Papur 1 / Paper 1

Hospital discharge

Discussion material

Prepared by Jon Glasby (November 2023)

How you can use this discussion material

This discussion material is based on evidence from research, lived experience and practice knowledge. You can use it to reflect on your current services and to open up conversations with people, families, colleagues and partners about ways to make evidence-informed changes to what you do.

This discussion material is about hospital discharge for older adults. In particular, it suggests that lots of the key themes have been the same over time (in different nations of the UK and in different policy contexts). In many ways, hospital discharge is a key ‘fault line’ on the boundary between health and social, with competing notions of what constitutes good practice and different definitions of success. For older people stuck in hospital it can be incredibly frustrating. However, there is also a risk of premature discharge or poorly co-ordinated discharge – which can be just as damaging. Ultimately, we might make more progress if we saw things through the eyes of the older person, focused on delivering what matters to them; found ways to go beyond the boundaries of our own professional/organisational role; and recognised that the problematic nature of hospital discharge is nobody’s fault – just a product of the way our system is designed.

What is the issue?

Hospital discharge is a really difficult area of policy and practice for a range of reasons (see below for further discussion) – but it tends to hit the headlines because of the impact it has on the health service, rather than the impact it has on older people and families. In practice, both are important – but we need to make sure that we’re focusing on outcomes that matter to people and that we don’t only see adult social care through the lens of the NHS.

Before exploring these issues further, it is important to be clear on key terms – which are very contested (see Box 1). In practice, anything we can do, individually and collectively, to avoid the term ‘bed blocking’ is basically a step in the right direction.

We also need to recognise that this is an international issue (affecting lots of different health and social care systems around the world). As but one example, a review of good practice in trying to tackle these issues found relevant studies from different parts of the UK, the US, Australia, New Zealand, Italy, Lebanon, Singapore, the Netherlands, Pakistan and India (Cadel et al., 2021).

These are also very longstanding issues (see Glasby, 2003 for some of this history). In the UK, for example, the first government guidance on this issue was published in 1963, and concerns about people becoming delayed go back to the very beginning of the NHS (and even further back). Thus, during the Second World War, there were concerns that the rest centres set up to support people whose houses had been damaged by the bombing would become ‘blocked’ by frail older people who came into the service due to an emergency housing need, but who might be unable to leave due to ongoing health and social care needs (the so-called ‘un-billetables’).

Box 1: The importance of terminology

Historically, people have talked about this in terms of **‘bed blocking’** (with people stuck in hospital described as **‘bed blockers’**). This is still the case in the media – and sometimes from a health professional – but most people see this as an offensive and unhelpful term, effectively blaming the victim (i.e. as if it’s the person’s fault they are still in a bed – when they’re almost certainly desperate to get home and only there because the system can’t organise itself to get the person out).

A more neutral term is **‘hospital discharge’** or **‘delayed discharges’** (used here). However, the use of the word ‘discharge’ runs the risk of encouraging hospital services to see their role as finished when the person leaves (i.e. their responsibilities end when they ‘discharge’ the person from their care, rather than playing an active part in a planned transition from one setting to another, with responsibilities to achieve a smooth transition shared).

Probably most accurate, therefore, is the term ‘delayed transfer of care’ – which captures this sense of a transfer rather than one set of responsibilities abruptly ending. However, it tends not to slip off the tongue, and policy tends to abbreviate it to ‘DTOCS’ (which sounds horrible and impenetrable).

The impact on health services (and often the media and policy focus)

Current policy and practice is very focused on tackling the huge backlogs which built up in the NHS during COVID – and freeing up beds by tackling delayed transfers of care is a key part of getting the waiting list back under control. Hospital beds are an expensive and (compared to a number of other health systems internationally) scarce resource, for which demand frequently outstrips supply. There is therefore significant pressure on health service colleagues to ensure rapid throughput – and delays in people leaving hospital when they no longer need the services provided there are a major source of frustration.

This has sometimes been likened to the motorway on a bank holiday, when there is just too much traffic for our road network to cope. It only needs a minor change – too many cars joining at a junction, a piece of debris on the road, a really minor shunt, some minor roadworks – and the whole thing can ground to a halt.

Another parallel is a bath filled to the brim. If even a small glass of water is poured in, the entire contents of the glass spills out onto the floor, because there is literally nowhere else for it to go.

However, there is a danger that pressures on the health service come to dominate other priorities – and that we end up interpreting what social care does through the eyes of the impact it has on health partners, rather than valuing the contribution it makes in its own right. Certainly this is a risk in the media and in some policy circles. Just to put this in context, about half the adult social care budget is spent on people of working age (not on older people at all), and supporting discharge from hospital represents a fairly small amount of what adult social care does at any one time.

Moreover, although waiting for various forms of social care can lead to significant delays (and the number of social care-related delays has been increasing) – it often accounts for less than half of delays. Prior to the pandemic, for example, social care accounted for about 40% of delays (either social care delays or joint health and social care delays). While significant, the NHS was solely responsible for the other 60% (Cavallaro et al., 2023).

