

Insights into Hospital Discharge

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



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We are, first and foremost, indebted to the patients and carers who shared their experiences of hospital discharge at Broomfield Hospital. Their stories offer rare and invaluable insight into where improvements can be made and we hope other patients and carers will benefit from them.

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Abbreviations

CCG Clinical Commissioning Group

CHC Continuing Healthcare

DST Decision Support Tool

EoL End of Life Care

HWE Healthwatch Essex

NHS National Health Service

NRES National Research Ethics Services

OT Occupational Therapist

PALS Patient Advice and Liaison Service

SW Social Worker

TTA 'To Take Away' (referring to medicinal tablets)

TTO '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 Broomfield Hospital in Essex. This is the first of a series of reports based on research carried out by Healthwatch Essex. Further reports for Colchester Hospital 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. 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 in the healthcare system and undoubtedly contributes to their overall physical health and emotional well-being, and to their assessment of how the NHS and social care function in meeting their needs.

* 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].

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). 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,¹ and rising hospital deficits have all contributed to the challenges in achieving a timely, safe and satisfactory discharge for patients.

¹ 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). 36% 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).² 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. 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 their lengths of hospital stay are, on average, a quarter longer than for those without dementia.³ 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'⁴ 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.

² 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.*).

³ 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).

⁴ 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 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: Broomfield (Mid Essex), Colchester (North East Essex) and Princess Alexandra (West Essex).⁵ 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 discharge preparations and patient experience of care.

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.

⁵ 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 Broomfield Hospital

Broomfield Hospital is an acute hospital in Mid Essex providing accident and emergency, medical care, surgery, critical care and other core services. During the months of June, July, August and September, a total of 1,838 delayed transfer of care days were reported at Broomfield Hospital (NHS England, 2016). The majority of these delays were due to one of the following reasons: 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 (ibid.). These figures only represent the experiences of a relatively small number of patients (ibid.) who were delayed an average of 31 days each (ibid.). As such, these figures are indicative of the duration of delays experienced by some patients and they illustrate the challenges and complexity for the hospital in finding satisfactory discharge outcomes for these patients, hinting at the distress of 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,⁶ 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. The study at Broomfield Hospital was facilitated by the Medical Director, Dr Ronan Fenton, who supported the hospital's involvement in the study from the outset and who was involved in early study planning meetings. He also 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 discharge staff leads.

3.8 Previous research and stakeholder views

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'⁷ 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.

⁶ '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)

⁷ 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/

3.9 Study aims

- To develop insight into the 'lived experience' of hospital discharge processes in Broomfield 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.

3.10 Ethics

Ethical approval for the study was granted by NHS National Research Ethics Services, NRES Committee East Midlands - Nottingham 1 on 27 March 2015. Following submission for NHS site approval from the Research & Development department at Broomfield Hospital, 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 participants' 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 to take part.

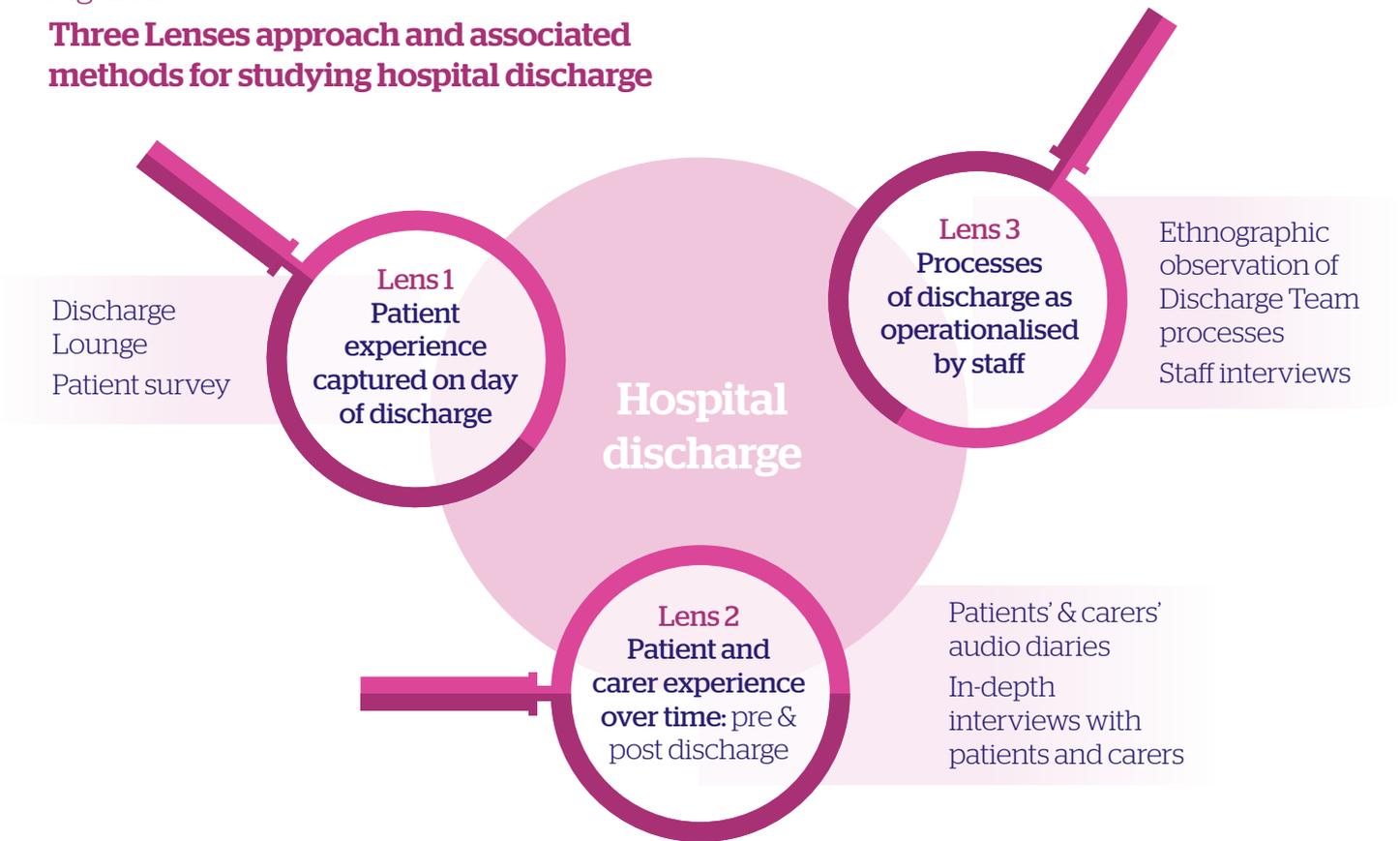
4. Methods

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 the 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 a member of the research team with expertise in statistical methods who had 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 (e.g. 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.

Twenty-seven people gave their consent to participate in the survey. Twenty-four were patients who answered the questions themselves, while a further three patients requested that a friend or family member do so on their behalf. All but one 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. Six patients and two carers participated in this aspect of the study. Of these, five patients provided diary information about the discharge process during their stay in hospital and while at home following discharge. Patients were recruited from Rayne (vascular, urology and surgical) and Danbury (gastro and oncology) wards. Although several attempts were made to recruit patients and carers from Baddow ward (care of the elderly), this proved unsuccessful as many of those approached were too frail, too ill or lacked the capacity to consent. See Table 1 (pg. 19) for a profile of participating patients. 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. As discharge planning occurred mainly during working hours (8.00-16.00), observation took place during these hours. 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 teams were located in different offices. The researcher spent 65 hours observing, visiting the hospital on eleven occasions, shadowing the health team seven times and the social care team four times. Both teams welcomed the presence of the researcher and worked collaboratively to facilitate the research process. 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 in 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, eight semi-structured interviews with members of the discharge team (five with healthcare staff and three with social care staff),

and a further four interviews with senior staff involved in discharging patients were carried out. The interviews were primarily reflexive and focused on how the team 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 What data did we collect?

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

Lens 1

- Survey interviews with 24 patients and three relatives/carers in the discharge lounge.

