

What works in delivering effective hospital discharge services?

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Effective hospital discharge services are important on multiple levels: for patients, hospital staff and organisations as a whole.

We reviewed¹ evidence from pilots and research articles and good practice guidance on hospital discharge and transfers of care. Here we highlight the factors that enable effective and timely hospital discharge and provide a good practice benchmark against which current hospital discharge practices and processes can be compared. We also highlight the key barriers to effective hospital discharge.

Please get in touch with our Head of Research, [Dr Stephen Boxford](#), for more detail or to continue the conversation.

1 Context

1.1 Key definitions

NHS England (NHSE) defines a Delayed Transfer of Care (DToC) in its Monthly Delayed Transfer of Care Situation Report ([NHSE 2015](#)) as follows:

Delayed Transfer of Care: “*delayed transfer of care from acute or non-acute (including community and mental health) care occurs when a patient is ready to depart from such care and is still occupying a bed. A patient is ready for transfer when:*

- a. A clinical decision has been made that patient is ready for transfer **AND**
- b. A multi-disciplinary team decision has been made that patient is ready for transfer **AND**
- c. The patient is safe to discharge/transfer.”

Assessment is a crucial component of the discharge process, involving examination of a patient’s conditions to determine whether and when they may be ready for discharge. The Department of Health (DoH) has defined assessment as ([DoH 2003](#)):

¹ If you would like details on the methodology used for the literature review, or a full bibliography, please get in touch with the Cordis Bright research team: info@cordisbright.co.uk

Assessment: *“a process whereby the needs of an individual are identified and their impact on daily living and quality of life evaluated”.*

Multi-disciplinary assessment: *“an assessment of an individual’s needs that has actively involved professionals from different disciplines in collecting and evaluating this information.”*

1.2 Why is effective hospital discharge important?

Effective hospital discharge is important in terms of outcomes for patients and quality of care, but also in terms of costs.

Delayed discharges can have an adverse impact on patients’ physical and mental health:

- Staying longer in hospital exposes people to a higher risk of contracting a hospital-acquired infection (such as MRSA or Clostridium Difficile) ([DoH 2010](#); [Bryan 2010](#); and [Jasinarachchi et al. 2009](#)).
- Longer hospital stays can lead to malnutrition and falls ([Jasinarachchi et al. 2009](#)). Jasinarachchi et al. also find that delays in transfer of care in particular are “associated with substantial additional hospital stay(s), occurrence of acute illness episodes and death during the delay.”
- National Institute for Health and Care Excellence (NICE) guidelines suggest that effective discharge helps patients to get good quality and experience of care from both a physical and psycho-social point of view ([NICE 2015](#)). For example, Jasinarachchi et al. have shown that long hospital stays can increase frustration, boredom and low mood ([Jasinarachchi et al. 2009](#)).
- Patients in hospital also tend to become very dependent on the help they get there, and this makes it more difficult for them to go back to their pre-admission routine ([DoH 2010](#); and [Bryan 2010](#)). Prompt discharge can therefore also promote patient independence and ability to make choices about their care ([NICE 2015](#)). A review of 26 early discharge trials showed that patients recovering from a stroke and elderly patients with a mix of conditions who were discharged early were less likely to be admitted subsequently to residential care than those who continued to be treated in hospital ([Shepperd et al. 2013](#)).
- More generally, delayed discharges are usually a sign of poor discharge practices, which can have other negative consequences. For instance, if discharge is not properly planned, patients may be unprepared to go back home or may end up in unsafe environments, in turn making their readmission more likely ([DoH 2003](#)).

Delayed discharge is also a significant issue in terms of effective use of resources and costs:

- Delayed discharges often mean that that medically fit but hospitalised patients deprive others in need of a bed ([Longley et al. 2008](#)).

- Organisations with effective discharge procedures are also likely to have shorter average lengths of hospital stay, reduced rates of re-admissions, and fewer Accident & Emergency (A&E) visits, which represents a reduction in costs per patient ([NICE 2015](#)). For example, Bryan ([2010](#)) and the DoH ([2010](#)) estimate that DToC costs the NHS around £170 million a year. Furthermore, inappropriate discharges that lead to avoidable readmissions are estimated to cost the NHS more than £2 billion a year ([Healthwatch England 2015](#)).

1.3 What is the policy context?

1.3.1 Legislation

The Department of Health has published a number of policies, guidelines and white papers regarding effective hospital discharge. These outline the legal framework around discharge and also make recommendations on good practice.

From a legal perspective, the most important is the [Community Care \(Delayed Discharges etc\) Act 2003](#), which gave NHS hospitals in England the power to charge Social Services Departments (SSD) a daily fee if they are responsible for delayed discharges. The Act also stipulates that SSDs should measure delayed discharges as a key performance indicator (KPI). This is also recommended in the DoH guidance for the NHS and local authorities, *Intermediate Care – Halfway Home* ([DoH 2009](#)).

