

**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 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](mailto:hsmc-kes@contacts.bham.ac.uk)



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