Lens 2

- Six interviews with patients and two relatives/carers (two recruited from wards)
- Five patient diary recordings (recruited from wards)

Lens 3

- 12 in-depth interviews with clinical staff involved in discharge (eight staff from discharge team and four ward staff)
- 65 hours of observation shadowing discharge team staff.

5. Lens 1

Patient survey in discharge lounge

5.1 Discharge lounge use

We found that the discharge lounge was not in frequent use and our research ambassadors⁸ administering the survey were informed that many wards chose not to send patients to wait there. This was subsequently confirmed during our stakeholder meetings in which hospital managers informed us that, given the well-known delays on the day of discharge, wards chose to keep patients on the wards with a level of care and comfort not available in the lounge.

The majority of patients who had been discharged and were waiting in the lounge, had undergone a relatively short hospital stay of one to three days, with just three patients staying for one to two weeks. All but four of the patients were over the age of 60, with more than half aged 70 years or older. Fifteen patients reported that they had a long-standing health condition or disability.

5.2 Delays

Just over half of respondents reported that their discharge was going well. However, many of those who were approached to take part did so soon after they arrived in the lounge and, given that they often had a considerable wait after completing the survey before finally leaving the hospital, this response would inevitably have been different if they had been interviewed later (see Figure 2).

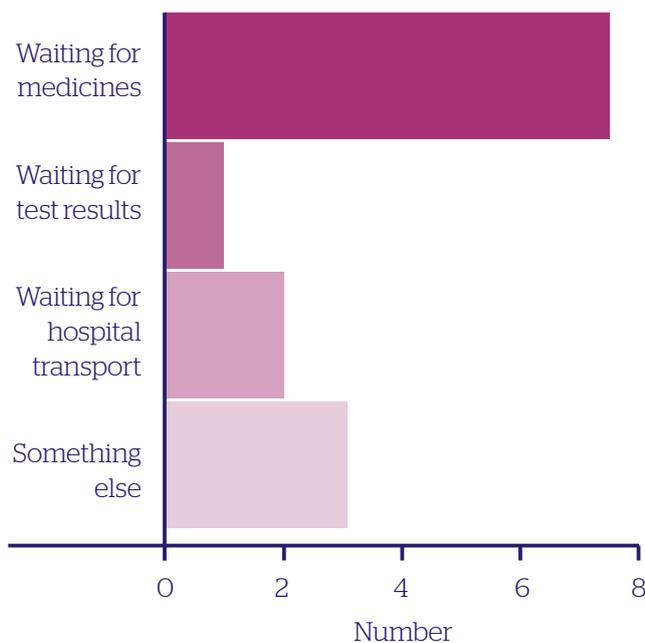
⁸ These were HWE volunteers who had participated in our ambassador training programme and undergone specific research training for the study.

Figure 2:
Discharge description



Most people who described their discharge as 'not going well' had experienced delays. Patients were frequently told they were ready to be discharged but then had to wait for medication, transport or a discharge letter (see Figure 3).

Figure 3:
Reasons for delay



Waiting for medication was the main reason given for delays. For example, a patient who had been in hospital between one and two weeks was told at 10:00 that she had all the medication she needed, but when her relative arrived soon afterwards she was told they were still waiting for one type of medication. When surveyed at 12:35 the medication had still not arrived. Furthermore, a patient who reviewed their care and the discharge lounge as positive on the whole, had been waiting 3.5 hours for medication when surveyed:

Tablets requested at 10am. Still waiting at 13:30 in discharge lounge. Totally letting the hospital down.

The wife of a 77-year-old patient arrived to visit and was told the patient was ready to go home at 12:00, but, when surveyed over two hours later, they were still waiting for medication.

5.3 Involvement in decision to discharge

While 63% of respondents felt that they had been involved in their discharge, a number of patients felt that they had not been and they depicted a very negative experience. One 69-year-old patient said she didn't feel ready to be discharged:

I know I'm 'bed-blocking' but really I'd like another day.

When asked if they could give examples of what was good or bad in the planning process one respondent said:

It was nothing to do with me - they were arranging my discharge.

Just over one third of respondents reported that a family member or a close friend had been given the information needed to help care for them after discharge. Given that our survey also revealed that the majority of patients were being

discharged with no further formal support and that they would look to a family member or friend in the first instance, this had negative implications for their continued care and support once home. forty-six per cent of those interviewed reported that they did not feel confident that they would be able to look after themselves when discharged from hospital. One eighty-five-year-old patient told us that staff did not provide information to her family about her care, they did not discuss with her the need for any additional equipment in the home, although she would have liked them to, nor did they discuss with her whether she might need any further health or social care support after leaving hospital, but she would have liked them to. Furthermore, she did not think she had received a copy of her discharge plan and she felt that not all of her health conditions had been properly considered in the discharge planning:

[They] just come and say you're going home, and then change their minds over tablets, so I had to stay an extra night, which upset me.

5.4 Information and communication

Almost half of our respondents reported that they did not think they had been given a discharge plan (see Figure 4).

It is possible that many of these patients had received a discharge plan but that they were unaware they had and/or healthcare staff had not explained the information to them.

A seventy-two-year-old patient who ticked 'no' when asked if their family or friend had been given information, also said:

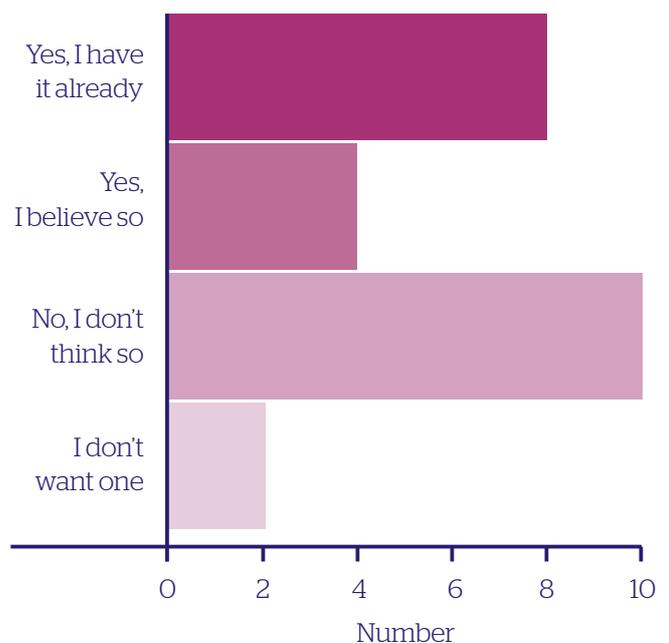
The consultant surgeon was away (out of the country) when I was discharged but there was no advice about what I could/should do regarding activities etc.

A patient who was waiting to be discharged to a care home told us 'I felt that when I asked staff a question they just walked away'. Subsequently when asked how well doctors, nurses and other care staff listened to her, she said 'badly' and that she didn't feel ready to be discharged.

The wife of a 77-year-old patient also said they had not been involved in decisions about leaving hospital, nor had their family or home situation been taken into account. Another patient said that few arrangements had been made for her in preparation for discharge 'apart from putting me in a chair and wheeling me here (the discharge lounge)'.

Figure 4:
Availability of discharge plan

Are you being given a copy of your discharge plan?



5.5 Transitional care

Just over half of those who participated in the survey said they were confident they could look after themselves when they left hospital, with help, and felt ready to go home. However, among this group one patient said she was worried about her health condition and felt that she was at risk of an accident. Another said she felt staff could have done more to set her mind at rest and provide some reassurance. A ninety-six-year-old patient expressed concern that the ward did not compare his medications taken previously with the medication he was given on discharge. There might have been a good reason for his altered prescription, but this had not been communicated to him and he felt worried. A very elderly patient ticked 'very badly' in answer to 'How well do you think doctors, nurses and other care staff listened to you during the discharge process?' He said he felt that staff should have set his mind at rest and reassured him. This patient was also concerned that the ward didn't compare medications taken previously with the medication given on discharge.

5.6 Lens 1 summary of survey findings

The majority of patients who participated in our survey interviews were elderly and could be classified as having undergone a relatively simple discharge process from hospital insofar as most 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, many rated their overall experience of discharge as good or excellent, however common negative experiences were identified.