The Act also introduces Section 2 and Section 5 notifications. A Section 2 notification applies to patients who need input from social services to be discharged. A Section 5 notification applies to patients who have been assessed as fit for discharge, but are still in a hospital bed due to delays in the local authority social care provision.

The core functions of the 2003 act are re-enacted in the [Care Act 2014](#), although the mandatory system of reimbursement from local authorities is amended to be discretionary, aiming to promote more collaborative working. This spirit of integration is also the driving force behind the introduction of the Better Care Fund, which creates shared budgets between health and social care with the aim of providing more joined-up care and reducing delayed transfers of care. One of the Better Care Fund conditions for 2017-19 is “managing transfers of care” ([House of Commons 2017](#)).

1.3.2 How stakeholders should experience hospital discharge

The DoH guidance, *Discharge from hospital pathway, process and practice*, outlines how key stakeholders should experience discharge in an ideal hospital discharge process ([DoH 2003](#)):

- **Patients** feel empowered, they experience a seamless service, understand what is happening and agree to it.
- **Carers** feel valued, they understand what is happening, they have a choice and feel confident.
- **Staff** can make decisions based on the right information, work in an efficient system, feel that their expertise is used, can develop new skills and roles.

- **Organisations** use resources effectively, receive fewer complaints, have lower turnover rates and develop good relationships with the local community providers.

A 2015 survey ([Healthwatch England 2015](#)) investigated service users' expectations of the discharge process. The survey found that they would like:

- To be treated with dignity, compassion and respect.
- Their needs and circumstances to be considered as a whole – not just their presenting symptoms.
- To be involved in decisions about their treatment and discharge.
- To move smoothly from hospital to onward support available in the community.
- To know where they could go for help once discharged.

1.3.3 Official recommendations and good practice guidance

The government and Department of Health recommendations on effective discharge practices are outlined in a range of documents: see DoH ([2000](#); [2001](#); [2003](#); [2005](#); [2010](#)), Delayed Discharges (Continuing Care) Directions ([2009](#)), NHS Interim Management and Support ([2012](#)), NICE ([2015](#)) and the Welsh Health Circular ([2005](#)).

We have grouped these recommendations under the ten headings below.

Stakeholder engagement

- Commissioners and providers should give discharge strategic priority.

Effective leadership

- Good leaders ensure that professional boundaries and silos are overcome and that staff work towards the same goals.

Performance management

- Audit – regularly review the discharge process, analyse long stays to see what went wrong and what could be improved.
- Commissioners and providers should be accountable for performance on discharge processes. Discharge measures should be key performance indicators.

Information systems

- IT systems should be put in place to facilitate information sharing across organisations, and to reduce mistakes and delays.

Integrated care

- Intermediate care, housing agencies and social services should be used as step-down settings for patients who no longer need acute care, but still need some clinical input.

Interventions tailored to patients' needs and wishes

- Patients, carers and their families should be involved at every step of the process. This includes being informed about their health condition and any medication, being notified of discharge plans, being signposted to relevant information and resources and being given time to make informed choices.
- Vulnerable patients, such as those with dementia, mental health care needs or the homeless, should be safeguarded and receive specialist care.

The start and end of discharge planning

- Discharge planning should start as early as possible (even before admission where possible). It should be simple and lean, and occur seven days a week.
- Discharge processes should involve patients, families and carers and consider longer-term planning. Patients, families and carers should not have to make decisions about longer-term residential or nursing care whilst they are in crisis.

Clear and timely patient pathways

- Transitions between hospital and other care settings should be seamless (also referred to as a 'whole system approach'). Health and social care services work together to improve patients' quality of life and experience of care. Services are responsive and stakeholders agree on goals, roles and responsibilities.
- All services should run seven days a week, to avoid delays or lower quality of care at weekends.
- Early supported discharge should be encouraged where appropriate and safe.

Clear and effective communications

- Staff should promptly and effectively share relevant information with each other, with patients, with GPs and with all other people involved in the patient's care.
- Patients, carers and families' feedback should be sought in order to plan discharge and to review discharge processes.

Multi-disciplinary approach

- Staff from different professions should be involved at all stages of the process, from admission to when patients are assessed and then discharged.
- Discharge co-ordinators should be introduced that aim to bring together the multi-disciplinary team (MDT).

2 Effective practice in hospital discharge

2.1 Overview

The government policies and guidelines outlined above make suggestions as to what should be done to reduce the number of delayed discharges. Since policies often make strategic recommendations, this section aims to offer more practical guidance and suggestions.