The impact on older people and families

While delays leaving hospital have a significant impact on the NHS, they are also problematic for patients and families. Hospitals are busy, stressful environments, and most people want to get home as quickly as they can. Staying for longer than you need can also put you at risk of a hospital-acquired infection, and being in bed all day can reduce people's independence and functional ability. People with learning disabilities or with dementia might also find hospital really confusing and disorientating, making it even harder to keep independent.

Beyond the issue of delays, moreover, there is a longstanding literature on hospital discharge, with common themes emerging time and again over decades (at least as far back as research in the 1960s and 1970s – see Glasby, 2003 for a summary). These include:

- Poor communication between hospital and community
- Poor planning in situations where people are likely to have ongoing needs after they leave hospital
- Inadequate notice of discharge
- Inadequate engagement and consultation with patients and their carers
- Over-reliance on unpaid carers at the point of discharge (when someone might have particularly significant needs) and lack of (or slow) statutory service provision
- Inattention to the needs of groups who might need even more support (such as people with dementia, homeless people)

What stands out from this literature – particularly from studies which have talked to older people and to families – is how distressing it can be to be on the receiving end of all this (see Box 2 for some practical examples from Age UK's advice line). People describe being at their wits end and feeling completely helpless, with no ability to influence what happens to them, and with families feeling completely taken for granted and left without adequate support. This latter issue was brilliantly but heart-breakingly captured over 20 years ago by IMPACT's Emily Holzhausen in the title a national report for Carers UK: 'You can take him home now.'

Box 2: Negative experiences of hospital discharge (case studies from the Age UK [2016] helpline)

Mary: Paul's wife Mary, 85 years old, is in hospital. She has lost her mobility during her hospital stay. Yesterday the hospital told him Mary was ready for discharge today and she can't occupy a hospital bed anymore. Nobody has assessed what she will need to help her recover at home, whether she can regain her mobility, or what adaptations are available to help them manage. Paul was able to delay the discharge for a day by getting the Patient Advice and Liaison Service involved but he still wasn't given any information about her rights, or about how they are going to manage at home.

Phil: Phil is in hospital and nearing the end of his life. The hospital says they can't do any more for him and want to discharge him. Phil lived in a care home with nursing prior to going into hospital, but this home is now unsuitable. Social services have identified a couple of alternative care homes, but his daughter Susan and her family have refused them because they are too far away for the family to visit him regularly.

The family have found what they consider to be a suitable home nearer to them but there aren't any vacancies. They've asked the GP to refer Phil to a hospice, but the GP has refused because Phil's diagnosis doesn't say he has a specified time to live.

Alfred: Alfred is in hospital following a series of strokes and is due to be discharged in the next two weeks. It is being recommended that Alfred now goes to a care home. Alfred lacks mental capacity to make decisions about his care arrangements but his son has a registered Enduring Power of Attorney for Alfred's property and financial affairs. The hospital social worker is advising the family that social services will choose the care home and that it will need to be some way away to meet local authority cost limits. The family is unhappy about this because they think he needs to be closer to them so they can visit regularly.

Bob: Hannah's father Bob has a range of health problems, including dementia. At a discharge planning meeting two weeks ago the consensus was that Bob should return to his sheltered accommodation unit with a care package in place. However, the housing association that manages the sheltered accommodation says they do not want him to return because he is no longer well enough to manage, while Social Services are saying that sheltered housing is his best option at the moment as he does not yet meet the criteria for specialist residential dementia care. Hannah feels that they are now at an impasse and that she is going to be forced to agree to something she doesn't believe to be the best option for Bob.

Rachel: Janet's mother Rachel is in hospital for the second time in 10 days. Rachel lives in her own home. Janet feels she shouldn't have been discharged home on the first occasion and intends to complain. Before her readmission the Intermediate Care Team agreed that she wasn't safe at home. Now that Rachel is back in hospital Janet fears the same thing will happen again. She's trying to find someone who can help them find out what the options are and wonders what the responsibilities of the hospital social worker are and who, if anyone, joins everything up.

Putting these issues into a broader context

Taking a step back, therefore, some of the biggest issues aren't about delays in isolation. Instead, there are a series of broader challenges and dilemmas:

- While there is significant focus on delayed discharges, there can be just as much of an issue with premature discharge (when someone feels pressured to leave hospital before they feel ready to be back in the community) and/or poorly co-ordinated discharge (where all the focus is on getting the person out of hospital, not on enabling a smooth transfer to community services).
- When pressures increase on hospitals, there can be pressure to get people out at almost any cost – and this can lead to premature admissions to care homes, rather than taking the time to help people return to their own homes. Even if a care home placement is intended to be short-term, the risk is that under-staffing and lack of access to rehabilitation can turn a short-term admission into a permanent one, prematurely 'writing people off' as unable to be at home. Lots of people would argue that no one should be admitted straight to a care home from hospital, unless they were living in a care home before they were admitted (a 'home first' approach).