Our survey revealed that some patients had less satisfactory experiences. The main problems we identified are as follows:

- **Delays on day of discharge.** These were mostly due to medication taking a long time to be made available and delays with hospital transport.
- **A lack of information.** In particular the provision of a discharge plan and a lack of information to help friends and relatives provide support for patients following discharge.
- **A lack of patient and relative/carer involvement in discharge planning.** There was a perception by some that discharge was planned entirely without their input.
- **Concerns about transitional care.** Some patients expressed anxiety about their ongoing treatment and care and expressed their disappointment at not leaving hospital feeling reassured about their condition and follow-up care before being discharged.

While our interviews with patients and their relatives 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 and, as we shall see, many of the same issues recurred.

6. Lens 2

Patients recruited from wards

Six patients and two carers participated in this aspect of the study. Of these, five patients also provided diary information about the discharge process during their stay in hospital and while at home following discharge. Patients were recruited from Rayne (vascular, urology and surgical) and Danbury (gastro and oncology) wards. See Table 1 for a profile of participating patients - pseudonyms have been used to protect patient and carer identities.

Our interview data, gathered from patients (and in some cases relatives/carers) once they were discharged from hospital, and data derived from diary entries made during and after their hospital stay, provided us with an in-depth perspective on patient and carer experiences over time. Some patients described their hospital discharge as a positive process, largely stress-free and straightforward, reporting that the healthcare staff kept them informed and updated them regularly about the progression of their illness and treatment and provided them with information about their discharge follow-up care.

They took very good care of me while I was in hospital; everyone was more than polite to me. I always got everything when I needed it. ... Yes, I just can't be complimentary enough of how the staff were to me.

However, many participants had a more negative experience of their hospital discharge, describing it as stressful and badly co-ordinated.

Table 1:

Patient profiles for Danbury and Rayne wards

Patient	Age	Home town and living situation	Condition	Ward recruited	Length of stay
Angie (female)	80s	Lives alone, sheltered housing 26 miles south east of hospital	Blockage in lower digestion, pain, unable to eat	Rayne	5 days
Bob (male)	40s	Lives alone, 10 miles from hospital	Suspected DVT, ongoing health condition causing falls	Rayne	6 days
Samantha (female)	90s	Lives alone, in town 15 miles from hospital	Liver cyst	Danbury	17 days
Tom (male)	60s	Lives with wife, 10 miles from hospital	Gallstones	Rayne	7 days
Richard (male)	20s	Lives with family, local village	Emergent surgery on an old injury	Rayne	1 day
Ian (male)	Late 60s	Lives alone, Chelmsford	Bone marrow aplasia/ aplastic Anaemia	Danbury	5 days

6.1 Information and communication

An important issue we identified was the extent to which patients and relatives received clear information and communication with regard to their discharge. Some participants reported that, despite being told that they would be discharged soon, it was several hours before they received their discharge summaries and managed to leave the hospital. Participants acknowledged the fact that the ward staff had been busy and over-stretched, however, they also talked about how they did not know how long they would have to wait before being discharged and that it was difficult to get updates from the ward staff.

When I was ready to be discharged I was told I'd be discharged and I'd be fine to go fairly soon and then it took about three hours to actually discharge me ... I had to come out once because I was sort of like, 'What the hell's going on here?' but when I came out and I spoke to the head nurse, he just said, 'Well, you should have been discharged ages ago.' He said, 'I had no idea',

because the lady said that I needed to be given a discharge pack and then he was like, 'Oh, for God's sake' and then he did it and 20 minutes later I was out the door, but I understand completely. (Richard)

The above quote also illustrates how difficult it could be to identify the correct staff member responsible for their discharge and that different things were often told to patients by different members of staff. When we asked participants questions about the information and communication they received it was clear that they were often passive rather than active in requesting specific information. However, in cases where they were more active and did ask for specific information, then this was often forthcoming. For example, one patient who was concerned to ensure that the follow-up tests he was told he needed would be carried out, requested information about the appointment before agreeing to be discharged.

I thought that if I was not there, under their supervision, they'd forget about me, and I'd go out, and then each time somebody was admitted to the ward, they'd put them before me. But the doctor reassured me, and he said, 'No, I'm going to make you an appointment there, and I'll push for it to be done.' And he did actually, and he got it moved forward. And he said, 'This is your appointment', and it was there. And we rang up, and I was so pleased, because ... we knew we were in. (Tom)

One patient felt that part of the difficulty she experienced in getting the information she needed was not that individuals did not reply to such requests, but that the system was chaotic and staff did not have all the information to hand. As Angie observed:

I could ask a question, and I would have thought that they could use the computer and the answer would be there, but ... they did their best, they chased around. They found a doctor and he did his best.

In another case, a patient told us that he had no problems whatsoever with communication or with the information he received:

I told them constantly how I felt, because obviously if you don't give them feedback, then they're not going to know how you feel. So I think it's more of a two-way thing than people realise, you have to give them feedback for them to help you. It's like being a Formula One driver, I suppose, you have to give your team feedback or they can't help you. So it was that kind of thing really where they asked me, 'How are you feeling? What do you want to do?' I was like, 'I'm sure I'm safe to be discharged in the next few hours' and they keep an eye on me, make sure I'm all right. (Richard)

As Richard is in his 20s, he was much younger than the majority of our patients and was clearly working with a more active model of communication where patients are 'partners in care'. However, it appears to have been much more difficult for relatives of patients who were more proactive to gain access to information regarding discharge. Fiona, Samantha's daughter, told us that on the first occasion her mother had been discharged from hospital she had been given no information in advance about her mother's discharge.

I got there and Mum was ready to come home. I said, 'Well, could I speak to someone?' It was a doctor I hadn't seen before. She had to look at the notes, and she just said, 'Oh, well, it's not life-threatening.' (Fiona, Samantha's daughter)

We also found that poor communication and a lack of information often had a negative impact on patients' experience of continuity of care.

6.2 Involvement in discharge planning

A large proportion of participants linked their lack of, or limited, involvement in discharge planning with unexpected or delayed discharges. Some of these participants talked about the limited information they had received regarding their discharge date and others talked about their long wait to be discharged. Again, following her mother's 'inappropriate' discharge and subsequent readmission, Fiona reported that they had not received any information about her mother's discharge and hence they had not made the necessary preparations for her to return home.

When I turned up on the Wednesday Mum was sitting there ready to come home, in her nightie. They hadn't telephoned me like they said they would, so I wasn't prepared to take Mum home. (Fiona, Samantha's daughter)

Fiona told us that, despite requesting that staff forewarn her about when her mother would be discharged so that she could arrange post-discharge care support, this did not happen.

It was noted that, for some, insufficient involvement in discharge planning had a negative effect on their discharge experience, as it contributed to their feeling a loss of control over the process and thus created obstacles for planning ahead and organising their lives after leaving hospital. Limited through-care planning after discharge was another factor that was closely related with insufficient participant involvement in discharge planning activities. The majority of participants were not eligible or, as we see in 5.3, were not assessed for care needs after discharge (i.e. social care package or reablement⁹). Limited through-care planning after discharge seemed to contribute to participants' lack of control of their discharge and care after discharge; this was particularly problematic for those patients who reported that they had limited support from friends or family members.

When I turned up on the Wednesday Mum was sitting there ready to come home, in her nightie. They hadn't telephoned me like they said they would, so I wasn't prepared to take Mum home.

6.3 Early discharge and transitional care

A number of patients we spoke to expressed concern and some anxiety about leaving hospital without having felt that they understood the underlying causes of their condition or, indeed, whether their illness had been treated.

Well, I don't know. I was a little bit shocked [to be discharged], really, because the way I was feeling, I felt I should have had another day there for them to just check me. Check the water, the urine, to see if the kidney infection had cleared and to check that the bowel had cleared. So that's all I felt, but he [the doctor] said, 'We want the bed, so you've got to go home.' (Angie)

Samantha's daughter reported that she was concerned about her mother's forthcoming discharge and her ongoing care needs. She felt she had been given insufficient information about her mother's condition and the care her mother might need following discharge.

