6) 443-452.
- Wittenberg, R., Sharpin, L., McCormick, B. and Hurst, J. (2014) *Understanding emergency hospital admissions of older people Report No. 6*, Centre for Health Service Economics and Organisation (CHSEO)



## Information Service

We can answer your questions about health and social care services

Call

**0300 500 1895**

Monday to Friday 9am to 5pm  
for the cost of a local call

## Why not get involved?

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