- Hospital is a really bad place to make fundamental, long-term decisions. You might be scared, in pain, disorientated – and just not yourself. Wherever possible, people are usually desperate to get home, so that they can take stock, start to recover and get support to be the best that they can be, before taking any longer-term decisions about their care and support.
- Various policy initiatives have tried to create new services that people can go to for additional support and rehabilitation after hospital. However, if an underlying issue is that there isn't enough capacity in the system, then these services can quickly fill up, becoming just as 'blocked' as the hospital beds they were designing to free up. There are some fantastic services that provide really tailored care and support, build people's confidence and help them return home – but there's also a danger that we just shift a problem somewhere else, so that it's 'out of sight and out of mind'. The risk of this usually increases when we do something under significant pressure/quickly, when we don't consult partners first and, above all, when we don't engage with older people and families to design services.
- While all the policy focus tends to be on discharging people from hospital, it's just as important to work in a more preventive way to help people stay as healthy and independent as possible, thus reducing the number of people admitted to hospital in the first place. Indeed, a former national body (the Audit Commission) helpfully identified a 'vicious cycle' where there is insufficient prevention and rehabilitation, leading to too many people being admitted to hospital and discharged to permanent care homes places, meaning there is even less money available to spend on prevention/rehabilitation – thus leading to even more hospital admissions and discharges to care homes. Instead, they proposed investing strategically in prevention and rehabilitation as a way of breaking out of this vicious cycle.

Some important gaps in our knowledge

Although these issues have been widely debated and frequently researched over the years, there are still a number of key gaps in our knowledge – both of which are important for this IMPACT Network to take into account:

1. Most previous research into the extent of delays has tended to be conducted by medical/clinical researchers, reviewing the case notes of patients in hospital (either based on professional opinion or using a structured tool to decide who is delayed in hospital and who still needs to be there). However, there have been surprisingly few meaningful attempts to involve older people, families and front-line social staff in this research and these debates. The risk here is that any solutions put forward may fail to draw sufficiently on this lived experience and practice knowledge, thereby failing to solve the issues at stake. In contrast, IMPACT argues that people are experts in their own experience, they often know what works for them and they are the only people who have an overview of their journey through services (with many of the professionals involved in their care and support often only knowing them at a particular moment in time) (Glasby et al., 2004a-b, 2006; see also Glasby et al., 2016 for a similar discussion around debates about 'inappropriate'/preventable admissions to hospital).

2. Some research is so focused on counting delays and on identifying risk factors and characteristics of patients who experience delays, that it fails to consider possible solutions. To counter this, an international review by Cadel et al (2021) looks at international good practice examples, in an attempt to be more solutions-focused (see Box 3). However, numerous problems remain – not least the facts that most studies are focused on quantitative outcomes rather than the perspectives of patients, families and staff; that sustainability of new initiatives is rarely considered; and there is a lot of contextual information missing from accounts of perceived good practice.

What needs to happen next?

In one sense, there are no real solutions – as suggested earlier, this has been an issue since before the NHS came into existence, in all four nations of the UK and in lots of different countries around the world. Although often associated with older people (which is the focus here), it's also an issue for other groups of people, including people with learning disabilities (Ince *et al*., 2022) and people with mental health problems (see, for example, Glasby and Lester, 2004; Poole *et al*., 2014). One of the reasons why no one has solved this issue is that it involves competing notions of good practice. Although it is a vast oversimplification, hospitals tend to be focused on/rewarded for efficiency and 'throughout' (getting someone in, treating them, getting them out again and using the bed for someone else), while social care tends to be focused on empowerment (looking at outcomes that matter to the person, and helping them make very difficult and potentially life-changing decisions about their long-term destination and needs). It's not that one of these is right and the other is wrong – they're just different (and arguably incompatible at this particular fault line in the system) (see Glasby, 2003; Heenan, 2023 for further discussion).

Box 3: Initiatives for improving delayed hospitals discharge: an international scoping review (Cadel et al., 2021)

This international scoping review argued that most of the current literature focuses on the risks of being delayed and the groups of people most likely to be delayed (i.e. some of the 'problems' to be solved) – not on practical solutions. In contrast, they reviewed initiatives that seek to tackle delays in order to identify best practice.