I felt I should have had another day there for them to just check me...but he [the doctor] said 'We want the bed, so you've got to go home'.

It was the Wednesday when I visited. She still had this huge painful cyst, couldn't eat and drink, so I asked to see a doctor, and they said, 'Oh, well, make an appointment for six or eight weeks' time, and she can come back in and have it drained.' I just said, 'She's in pain.' 'Oh, yes, paracetamol will be alright.' And went home thinking that paracetamol will be alright. (Fiona, Samantha's daughter)

In the event, Fiona told us that Samantha was readmitted soon after discharge and her GP was involved in her readmission. Fiona said that the GP thought Samantha's discharge was 'outrageous' and that it was inappropriate for her to have been discharged so soon.

⁹ 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.

Some participants reported that, when planning for discharge, they felt that healthcare staff did not take into account the difficulties they may experience once home, and they did not appear to approach with sympathy how participants viewed their illness and its impact on their daily lives. For example, as we have illustrated, some participants felt they were discharged without having had their health problem(s) treated and resolved. A proportion of these participants talked about their anxiety and frustration in having to continue worrying about their illness once discharged from hospital while in pain and discomfort. This concern stemmed from their being discharged without feeling that they had been properly informed about the causes, consequences and possible treatment options. They also felt uncertain about follow-up hospital appointments where these issues could be addressed.

Other participants commented that through-care after discharge was inadequately planned as ward staff paid limited attention to their post-discharge needs. These participants reported that, due to the complexity of their needs and/or the consequences of their illness(es) on their health, they could not easily resume their daily activities once they were discharged. This placed additional strain, in particular, on the carers of the patients, as they reported that they found it difficult to organise their relative's care and simultaneously carry on with their lives. As Fiona told us:

I just said, 'You're sending Mum home and we've got nothing in place, and we thought Meals on Wheels', and this guy just gave me the Ronnie Corbett leaflet,¹⁰ and wrote some sort of Essex carers phone number on. As I say, I got back here at five to five, just in time to ring my job and say

I can't come in tomorrow, and I spent five hours trying to get Meals on Wheels. (Fiona, Samantha's daughter)

Inadequate through-care planning after discharge was particularly problematic for those participants who were frail and who had limited support from either friends or relatives in the community. Angie said she returned home with no written information or advice to read and that she had not been given a contact number in case of a problem. She felt that someone from the hospital should have followed-up on her with a phone call. Angie was experiencing ongoing problems with her condition after discharge. She lives alone, though is close to her son, but he has other responsibilities and can only provide limited support. Overall, she felt her discharge had been hurried and somewhat incomplete.

Noticeably though, participants did not critique the ward staff for their negative discharge experience but praised them and admired their persistence in delivering care while experiencing work-related pressure, such as caring for very sick patients with complex needs and seemingly being very short staffed. Instead, participants criticised the healthcare system and its current configuration, which did not appear to accord any control or flexibility to issues that arose and that contributed to a participant's negative discharge experience.

Yes, it's the system. It's the system that you're up against. It's the system that doesn't take into account that you need that done ... As I said, staff, you can't fault the staff, you can't. And the nurses, they're wonderful. But it's just the system. (Tom)

¹⁰ The provision of 'meal on wheels' by local authorities has largely been contracted to private companies and the 'Ronnie Corbett' leaflet refers to a farm food supplier that supplies readymade meals promoted by the actor Ronnie Corbett.

6.4 Lens 2 summary of patient diaries and interviews

Accurate information and good communication are important for all aspects of patient care but, while this was reported by some of our participants, it was a far from consistent finding. While individual staff members were often praised for their care and helpfulness, patients felt that the system let them down. Staff were often very busy and it was not always possible

to locate someone to speak to with regard to discharge, or to know who best to approach. Poor communication was also a problem expressed by relatives and carers of patients. Furthermore, many of the issues raised by our more in-depth interview and diary data chime with the survey interviews carried out in the discharge lounge.

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

- **Nursing staff.** While nursing staff, and hospital care staff more generally, were frequently highly praised, participants felt that wards were understaffed and that care and communication suffered as a result.
- **Lack of information and poor communication.** Participants reported that they were sometimes given conflicting information about the timing of their discharge and that requests for information were not always forthcoming. There was some confusion and uncertainty expressed about who was responsible for communicating information with regards to their discharge and who to believe when conflicting information was given.
- **Early discharge.** A small number of patients and their relatives/carers felt that the discharge had been premature and in one instance a patient had to be readmitted soon after. Some patients felt under pressure to leave and there were reported cases of patients being told by staff that they were bed blocking.
- **Lack of patient and relative/carer involvement in discharge planning.** While most patients were content overall with their discharge experience, patients generally felt that they had little control over the discharge process. While most patients did not actively seek this, a few who did were more satisfied with their discharge. It was more difficult for patients' relatives to be involved in the discharge planning and this had a negative impact on patient care following discharge.
- **Problems relating to continuity of care.** Many of these problems experienced by our participants related to a lack of information and poor communication. Some people reported that a lack of information about their ongoing treatment and follow-up care meant that they remained anxious following discharge and that a lack of involvement in discharge planning by family members meant that preparation for post-discharge care and comfort was more difficult to achieve.

In the following section we explore the experience of discharge and the processes surrounding it from the perspective of senior ward and discharge teams staff.

7.

Lens 3

Staff

In this part of our report we present the findings of our analysis of interview data with ward staff and of our ethnographic data based on interviews and observation of staff in the discharge team. A total of 12 in-depth interviews were carried out with senior staff involved in the discharge process. In 7.1 we present our analysis of the ward staff interviews and in 7.2, we present our analysis of our ethnographic observation and interviews with the discharge team. Pseudonyms have been used to protect participants' identities.

7.1 Ward staff

Interviews were conducted with four senior ward staff, two from Baddow ward and two from Danbury ward. All interviews lasted between 30 minutes and one hour. They were conducted on the ward in a private room, such as the relatives' room, the staff room or the ward manager's office. Staff were keen to share with us what they perceived to be the important issues that facilitated or inhibited effective and timely discharge for patients.

7.1.1 Shortage of key staff

It was clear from our interviews with ward staff that they thought that the safe and timely discharge of patients was often hindered by a number of problems outside their control. Pharmacy dispensing processes were often cited as a problem that caused delays on the day of discharge. Staff felt exasperated by staff shortages at weekends and doctors not returning to sign off the relevant (TTO or TTA)¹¹ prescriptions on the day of discharge until hours after patients had been told they could go home. In addition, staff reported that there were competing priorities for ward staff, who often needed to chase the progress on pharmacy. Although the wards have 'allocated ward

¹¹ TTO and TTA are abbreviations used to refer to take out medicines given to patients on discharge from hospital.

pharmacists' they are split between a couple of wards, so sometimes this means that it was up to the nursing staff to keep checking that the TTAs were in progress. As one nurse informed us:

You'll know the person is able to be discharged at about nine thirty, ten in the morning, but you won't get the medication until three, four, five in the evening. Sometimes even six. (Dana).

Our participants informed us that there were only limited opportunities to discharge patients in the evening or at weekends, this was due to lack of staff such as pharmacists, and others who are required to support discharge. For example, as Kate stated:

If somebody is admitted on Friday with a fall, and maybe EAU will say, 'We'll keep you in over the weekend, we'll get physio and OT, and we'll get you home Sunday.' When they come up to the ward we don't have physio and OT. They may have it down there, but we don't have any. So, we have to then be the bearers of bad news and say, 'I'm really sorry, but we don't have ... We won't be able to get you home today,' and that upsets somebody. (Kate)

You'll know the person is able to be discharged at about 9:30am, 10:00am in the morning, but you won't get the medication until three, four, five in the evening. Sometimes even six.