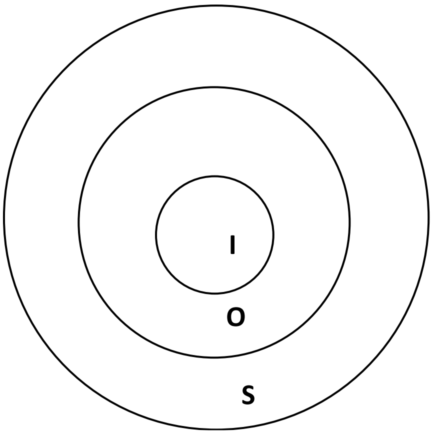
Their article is free to read (https://bmjopen.bmj.com/content/bmjopen/11/2/e044291.full.pdf), but summarises a number of practice changes, tools and guidelines, approaches to information sharing, and projects around infrastructure and finance that have been attempted in different parts of the world. A number (but not all) of these seemed to have some positive results – albeit the research to date tends to focus more on system outcomes than on the experiences of older people/families. There is also a lack of data over time (to see how sustainable any changes were) and a lack of information about the local context (making it difficult to share learning with others). It was also unclear whether some initiatives simply moved problems from one sector to another, rather than genuinely solving the problem. Overall, the review identified some potentially promising approaches, but also concluded that: *"This highlights the need to shift to a more patient-centred approach that focuses on improving outcomes and experiences, rather than system and hospital outcomes (i.e. length of stay and hospital occupancy) alone. Despite the number of unique initiatives aimed at addressing delayed discharges, current strategies may not be getting at the root of the problem… and there is a need for solutions to this problem that have a long-term and sustainable impact"* (p.26).

Even if we recognise that there are unlikely to be any ‘magic answers’, we might still be able to make progress by doing things such as:

- Focusing on the experiences of older people and on outcomes that matter to them. Although it is now very dated, there is a wonderful example of this in action from Age Concern Fife; another really good example comes from the work of SCIE (see Boxes 4 and 5). Neil Crowther (2023) from #SocialCareFuture has also written a beautiful blog about his Mother’s experience, what mattered to her, the support that helped and why this isn’t social care as we usually think about it.
- Focusing on doing what we can to go beyond the confines of our role/organisation/ profession in order to ensure that support is as joined up as possible. Rather than passing the buck off on others and getting frustrated with partner agencies, we need to acknowledge that this is often no one's fault - and spend more time looking for answers than blaming each other
- Local organisations establishing good relationships with each other and finding practical ways to smooth over some of the tensions and fault lines that get in the way of effective joint working. As but one example of the way in which partners can work together to better understand and respond to these issues, the report ‘Why not home? Why not today? sets out some practical suggestions and advice which may be of interest to local Networks (Better Care Fund/Newton, 2017).
- National policy makers trying to avoid the dangers of focusing solely on discharge at the expense of other issues and of viewing adult social care through an NHS lens. There may also be scope for more work nationally in order to remove some of the administrative, legal and financial barriers that get in the way of joint working, and better align different health and social care incentives so that joint working happens because of the system rather than in spite of it.

Interestingly, this suggests action at three different but inter-linked levels: individual, organisational and structural (the ‘IOS’ model - see Figure 1). Thus, the contribution of individual workers, although significant, takes place within an organisational context, which itself is influenced by structural barriers to improved joint working. Similarly, structural barriers derive at least in part from certain organisational features associated with particular types of health and social care agency and, ultimately, from the individual practitioners working within the organisations concerned. As a result, co-ordinated action might be needed at all three levels if we are to make significant progress.

Figure 1: The ‘IOS’ model of hospital discharge (Glasby, 2003)



I	**Individual level**
O	**Organisational level**
S	**Structural level**

Box 4- Focusing on things that matter to older people – insights from the Fife User Panels project

Although nearly 30 years old, an interesting example comes from work undertaken by the ‘Fife User Panels’ project. While there was a growing emphasis on involvement and engagement, many examples at the time focused on people of working age; it was much less common to seek to engage groups of frail older people in sharing experiences and exploring opportunities to improve care and support. Once they started meeting each other, the group quickly realised that they all had personal (and often negative) experience of hospital discharge. This included:

- “Being given no advance warning and being told during a relative’s visit that they could go home immediately
- Being packed and ready to go but having to wait hours until an ambulance service was available
- Returning to cold and empty houses with no services available until the following day” (Barnes and Cormie, 1995, pp. 30-31).

In response, they developed a practical guide to good hospital discharge – examples included:

- The heating should be turned on in the house from the morning of discharge. The bed should be made up and warm for the patient
- There should be fresh staple goods (such as milk, tea, eggs and butter) in the house
- One meal should be ready for the person coming home
- The home carer should be in the house awaiting the patient’s arrival if no friends or relatives are available or if requested by the patient

- Adequate notice of discharge should be given to family members (remembering that this person in turn will have to make their own domestic arrangements)
- Discharge times should be given within reasonable parameters (for example, whether discharge will take place in the morning, afternoon or early evening). People should not be kept waiting for hours
- At least 24 to 48 hours' notice of discharge should be given
- Services should be in place on the day of discharge, not the day after
- Services following discharge should be available 7 days per week, including public holidays.

This advice has since been built into senior NHS leadership development programmes in England, as part of an exercise to think about the insights provided by different types of evidence. In addition to a systematic review, a randomised controlled trial, professional guidelines and a national survey of carers, participants were given this good practice guide and asked which of the sources was the most valid/reliable, and which was the most helpful in terms of helping to tackle the issues at stake. Participants always felt that this material was really powerful (because it drew on lived experience) and very hard to argue with – we may or may not have a research study that 'proves' if it matters if someone's heating is on in advance, but not many people would disagree that an older person coming out of hospital in the middle of winter and late at night should come back to a warm house. Ironically, the advice given by the Panel is also fully consistent with all the research published on this topic over the last few decades (Glasby, 2003).

Box 5: Focusing on things that matter to older people – insights from SCIE's systematic review

In 2006, the Social Care Institute for Excellence (SCIE) sought to develop approaches to reviewing evidence that were rigorous and transparent, but which could include people's lived experience in a way that was less common in more medically-orientated research (which often focused on quantitative research about effectiveness) (Fisher *et al*., 2006). They chose to focus on hospital discharge - a topic which they felt had recently been subject to "a conventional, high-quality systematic review, but which lacks attention to the views of older people about what they value in terms of both process and outcomes."

By asking a different kind of question – focusing on older people's experiences, rather than on issues of effectiveness – they were able to prove that such approaches to reviewing evidence could be feasible and productive, producing different answers to reviews that adopted more traditional methods. In particular, they found that professionals often see discharge as a discrete event and focus on risk, safety and functional independence. In contrast, older people saw their hospital stay and discharge as part of a broader process of coming to terms with the impact of illness on their lives and future plans, and were often anxious about the implications for their self-sufficiency and the control they had over their own lives. They therefore really valued things such as education, training and continuity of staff to help them regain control and reduce uncertainty and anxiety.

Overall (p.48):

> *"The synthesis shows that, while health staff may know more about the physical effects of illness and its likely impact on daily life, they know much less about what this means for older people and their life plans. Older people know their own life plan, and what they fear might be the impact of the illness, but need carefully delivered information, and carefully constructed opportunities, to review their life plan in the light of their illness and to make their own plans accordingly. They also need the recognition that discharge might involve far more important issues (to them) than safety per se, and far more than being expected to accept passively any limitations consequent on illness. The synthesis shows that, in older people's eyes, coming to terms was not a passive process of acceptance but an active process of working out how to manage, and how to preserve control over the most important things while accepting what must be given up.*
>
> *Thus the value of this qualitative synthesis for the topic of older people and hospital discharge is that it reveals some of the mechanisms underpinning successful interventions to support older people after discharge, and that it points to a lifeplanning framework for understanding the impact of illness, admission and discharge. This life-planning framework is completely missing from the original review, and yet it has the capacity to change profoundly the construction of interventions to support older people through their experience of illness and hospital."*

Thus, the review produced practical learning for health and social services – but did so in a way which valued and built on people's lived experience.

Having read this discussion material:

1. Are there things in the document that remind you of your experience of hospital discharge?
2. What do you think can help or hinder older people from having a positive experience of discharge from hospital?
3. What do you think can support the experience of professionals involved in hospital discharge?
4. From your experience, is there any good practice which could help to address potential issues around premature/poorly coordinated discharge?
5. Reflecting on the list of advice from the 'Fife User Panels' project in Box 4, do you think these are in place in your local area?

References

- Age UK (2016) Age UK briefing – discharging older people from hospitals (www.ageuk.org.uk/globalassets/age-uk/documents/reports-and-publications/reports-and-briefings/care--support/age_uk_discharge_from_hospital_briefing_june_2016.pdf)
- Barnes, M. and Cormie, J. (1995) On the panel, Health Services Journal, 2 March, 30-31