7.1.2 Lack of resources for fast track

Broomfield, in common with other hospitals, aims to establish a 'Fast Track Continuing Care Assessment' to get appropriate care in place as soon as possible. As part of this process, they aim to put appropriate end-of-life support

in place quickly, as there is a need to provide appropriate care for the patient in their preferred location for dying. However, this process is often slow and sometimes does not happen on time; consequently people die in hospital against their and their family's wishes:

There is a small team here, and fast track referrals sometimes are done very quickly, but if there happens to be four or five people on the list, obviously they take quite a while, and if there is only one lady assessing them, it can take a little while. (Emily)

Ward staff we spoke to identified reasons for this slowness. Many issues were related to a lack of resources (staff and facilities) needed to provide continuing healthcare in the community. One nurse typified the views of other nurses on fast track issues:

By the time they come to do the assessment, [the patients] are too unwell to be discharged from the hospital. That's awful. It takes far too long. Can take over a week. Sometimes it takes one, two, three weeks ... if they are short-staffed, obviously the end-of-life referrals take priority but you still don't get any extra staff ... And that is not something a [junior] nurse on the ward would be able to co-ordinate, because you have to liaise with the district nursing team. You have to find a care agency that can go in 24-hours, if it's at home, or liaise with a residential home ... and if the person wants to go to a hospice, that's difficult because there are only ten beds available for Mid Essex area. So ten beds and we've got a huge hospital like this ... You have patients who would like to go to the hospice but they can't ... So it's really tricky. So very sad. (Emily)

Ward nursing staff and, as we shall see later, discharge staff frequently expressed upset and some frustration when they were unable to provide those places of care that patients wanted or needed.

7.1.3 Co-ordinating care

Continuing healthcare and patient transport services remain the most highly reported issues in both formal patient complaints and issues reported to PALS.^{12,13} The nursing staff also reported the significance of hospital transport and how it impacts on effective discharge and on other service providers. Ward staff reported that hospital transport often arrived late, and if care staff are waiting at the patient's home to start or reinstate a home care package (often to put the patient to bed) then this can result in the care staff having to leave so the patient is unable to be discharged that day. As one nurse reflected:

You have it where you have to try and co-ordinate the discharge of the patient with hospital transport to meet the [paid] carers at the home address and that's always a real challenge. Because the care agency can't always be there for a long period of time, because they've got other people that they have to care for as well. And the transportation, at the moment, if you book for a certain time they are allowed two hours ... so that's difficult. (Emily)

However, several staff mentioned that the hospital transport is efficient for patients in need of fast track support (i.e. they are dying), as they are prioritised over other patients.

The co-ordination of patient care was also negatively affected by resource-related problems.

For example, the ward staff reported that older patients and people with complex needs often spend longer on the wards due to lack of, or limited, appropriate home support or nursing care home placements. The nurses we interviewed told us that older patients are often left waiting on the ward for days - and sometimes weeks - despite being deemed medically fit to be discharged as many elderly, frail patients are unable to return home without additional support, or they need to be transferred into a care or nursing home.

I think there is a lot of social needs on this ward, and trying to co-ordinate the person being medically fit, with their care or residential home placement, or whatever it may be, they don't always co-ordinate. (Emily)

7.1.4 Information, communication and processes

All the staff who were interviewed commented on the fact that the communication systems are complex and repetitious and that the processes take up a lot of their time. Staff said that they often had to repeat the same information on paper forms, computer records, fax, telephone and face-to-face interaction. Several staff said that they spent a lot of time chasing up communications, especially faxes, as they often appeared not to arrive. In addition, when patients originate 'out of area' different forms need to be filled out and this can be both repetitious and time-consuming, taking nurses away from patient care.

While paperwork processes were often seen as being overly time-consuming and inhibiting time spent with patients, there were occasions when a lack of administrative processes presented a challenge to the discharge of patients. For

¹² 111 Mid Essex Clinical Commissioning Group Public Board Meeting 13/7/2015.

¹³ The Patient Advice and Liaison Service (PALS) offers confidential advice, support and information on health-related matters.

example, one nurse described problems due to the fact that there was no appropriate discharge pathway for a patient with transient delirium or confusion. Several of the wards are dedicated to the care of older people and often beds are occupied by patients with diminished mental capacity, who have unique issues. Because they are in hospital, most patients with delirium or dementia have very high levels of observation and therefore, when considering discharge, it is often assumed that the person will need one-to-one care. However, the ward staff suggested that, in their experience, this would not be required in a home environment because of its familiarity to the patient. While there was a perception among staff that most people would be better off being assessed in their own home there was also a realisation that people with perceived temporary diminished mental capacity would be unsafe to go home and, on occasion, needed to remain in hospital.

We had a lady on this ward who had delirium, as a result of medication she was taking. It was identified that it was a resolving delirium. It was expected that within three, four weeks, she would return to full capacity. But there was significant danger to her and others if she returned home in the resolving delirium time. ... Actually the only solution was the lady remained in an acute bed for four weeks while her delirium resolved. The delirium did resolve, she regained capacity, she returned home to independent living. That to me is not the ideal use of acute hospital beds. (Emily)

This particular nurse thought there should be a delirium pathway developed where patients could go for a period of up to six weeks to recover from their delirium before decisions are made about their long-term care. Another complication was the uncertainty in determining if a patient's delirium was likely to be permanent or temporary. The ward staff also reported similar difficulties for patients with dementia. For example, several patients who were living in care homes and were diagnosed with dementia overstayed in the hospital because the care homes would not accept them back. In these cases patients experienced problematic hospital discharges. While the reablement pathway seemed to be a positive approach to returning people home, the criteria did not apply to patients who experienced delirium or those with dementia.

7.1.5 Challenges with families

Many of the ward staff we interviewed felt that family members could and should do more to support patients in their own home to facilitate discharge. For example, staff reported that for many patients with dementia who exhibited challenging behaviours, there are a lack of nursing homes/care placements and they felt that family members were often risk averse and frequently pressed for patients to go into care, rather than go home with support.

A few nurses commented that when discharge planning for people with dementia, it was often the views of the family, rather than of the patient, that were heard.



I think that crème de la crème discharge for me would include the patient's views. Particularly if they lack capacity, that their current views and past wishes are still adhered to and still seen as paramount. I think that would be very, very important to me. (Emily)

Ward staff told us that when a patient was told they were medically fit to be discharged, the nursing staff would normally contact the family, or significant others, to inform them. However, several nursing staff reflected that it is often only at this point of discharge that family members raise concerns. Ward staff informed us that they often experience resistance from the family when the topic of discharge is raised and that hospital discharge, especially for the frail elderly, can often act as a catalyst for previously unresolved family care issues. Some nurses told us that care homes refuse to take patients back, and when families also refuse, the staff are left to sort it out.

Family members sometimes tell staff: that they are no longer able to continue caring; or that they live too far away from their relative to be able to offer support; or that their families may be unable or unwilling to offer support to their relatives. Staff reported that often family members were willing to offer support for the patient once home, but not immediately due to other commitments (such as working full time, or living abroad). Staff felt that these were all issues that caused delays in the discharge process. Practical issues, such as locating house keys so that the patient can be returned home, can involve communication with the family and lead to delays. Indeed, several staff mentioned that often patients arrive in hospital following an emergency and do not have their door keys. In such cases even if a patient is well enough to return home, there may be a delay while waiting for a relative to return from work or travel a long distance. Again staff indicated that a lack of time and other resources exasperated these delays.

Sometimes, I feel that it's not right. I am treating patients like beds, I just go there, 'Do you have transport? Do you have TTAs? Okay, let's go and do this.' There's so much pressure.



Sometimes, I feel that it's not right. I am treating patients like beds, I just go there, 'Do you have transport? Do you have TTAs? Okay, let's go and do this.' There's so much pressure. I explained that on the ward meeting and even to the office ... They really understand. They said, 'We can try to do something, but there's so much pressure on this hospital. There are so many patients coming that sometimes it's just hard (Kate).

While ward staff reported the challenges they faced while trying to plan and execute patient discharge, in the following section we explore the challenges faced by discharge team staff when dealing with patients with complex discharge needs.

7.2 Discharge team staff

The work of the discharge team is complex and involves working 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 fulfill certain criteria for continuing health or social care provision.

7.2.1 Resource challenges

Participants talked about resources that were offered either within the hospital (i.e. discharge team, ward staff, equipment and transfer team) or out of the hospital (i.e. CCGs, residential and nursing homes).

The majority of the discharge team staff interviewed reported that both the discharge team and the wards were severely under-resourced, and this was an issue that challenged their ability to make timely discharges. Within the discharge team, and in particular in the healthcare team, participants reported that the very low numbers of staff meant they had a large number of cases to manage and this slowed down the rate at which they could process referrals for checklists and DST¹⁴ assessments. In order to deal with the increasing workload participants reported that they had to delegate responsibilities to keep up a minimum level of progress in each case. Sophie, a member of the healthcare team, talked about how the low number of staff had an impact on her workload and the overall progress of the team in discharging patients, ***“I think obviously our main challenge at the moment is that there’s not enough of us in our team. That’s the main challenge.” (Healthcare team, Sophie)***

Indeed, during the shadowing of the discharge team, it was noted that over a period of several days there was only one member of staff in the healthcare team in charge of complex discharges. The staff we spoke to were critical of management for not acting proactively to ensure that enough staff would be in place to work on discharge cases, despite their knowing

that there would be extreme staff shortages. Participants said they felt this placed further strain on the already over-stretched discharge team. This had a negative impact on the smooth running of checklists for continuing healthcare or end-of-life care, insofar as many patients were asked to be transferred to intermediate care facilities and have their assessments completed there. However, many patients and families rejected this option because they did not want to be transferred between care settings and/or they believed that, if they were transferred, they would remain in those care settings.

Many participants also described staff shortages on the ward as another resource issue that impacted negatively and challenged the discharge process. Training for staff about how to process patients for discharge was described as particularly problematic, as ward nurses could spare little, if any, time to carry out non-clinical work. Maria, a healthcare staff member, talked about this challenge during her interview:

But I think again that comes down to they are so short-staffed at ward level that they don’t have the luxury to be able to pull them out for some communications training around discharge planning. Which is something they desperately need. (Healthcare team, Maria)

Both the discharge team and the ward staff felt that staff shortages were the norm, which often caused problems in providing timely and well-organised discharge to patients. Coupled with the poor communication among hospital staff, these were the two major factors in creating problematic discharges.

¹⁴ Decision Support Tool: The DST asks multidisciplinary teams (MDTs) to set out the individual’s needs in relation to 12 care domains. Each domain is broken down into a number of levels, each of which is carefully described. For each domain MDTs are asked to identify which level description most closely matches the individual’s needs. (DH, 2012)

Other resource-related issues that appeared to adversely influence discharge planning were problems with transporting patients and the delivery of equipment to patients' homes. Despite the fact that they received notifications within agreed timelines, the transportation company frequently declined to transfer patients on the grounds that their transport would take too long. Discharge staff reported that it could take days until equipment was delivered to a patient's home (particularly during weekends). Staff felt these 'resource' problems further delayed and hindered the timely discharge of patients.

Resource problems linked to funding from the CCG posed another set of challenges that were inextricably related to financial issues. The problems identified earlier regarding patients with unresolved delirium were compounded by funding structures. Hannah, a social worker, talked about how funding restrictions prevented them from developing a new delirium pathway. A new pathway for other conditions had been successfully developed in the past and she contrasted that experience with the present:

We got it [non-weight bearing pathway] up and running, and it used to be over at [name of nursing home]... we revamped the pathway. We got a spec for it and it was signed off by the CCG. It's funded by Health and Social Care. That's what we need to do with the Delirium Pathway, and I've been trying to do that for years, but haven't been able to get any interest whatsoever in anybody doing it, because nobody has got any money.

(Social care team, Hannah)

Shrinking budgets also influenced the number of people who met the eligibility criteria for continuing healthcare (i.e. end-of-life care or full NHS-funded care in the community. Some participants commented that CCGs had become much stricter in the application of criteria, which led to many patients being diverted to social care services. Despite the seriousness of their conditions, these patients and their families had to undergo another set of lengthy assessments, including those based on income.

Discharge team staff reported challenges regarding their interactions with - privately run - social care providers. The limited number of care homes in the area, the lack of diversity in the types of patients they accepted and their level of needs, and the poor communication between care agencies and hospital staff, were some examples that participants used to illustrate the challenges they faced in collaborating with social care providers.

Split budgets between health and social care made sourcing care packages particularly difficult:

I know the Care Act talks about combining the resources to create a more effective discharge. I know that's a utopia and we should aim to it, but I also know it's very difficult ... when I asked, 'Could we not offer support of this from [the] health [budget]?' you just get, 'No, it's social care's,' or, 'No, it is health's,' and that's it. It's very, very, very difficult to get people discharged from hospital, they stay in. I've had one patient stay in hospital for probably two months longer than they should have, because you can't find a placement for them, because they are declined, there is no extra support from social care or health. They are stuck on the battle lines and that's it.
(Healthcare team, Jack)

Patients getting stuck in the system of continuous assessment and not fitting eligibility criteria for pathways on offer was a common observational finding. Despite the fact that participants reported some challenges with external agencies, the researcher noted that, on many occasions, the discharge team manager, who had several years' experience working in the local CCG, was able to resolve potential issues that could become challenges/problems with either the CCG or other partner organisations. This illustrates the positive impact of discharge-related knowledge and knowledge sharing on hospital discharge planning.

7.2.2 Poor communication and disputes between hospital staff

The discharge process was central to the smooth running of the hospital, and of the wards in particular, however, its management was an area of controversy among the hospital staff. More specifically, it appeared that controversies emerged in two separate but interrelated levels of interaction - disputes between health and social care staff within the discharge team; and disputes between the discharge team as a whole and the wider hospital staff (i.e. ward staff, senior management team) - and that poor communication was a common denominator that underpinned the two levels of interaction. The perceived inability of the discharge team to change the power dynamics between and within the different teams involved in discharging patients, appeared to have a negative impact on their morale and wellbeing.

Participants provided mixed accounts regarding the quality of their communication with others within the team. Some participants described their communication with their health or social care colleagues as particularly problematic, whereas others described it as at least functional. Those participants who described communication as problematic, and particularly the social care workers, linked it to the emergence of a blame culture within the discharge team, an association not made by the other participants.

Participants reported that there was poor communication across the hierarchy of the discharge team, from management to frontline staff. With regard to management, participants mainly talked about the complex structure of the social care team, which prevented them from establishing clear communication channels for exchanging and acting upon the information they received from each other. For example, Maria, a member of the healthcare team, talked about the challenges of joint working:

There is that real disconnect between the teams; so (name of social worker) for instance, very good, chases, tracks, comes down to the eleven o'clock, comes back at half past three, gives us updates. ... Does what you want her to do and keeps you in the loop for all of that. The other managers don't do ... they kind of think, 'Well we're social care and we're over here and we do our bit and you do yours. (Healthcare team, Maria)

Participants from both the health and social care teams talked about the unwillingness of each side to exchange and share information, create partnerships and collaborate on discharging patients. Sophie, a member of the healthcare team, commented on the lack of clear and open communication lines between the teams:

They do make it sometimes feel like it's us personally. Sometimes communication between us isn't very good. We can be waiting days for updates. Then sometimes they come and update one person but that information might not get communicated through. Sometimes the band sixes [senior nurses in the healthcare team] feel like we don't know what's going on because the social care aren't communicating it to us. (Healthcare team, Sophie)

Similarly, social care staff described communication with their health colleagues as inconsistent; they reported that they did not receive regular updates about a patient's discharge status and that they were frequently blamed for delayed discharges. Participants who worked in the social care team reported that they were unduly blamed for delaying and causing problems in the discharge process. These participants talked about an emerging blame culture that appeared to prevent them from creating stronger partnerships and collaborative work with their healthcare colleagues. For instance, Adam, a social worker, talked about his experience working within the social care team and his interactions with his healthcare colleagues:

Generally, it's not too bad, but I think it's very much a case that they try and blame each other a lot. The discharge team will try and blame us, and in turn, we'll try and blame other things. (Social care team, Adam)

A main component of this emerging blame culture was the lack of trust between the teams. Our researcher noted that on many occasions the social care team requested further assessments to make sure that their healthcare colleagues did not refer a patient whose care needs could have been met by the NHS. This resulted in an increasing number of redundant assessments (as, on the majority of occasions, the patient did not qualify for NHS-funded care), which further delayed the discharge process, placed more pressure on the healthcare team and negatively influenced patient and family experiences of discharge. Similarly, though, the healthcare team were observed criticising their social care colleagues for not attending the board rounds, although our observational data shows that the healthcare team were frequently absent from board rounds. Even though participants reported several communication problems within the discharge team, participants from both teams agreed that there were a number of major communication problems between the discharge team, the wards and the senior management team of the hospital. Participants described a situation where there were mixed understandings of the discharge process among ward staff regarding the delegation of responsibilities. In particular, there were different understandings about who was responsible for sending notifications of discharge and arranging assessments, the timing of these events and the overall structure and management of the discharge process by the senior management team.