- Better Care Fund/Newton (2017) Why not home? Why not today? (https://www.local.gov.uk/sites/default/files/documents/NEW0164_DTOC_Brochure_Online_Spreads_1.0.pdf)
- Cadel, L. et al (2021) Initiatives for improving delayed discharge from a hospital setting: a scoping review, British Medical Journal Open, 11:e044291. doi:10.1136/bmjopen-2020-044291 (https://bmjopen.bmj.com/content/bmjopen/11/2/e044291.full.pdf)
- Cavallaro, F. et al (2023) Why are delayed discharges from hospital increasing? Seeing the bigger picture. London, Health Foundation (https://www.health.org.uk/publications/long-reads/why-are-delayed-discahrges-from-hospital-increasing-seeing-the-bigger)
- Crowther, N. (2023) It’s good to be on the road back home again. Online blog (https://makingrightsmakesense.wordpress.com/2023/06/13/its-good-to-be-on-the-road-back-home-again/)
- Fisher, M. et al (2006) Using qualitative research in systematic reviews: older people’s views of hospital discharge. London, SCIE (https://www.scie.org.uk/publications/reports/report09.pdf)
- Glasby, J. (2003) Hospital discharge: integrating health and social care. Abingdon, Radcliffe Medical Press
- Glasby, J. and Lester, H. (2004) Delayed hospital discharges and mental health: the policy implications of recent research, Social Policy and Administration, 38(7), 744-757
- Glasby, J., Littlechild, R. and Pryce, K. (2004a) Show me the way to go home: delayed hospital discharges and older people. Birmingham, Health Services Management Centre/Institute of Applied Social Studies (on behalf of the Department of Health Policy Research Programme)
- Glasby, J., Littlechild, R. and Pryce, K. (2004b) Show me the way to go home: a narrative review of the literature on delayed hospital discharges and older people - research note, British Journal of Social Work, 34, 1189-1197
- Glasby, J., Littlechild, R. and Pryce, K. (2006) All dressed up but nowhere to go? Delayed hospital discharges and older people, Journal of Health Services Research and Policy, 11(1), 52-8
- Glasby, J. et al (2016) Who knows best? Older people’s contribution to understanding and preventing avoidable hospital admissions. Birmingham, School of Social Policy/NIHR Research for Patient Benefit programme (https://www.birmingham.ac.uk/documents/college-social-sciences/social-policy/hsmc/publications/2016/who-knows-best.pdf)
- Heenan, D. (2023) Hospital social work and discharge planning for older people: Challenges of working in a clinical setting, Ageing and Society, 43(6), 1333-1350
- Holzhausen, E. (2001) “You can take him home now.” Carers’ experiences of hospital discharge. London, Carers National Association (now Carers UK)

- Ince, R. et al (2022) ‘Why are we stuck in hospital?’ Understanding delayed hospital discharges for people with learning disabilities and/or autistic people in long-stay hospitals in the UK, Health and Social Care in the Community, https://doi.org/10.1111/hsc.13964
- Poole, R., Pearsall, A. and Ryan, T. (2014) Delayed discharges in an urban in-patient mental health service in England, Psychiatric Bulletin, 38(2), 66-70

Cover image – Wilson Ren: https://www.pexels.com/photo/lit-up-exit-sign-in-a-hallway-5036652/

Website: **impact.bham.ac.uk**

X: **@ImpAdultCare**

LinkedIn: **impadultcare**

Hospital discharge is a really difficult area of policy and practice for a range of reasons – but it tends to hit the headlines because of the impact it has on the health service, rather than the impact it has on older people and families.

In practice, both are important – but we need to make sure that we're focusing on outcomes that matter to people and that we don't only see adult social care through the lens of the NHS.

What matters to older people and families?

An Ask IMPACT guide

Putting hospital discharge in context

In 2023-24, IMPACT has been running one of its national Networks on hospital discharge for older people, with groups all over the UK working on practical, evidence-informed changes in their local area and sharing learning about what makes a difference. This has revealed some helpful context to help introduce this guide.

Coming out of hospital has been a really difficult area of policy and practice throughout the history of the NHS and social care. It is also really difficult in lots of other countries around the world.

This might suggest that we struggle with it, not because we are not trying hard enough, but because it is really difficult (and built into how our services are designed). If it was easy, we would probably have solved it by now.

When health services in particular are under lots of pressure, the focus is often on tackling delays in leaving hospital, thereby freeing up hospital beds for new people to be treated. While this is really important for all of us, we also need to think about the impact that coming out of hospital has on older people and families, not just on the ‘service issues’ involved.

The dangers of getting it wrong

All the evidence suggests that coming out of hospital either before you feel ready, or without the right planning and support in place, can be really distressing and have really serious consequences. Sometimes we miss these because they often happen in private, behind closed doors – and we are busy trying to support the next person who is ready to leave hospital. There’s a also a risk that we can be so focused on getting people out of hospital, that we don’t do enough to keep people healthy and well at home (i.e. stopping people having to go to hospital in the first place).

More generally, these are such key issues that it can sometimes feel as if hospital discharge is dominating social care (particularly in some media accounts). Although helping people come out of hospital quickly and well is really important, social care is about much more than this – and attempts to improve discharge shouldn’t encourage us to do anything that makes it harder for people to lead ordinary lives in a place they call home. When there are lots of pressures on hospital services and lots of national scrutiny, it can sometimes lead to calls for short-term, single agency or knee-jerk responses. In our experience, this rarely solves the underlying issues, and could make things worse.

This guide

Instead of focusing on ‘freeing up hospital beds’ - important though this is - this guide looks at things that the evidence suggests matter to older people and families – some of which might not always be things that services think about as much as they perhaps could.

This should not get in the way of official policy and practice guidance already in place in different parts of the UK or the different initiatives and good practice examples that exist in different nations. However, this guide sets out some things that we could easily miss if we were not really focused on the needs of individual people.

Having reviewed the evidence, this guide focuses on six key issues:

- Feeling ‘forced out’ too soon
- Feeling confident that the practicalities are in place
- Feeling a ‘burden’
- Paying attention to emotional and social issues
- Good communication
- Feeling ‘done unto’

> **“Delayed hospital discharge experienced by people who can’t return home for lack of social care support is a *symptom* of the multiple faultiness in adult social care, it is not *the problem to be fixed.*”**
>
> **Neil Crowther, #SocialCareFuture**

[A note on terminology – when we talk about ‘going home’, we mean returning to the place that the person calls home, whatever type of housing this is and irrespective of whether it’s someone’s own home, living with family or living in some sort of group setting. The key thing is that it’s home from the point of view of the person].

Feeling 'forced out' too soon

Although lots of policy focuses on tackling delays in being able to leave hospital, there is also a risk that some people feel 'forced out' before they're actually ready (premature rather than delayed discharge).

Most people want their stay in hospital to be as short as possible, really appreciate the support they receive from different hospital staff and do all they can to be able to go back home as soon as they can.

However, people also have a clear sense that "sometimes you need to be in hospital" [Fowler Davies, S. et al (2019) Hearing the voices of older adult patients: Processes and findings to inform health services research, p. 4] and can feel "'ejected' from hospital – relieved, but also anxious about leaving the acute care environment" [O'Hara, JK et al (2020) 'Handing over to the patient': A FRAM analysis of transitional care combining multiple stakeholder perspectives, p. 9].

This could be because they still feel unwell, because there have been complications in their care and/or because they feel anxious about what might happen next and need further support and reassurance. It can also link to the sense of 'feeling a burden' discussed below.

This means that everyone involved in the discharge process needs to be focused on helping people get home as soon as possible, but has to work at the pace of the individual older person. This sounds basic, but is really important – and also very difficult to do in such busy and pressured environments.

Feeling confident that the practicalities are in place

The transition from hospital to home can feel daunting, leaving some people "feeling overwhelmed… by unforeseen difficulties" [British Red Cross (2018) Home into the unknown: Getting hospital discharge right, p. 12].

As part of this, there can be lots of practical matters to think about – often at a time when people are coming to terms with what's happened to them and might feel least able to cope with some of the issues. This can include:

- Getting home from hospital in the first place (e.g. practical transport issues)
- Making sure the heating is on, things are clean, the bed's been changed and there's food in in a home that might have stood empty for some time
- Having the lights on so that someone isn't coming into a dark house if it's late night
- Starting up previous care and support arrangements – this can sometimes be really difficult, especially if it's at short notice or at night/over the weekend
- Feeling able to manage your own home and daily routine if you're still recovering from ill health or if your mobility is temporarily reduced
- Taking any new medication and using any new equipment that might have been provided
- Attending any subsequent appointments and making sure that anyone who is meant to be following you up in the community does so in a timely manner

When these practical arrangements fall down, it usually falls to the person and their family (if they have a family nearby) to manage these themselves. Many people say they feel overwhelmed, and some families say they feel that the system gives them no choice – they're expected to step in, often without really being asked, sometimes irrespective of where they live, what's going on in their own lives or what kind of relationship the family has.

Above all, getting the practical help you need can be utterly baffling and incredibly stressful to anyone who doesn't already understand how the health and social care system works (which is most of us).

Feeling a ‘burden’

We may be trying our best to juggle multiple competing demands in our work, and to be supporting individuals as best we can – but older people in hospital are often aware of the general pressures surrounding them on the wards.

These pressures can shape how staff and patients interact, and people can feel excluded from the care process if staff appear unapproachable and seem too busy to really listen. Several accounts describe how some older people may “do as they are told” for fear of being seen as “a nuisance” (Hardicre, N. et al (2021) Doing involvement: A qualitative study exploring the 'work' of involvement enacted by older people and their carers during transition from hospital to home, p. 1941) – or may not ask for help or feel comfortable being open with health professionals.

In an ageist society, this can make people feel as if they’re ‘a burden’ and not deserving of support. This is particularly an issue when there are media accounts of ‘bed blocking’ – as if the person is somehow deliberately occupying a bed that someone else needs (when in reality they’re probably desperate to get home). In our view, this just blames the victim – people are sometimes stuck in hospital beds because we can’t find a good way to support them at home.

The consequences of all this – for people’s confidence and well-being, and in terms of people feeling comfortable seeking help, raising concerns and accessing services that should be available for everyone – can be really harmful.

Even if we can’t find a way to improve some people’s discharge from hospital, the least we can do is make sure we don’t make older people feel guilty or worse about themselves.

Paying attention to emotional and social issues

“When you come out of hospital, you get back to your flat and you're different. Mentally you're different because your life has changed, so you've got to do things in a different way.” [British Red Cross (2018) Home into the unknown: Getting hospital discharge right, p. 7].

While services are often focused on discharge as a physical transition between different settings and locations, it is also an emotional and social experience for older people and families.

For some people, being in hospital is “often defined by trauma and uncertainty and characterised by a loss of control and heavy reliance on others” [British Red Cross (2018) Home into the unknown: Getting hospital discharge right, p. 33] – and people consider recovery and discharge less in terms of their medical condition and more in terms of a return to normality and a greater sense of control at home.