The majority of the discharge team reported that the ward staff had no, or at best had limited, understanding of the discharge process, and that they rarely viewed discharge as part of their work. Although all participants felt that the ward staff

Sometimes communication between us isn't very good. We can be waiting days for updates.



were under-resourced and over-stretched, they reported that ward staff's lack of understanding of the discharge processes had a detrimental effect on discharge planning. For example, they reported that ward staff sent referrals too early and/or did not update the discharge team about the status of the patients. Jack, a member of the healthcare team, talked about his views and relationship with the ward staff:

It's not in my backyard, kind of thing. That's for someone else to do, at least I don't have to do that, and back on with something else. It's not all the time, but those one or two, three or four that do happen to be like that sour the rest of them quite considerably. (Healthcare team, Jack)

Indeed, our researcher observed several occasions when staff in the wards appeared particularly unhappy when a member of the discharge team had visited the ward to sort out a patient's discharge. The following field-note illustrates this point:

I visited (the ward) today with Jack. It was the first time that I had seen a nurse talking so abruptly and disrespectfully to another member of staff. Clearly that nurse did not want to share information and work collaboratively with Jack. On the way back to the office Jack told me that there are several members of staff who show a similar stance towards the discharge team. (Researcher field-notes, August 2015)

Poor communication also characterised interactions between the social care team and ward staff, as the latter frequently did not send

notifications for recalling discharges (i.e. Section 5b¹⁵). Some participants reported that this was an instruction from the healthcare team to the ward staff to sabotage the social care team and take the blame for delayed discharges. The following quote from Adam illustrates this point:

They were told not to. The discharge co-ordinators told them not to. I know they did. They might have said they didn't, but I know they did because the nurses would say to me, 'I can't do it. I've been told I can't.' They wouldn't do it ... we don't like them and they don't like us because they know we're always whingeing for these things and they don't get them. (Social care, Adam)

We also noted poor communication in the wards and, in particular, during handovers and in the medical notes. In the first instance, ward staff were not updating each other properly about the health status of the patients, and hence they could not provide the correct information during the board round. In the second instance, some ward staff rarely kept clear and concise notes about a patient's medical and nursing needs in their ward files. As a result, the discharge staff had to search for the ward staff (i.e. occupational therapists, physiotherapists, nurses) to get a more accurate picture of patient needs. The inaccurate documentation of patient needs in their medical and nursing notes contributed to the production of inaccurate reports on a patient's needs. Another area where the discharge team expressed discontent concerned the pressure they felt the management placed on ward staff to discharge patients too quickly. Some staff felt that this compromised the work of both the discharge team and the ward staff, as the latter

¹⁵ A Section 5 notification is made by hospital ward staff that a patient who will require social care support services is medically ready for discharge from hospital. On receipt of the Section 5 social care has 24 hours to put in place community care services and up until 11am of the day after the proposed discharge date before the reimbursement liability applies. At the time of carrying out our research the Act relating to Section 5 had been altered, but this system was still in use (Community Care Act, 2003).

were sending discharge notifications to health and social care teams even though the patients were not medically fit for assessment. Adam commented on this issue during his interview:

We can't have people sitting here that don't need to be here, but there is a difference between somebody sitting here and not needing to be here and somebody they're trying to push out before they're ready. That is a huge problem here. A huge problem. (Social care team, Adam)

Many participants talked about the limited attention and consideration they thought senior management gave to the discharge process. The discharge team staff we spoke to reported that there was a lack of strategic planning in the management of the process. A particular finding from the observation work we conducted was that the healthcare team spent much of their time administering the discharge process rather than assessing patients and informing and involving families. Our researcher also observed instances where patients were discharged before being assessed for support they may need once home. For example, the researcher noted:

Saturday morning, Hannah and I are heading to [name of ward]. Hannah received a Section 5 for a patient yesterday at 3pm. We looked for the patient in the ward but we could not find him. One of the nurses told us that the patient was discharged last night because they needed the bed. ... The patient left the hospital on Friday night without any care plan in place. Hannah called the daughter of the patient. She was told that they could cope for the weekend but they did not know how to manage the situation after that because both herself and her husband had to go to work on Monday. Hannah told me that this should not have happened; it could take long until the social care team assesses this person in his house. (Field notes)

These tensions within the hospital had negative implications for both the families and the discharge team. In the first instance, poor communication between the discharge team and ward staff often resulted in families receiving wrong or misleading information about the discharge process. Sophie talked about the impact of poor communication on patients and their families:

Doctors tell the family well they should get the funding but it's not based on their diagnosis, it's on their needs. Doctors automatically think they should get it. Until you're sat in the meeting hearing the evidence, you can't say whether they're eligible or not. Doctors don't understand that. I think they probably need to understand the process better. (Healthcare team, Sophie)

These tensions within the discharge team and between the discharge team and others appeared to have a negative impact on the morale and well-being of the discharge team and, in particular, of the healthcare team. Participants reported that their efforts were not recognised by either the wards or the senior management team, and that they felt unsupported by their colleagues in the hospital. Jack commented on this issue during his interview:

Unfortunately it's not been well supported throughout this period of time. It's been shoddily supported. It's worn down individual members and we still come in, we all have done extra time to try and keep the whole thing moving, keep the cogs, going to improve, despite the increasing workload and the other jobs that are being put on us by different parts within the hospital. The group is dedicated, there is no doubt about it they are dedicated. Unfortunately, ... they lose members of staff because it's just not being supported well enough. (Healthcare team, Jack)

We can't have people sitting here that don't need to be here, but there is a difference between somebody sitting here and not needing to be here and somebody they're trying to push out before they're ready. That is a huge problem here. A huge problem.



7.2.3 Managing relationships with patients and families

The majority of participants reported that they enjoyed their work with patients as, in the main, patients just wanted to leave the hospital quickly and were keen therefore to accept any service that could help achieve that and support them after discharge. Participants reported some problems when the wishes of the patient regarding the discharge destination were in contrast to the desires of the family (see Section 7.1.5). In this situation, the discharge team had to follow the wishes of the patient – if the patient had the mental capacity to make decisions – and thus they were inadvertently involved, participating in and influencing the family dynamics. For instance, Hannah, a social worker, talked about the challenging power dynamics that she has experienced in her work with families:

I suppose it's really difficult. If you're in a situation where a family member wants you to place their parent in a home, but the person wants to go home and they've got capacity to make that decision, families can get very cross. (Social care team, Hannah)

Participants reported that some families were difficult to work with as their requests exceeded the limits of what they were, by law, able to provide; this was particularly the case for the social care team. For example, Abi described some families as over-protective, which could frequently further disable the patient:

It is quite challenging when you speak with a family that is very over-protective and they demand miracles. They demand that we put something in place that is completely unrealistic and would, I'd say, would disable that person who may be, after a few weeks with reablement or something, become independent again. Families when they are trying to protect, this can be quite challenging. (Social care team, Abi)

Participants described several methods that helped them to navigate through and manage their relationships with patients and their families. For instance, Jack described how he managed the expectations of the families:

It is always about expectations. Again, it's being clear, making sure they understand what it is that you're there to do, making sure that a lot of the worry is about where are they going to go when they are discharged. They think, often, we're going to send them home or we are going to send them to a home. That's not what they had in mind. They've got their own thing in mind and they want to have a conversation about that. (Healthcare team, Jack)

Establishing clear lines of communication, setting up clear expectations regarding the discharge process and involving the family as much as possible in the process were some of the examples that participants used to demonstrate their management techniques.

It is always about expectations. Again, it's being clear, making sure they understand what it is that you're there to do, making sure that a lot of the worry is about where are they going to go when they are discharged.



7.3 Lens 3 data summary

From our analysis of staff interviews and observational data it has emerged that discharge is an active and dynamic process. Its execution involves a series of hospital and non-hospital based acts, performed by many agents and organisations that frequently held distinct understandings and views of patients and their

needs. Also, as these agents and organisations are situated within a wider politico-economic arena, financial influences also exerted power over their practices and thus shaped and defined the discharge process. Overall it appeared that, among professionals, there was a consensus that the following issues affected hospital discharges:

- **Resource constraints.** Staff shortages coupled with care/nursing home placement shortages created several obstacles to organising timely discharges.
- **Limited information sharing and poor communication.** Participants reported that information sharing was unsystematic and described the communication between different departments and wards as problematic.
- **Working with families.** Patients' relatives posed a range of challenges to the discharge process, which participants faced difficulties in addressing. Frequently, participants had to confront and deal with relatives' reactions and disagreements.
- **Fragmentation of care, diffusion of responsibility.** The lack of an integrated discharge interface allowed silo work to dominate the discharge practice; with each individual agent working in isolation and, as their stakes were different, they tried to impose their own priorities onto others.

8.

Conclusion and Recommendations

8.1 Concluding discussion

Our study has generated a multi-lens perspective on hospital discharge at Broomfield that has allowed 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 (and relatives/carers) whose experiences were captured from admission to hospital and following their return home; and staff involved in facilitating the discharge of patients on a daily basis. In doing so, we reveal a number of challenges for patients' and carers' 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 ward level and intermediate protocols and processes) and at the macro level (wider social, political and economic factors affecting resources). For this report we will concentrate our recommendations on issues pertaining to the meso level and the micro issues only. We will address all levels more fully, including the macro ones, 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).

8.1.1 Involvement in discharge planning

The findings from our survey (Lens 1) and patient interview data (Lens 2), suggest that, for patients and their relatives, a positive lived experience of hospital discharge was inextricably linked to the extent to which they were involved in the planning process. When patients were not informed about, nor involved in, their discharge planning, they were more likely to experience a negative discharge experience. On these occasions patients experienced difficulties in organising their transfer home, and in making the necessary arrangements to prepare for their safe return home (i.e. arranging visits from relatives/carers, preparing food and washing clothes).

Given that most patients who participated in our study did so following an emergency, unplanned admission, and that this is now the national trend more generally, there were additional pressures on patients and relatives who, in such circumstances, were unable to prepare in advance for a hospital stay and subsequent discharge from hospital. It is vitally important then to involve not just patients, but their relatives/carers in discharge planning. Our findings here are supported by other research on patient and family involvement in hospital discharge, which shows that while patients welcome the advice of hospital staff and gain information from different professionals (Roberts, 2002), involvement goes beyond staff communicating with patients and carers, and that patients and carers need to be actively involved in the process of hospital discharge (Huby et al., 2007 and Huby et al. 2004).

8.1.2 Communication and information

Our findings from the staff data (Lens 3) partially confirm the Lens 1 and 2 findings - problems with service integration, poor communication and knowledge sharing among healthcare staff contribute to patients' negative experiences of discharge planning. For example, patients may have communicated their needs and preferences to a care professional, but owing to poor communication and problematic knowledge sharing, their preferences and needs were lost during their stay (i.e. not written in their medical notes or not communicated to the professionals responsible for the patient's care).

8.1.3 Patients as active agents in their care

Our findings from patient and relative/carer interview and diary data demonstrate that when patients and their relatives act as active agents of their care, that is they use their power to gain information about a patient's ongoing health and care needs, this then leads to a more satisfactory discharge experience. However, we found that older more frail patients were more likely to be passive, waiting to be told about their discharge plans, and relatives were generally not involved even when they tried to be. We found that often when relatives tried to take a more active involved approach, such as requesting to be kept updated with regards to date of discharge, these requests were not followed up by staff and they remained excluded from the discharge planning process.



8.1.4 Lack of integrated care

Our findings from observation and interview data of the hospital discharge team demonstrate that a weak interface between health and social care providers contributed several challenges to the provision of integrated care. The different assumptions with regard to a person's care needs underpinning each organisational sector contributed to the development of silo working. This affected the care that patients received. Systemic issues relating to the division of access between health and social care services meant that professionals often challenged each other's decisions rather than work collaboratively to address a patient's discharge-related care needs. The distinction made between medical and social care needs was in sharp contrast to the ways that patients experienced and expressed their discharge-related care needs. Patients did not speak of 'my medical needs' or 'my social needs', instead they talked about both their medical and social needs and how their multi-level interactions challenged their hospital discharge and transition from hospital care to self-care. Rather than designing services that adopt a holistic view of the person, services are frequently developed by separating and classifying some needs as medical and others as social. Although the current system is designed to serve service delivery and the health economy, our findings suggest that it is inefficient and does not necessarily perform well for patients. This systemic disjuncture contributed to patients not receiving patient-centred care. Patient-centred care meets a patient's values, preferences and needs (Michie, Miles and Weinman, 2003) and where health and social care professionals work collaboratively with people who use services. Our findings from Lens 3 also suggest that

problems around discharge planning are often prevalent when patients have complex needs, and therefore their timely and safe discharge requires the coordination and collaboration of a range of professionals based either in the hospital or in the community. Consequently, our findings from Lens 3 expand our understanding of hospital discharge by demonstrating the difficulties that health and social care professionals experience when organising complex discharges.

8.1.5 Staff and patient expectation

It is clear when exploring themes across all three lenses, that the expectations of staff and patients are often at odds. For example, patients' relatives/carers often expressed frustration at their lack of involvement in discharge planning and yet staff we interviewed often spoke about patients' relatives being unwilling to get involved or take responsibility in agreeing to assist the patient post-discharge. In order to understand this seeming contradiction, it is important to appreciate briefly the impact that wider changes in healthcare and society may have.

We know, for example, that shorter hospital stays have resulted in a reduction in the number of hospital beds per capita across the country and that there has been a reduction in the number of residential care home places in recent years (Essex Joint Strategic Needs Assessment - Countywide Report, 2013). As such, there is evidence of a shift away from institutional care (long-term nursing or care homes) towards care in the community, often undertaken by spouses or adult children, frequently in difficult and stressful circumstances with little or no formal support.

Many of those undertaking the role of informal carer will be a spouse, and a good proportion of these will be also be frail or elderly and often not in good health themselves. Furthermore, adult children have been identified as the 'sandwich generation' and frequently have caring responsibilities for their children, who are often still living at home until their late twenties, grandchildren and elderly frail parents. A recent study (Centre for Longitudinal Research, 2015) reported that two-thirds of British adults in their mid-fifties currently have some kind of caring responsibility, whether for elderly parents or in-laws, children under 18, or grandchildren. There is also the increase in retirement age for women, who traditionally took on more informal caring roles for family members. While relatives may be willing, not all will be able to provide the same level of care support and involvement in supporting their relatives, although they are under greater pressure to do so. We believe it is important for staff to acknowledge these issues more generally while at the same working together with families to establish what practical support and involvement family members are able to offer; and also for elderly patients and their families to plan better for patients' health and support needs following discharge.

In making the following recommendations, we focus primarily on ways to effect improved patient and carer lived experiences of discharge and we will be offering to assist in implementing the recommendations we make regarding improvement to systems of communication for patients and carers.

8.2 Recommendations

8.2.1 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).

8.2.2 Information and communication: discharge and ward staff

- I. Healthcare professionals should replace outmoded means of communication (i.e. faxes) with more advanced means that could facilitate their work and improve their performance.
- II. Hospital staff should be encouraged to move away from attributing blame and to change the language they use from cause or fault to one that focuses on patient centred care and the need for their timely and safe discharge.

8.2.3 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 inter-related, 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.

8.2.4 Education and training

- I. Provide CPD training for ward staff about hospital discharge processes and how to engage with patients and their carers as partners in care.

8.2.5 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 Mid 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 Broomfield Hospital staff and the local CCGs 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.

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