There can also be broader issues – such as getting used to receiving care and support potentially for the first time, feeling comfortable with new equipment, coming to terms with longer-term changes that might be taking place in your life, and feeling worried for the future.

We might be desperate to leave hospital and get home – but it can also be a time of significant anxiety, fear and distress.This can be really difficult for the professionals involved, who are often under significant pressure to act quickly (knowing that rapid, quick-fire actions can sometimes be counter-productive).

Good communication

"Three weeks after her stay, Angela still wasn't sure why she was admitted to hospital, nor who was responsible for her care once she was discharged. She was unsure about what the next steps for her recovery were, particularly after receiving a letter from the hospital which she found very difficult to understand. She didn't know who to contact when she got home." [British Red Cross (2018) Home into the unknown: Getting hospital discharge right, p. 36].

Lots of people feel that they don't get meaningful, accessible information when they're leaving hospital – about what's happening in the short-term, about longer-term options, and about specific issues such as medication, how to contact key people and who is responsible for what.

All the evidence suggests that people and families value good communication, and see it as key to helping them understand what's happened to them, what will happen next and what might happen in the long-term:

"I wouldn't say there was any real plan at all […] – you're just kind of dumped in it." [British Red Cross (2018) Home into the unknown: Getting hospital discharge right, p. 37].

Longstanding and common issues include:

- Difficulties experienced by families contacting the relevant hospital staff during the person's hospital stay
- Not knowing who is taking the lead in organising and co-ordinating the discharge
- Hospital staff talking to the older person when it's convenient for the hospital, rather than when it's the best time for the person – and not always communicating fully with families
- People feeling that information is sometimes delivered as a 'monologue' with little opportunity to seek clarification or ask questions
- Too much professional and technical jargon
- Professionals not fully appreciating the emotional impact of being in hospital, and so mis-judging the person's state of mind or readiness to receive the information in question
- Different professionals prioritising different things, so that everything feels confusing and not joined up
- No one really talking to the person about what they want and how they best get back to a sense of normality after hospital

Feeling ‘done unto’

We all want to be involved in decisions about our own care – and we usually get better outcomes when the relationship between care professionals and the person is based on a partnership.

This can be difficult in some hospital environments, where things might be very pressured and busy, where there may be little space for private conversations and where it can be difficult to have the time to make potentially long-term decisions. People are often feeling really scared and ill, so might need support to feel comfortable speaking up, sharing what they’re really feeling and possibly even taking a different view to the health professionals around them. Some cultures have historically been quite hierarchical – and some older people might be used to the traditional view that ‘doctor knows best’ (even if this isn’t what the doctor thinks at all).

All this means that it can be easy for people to feel excluded from decisions about their own care and helpless about what happens to them next.

All this is really problematic, because we know that:

- People and families are experts in their own situation, their aspirations and what would work for them – overlooking this is to neglect a vital source of expertise that could lead to much better outcomes

- Families in particular can feel excluded and taken for granted by some health and care professionals

- If you feel ‘done unto’, it can really damage your confidence and self-esteem – and also make it difficult for people to feel comfortable regaining greater control over their lives and support when they get home

Summary

Hospital discharge is a key ‘fault line’ in our services – between being ‘unwell’ and ‘well’, between hospital and community, between health and social care, and between people from different professional backgrounds.

It’s always been difficult to get this right – especially when services are under significant pressure - and most countries struggle with it.

All this means that it’s easy for older people and their families to feel lost, overlooked, ‘done unto’ and sometimes even ‘forced out’ too soon.

While it’s important that everyone is focusing on supporting people to leave hospital and return back to wherever home is for them, some of the things that really matter to people include:

- Feeling in control of what’s happening to you, in the place that you call home
- Working at the pace of the individual
- Paying really detailed attention to getting the practicalities right
- Making sure that we don’t fall into the trap of making older people feel like a ‘burden’
- Recognising that being in and leaving hospital is an emotional and social issue, as well as a physical transition between different settings
- Meaningful, two-way communication and relationships, with a partnership of equals

Despite all this, leaving hospital is also a chance for health and care professionals to make a real difference to people and their families, at a time when many of us feel at our most vulnerable. Getting it right for people and families, and seeing it through their eyes, is crucial.

About this guide

Ask IMPACT materials are designed to be trusted, accessible and practical. They are based on reviewing evidence – including research, lived experience and practice knowledge – that is captured on academic databases and on the websites of adult social care policy and practice organisations. The HSMC Knowledge & Evidence Service (KES) is a specialist information service providing a range of research, communications and information literacy skills services to the health and social care community. The evidence search conducted covered material published between January 2017 and January 2023. To find out more about KES, or about the searches behind this guide, you can contact them at: hsmc-kes@contacts.bham.ac.uk

IMPACT
Improving Adult Care Together

UKRI
Economic and Social Research Council

The Health Foundation