We have grouped enablers that contribute to reducing delayed discharges around key themes and described examples of good practice taken from pilots and trials run across the country. We also shine a spotlight on key barriers to effective hospital discharge. It is important to keep in mind that there is interplay between all these factors, so it is not always possible to make definite classifications. For instance, leadership, stakeholder engagement and partnership working are intimately related, since effective collaboration across organisations cannot be achieved without giving it strategic priority, having effective leadership and having shared methods and goals ([Bryan 2010](#)).

2.2 What are the key success factors for effective hospital discharge?

This section outlines the key enablers for effective hospital discharge as identified by empirical research.

2.2.1 Stakeholder engagement and effective leadership

As highlighted above, stakeholder engagement and leadership are important in achieving positive outcomes. This is particularly important when trying to deliver change in hospital discharge processes. These processes are complex because they involve several organisations and stakeholders, and affect patients at stressful times in their lives. For instance, if the hospital decided to introduce a new discharge policy without consulting with all other stakeholders, this would lead to delays and probably failure in the implementation of the policy because those that had not been consulted would be excluded from the decision-making process and thus not feel valued. The resulting process is also likely to be of lesser quality than if the hospital had consulted with all relevant parties, utilising their expertise and knowledge.

Stakeholder engagement ensures that all parties are involved in the design phases: this can also lead to effective work agreements, such as the pooling of resources (see relevant section below). Good leaders then continue this process by cascading the messages down to the frontline and making sure that all professionals involved commit to the new strategy. This is all confirmed, among others, by Scott ([2010](#)), according to whom personnel and stakeholder buy-in into the discharge process are crucial to its effectiveness.

2.2.2 Performance management

Performance management is useful for organisations to monitor how they are doing (e.g. via delayed discharge rates) and to know where and when resources are most needed. In its report on patient flow, i.e. the patterns of patients' visits to A&E, outpatients, admissions and discharges, The Health Foundation argues that analysing patient flow can

bring to light a number of improvement opportunities, both for the quality of patient care and the effective use of resources ([The Health Foundation 2013](#)). These pieces of information can then be used to deliver improvements and make a positive impact on patient pathways and hospital processes. In particular, it recommends to:

- Record, analyse and understand patient flow, in order to identify important patterns (when do most people go to A&E, when do most people referred by their GP go to hospital, when do most people get discharged).
- Match capacity to meet demand (review the consultants' and junior doctors' working patterns so that staff are available when patients need them most).
- Develop a Frailty Unit dedicated to elderly patients (using MDT assessments).

On this theme, Anthony et al. ([2005](#)) describe a combination of tools which can help identify what contributes to delayed discharges, which patients are more at risk of being delayed, and where intervention and changes would be most effective. These tools are: probabilistic risk assessments (i.e. estimating the risk of readmission by monitoring patients' age, length of stay, number of prior admissions and Charlson Comorbidity Index); process mapping (the map is given to staff and service users and revised based on feedback); qualitative interviews (for example, survey instruments to assess patients' physical and mental health, substance misuse, social support and nutrition) and root cause analysis. Using these tools, organisations are able to decide what improvements need to be made and where.

2.2.3 Resources

London Borough of Havering and NHS Outer North East London's Joint Strategic Needs Assessment ([2012](#)) provides one example of how resources can be invested into specific parts of the system in order to have a broader impact on other parts of the health and social care system, thus reducing DToc. Havering and partners' approach to reducing DToc was to invest in a series of systemic interventions. These include increasing social work capacity and presence on hospital site, reviewing current arrangements to streamline processes, and enhancing integrated intermediate care services.

They also supported these initiatives by training hospital staff in understanding social care services. From a process point of view, they introduced regular audit of delay cases, to learn from past experience and understand what could be improved. Finally, from a partnership point of view, they shared their learning with nearby partners, thus promoting stakeholder engagement and alignment.

'Resources' does not only refer to budgets and government funding. Human resources initiatives can also contribute to effective discharge, though not in isolation. For instance, Bryan ([2010](#)) recommends employing liaison nurses in A&E and introducing medical assessment units to stop unnecessary admissions (which in turn reduces delayed discharges, because there are fewer people to be discharged). Bryan also argues that discharge co-ordinators are important figures, but that they cannot solve the problem alone. All the other elements discussed above play a role, in addition to staffing initiatives.

The Health and Social Care Scrutiny Review Group ([2004](#)) offers a clear example of how human resources initiatives can make a real difference to improve delayed discharges. Harrow PCT trained their staff at the stroke ward on making a discharge plan at

admission. They also improved the recruitment process and introduced a rotation for staff around all the PCTs wards, in order to enhance the sharing and learning of good practices. These initiatives were supported by good communications between staff, patients and families about the available options post-discharge such as enhanced care in the community. Over a five year period, the stroke ward has reduced its average length of stay from 40 days down to 21-28 days, which the Scrutiny Review Group attributes to the training intervention combined with better care in the community.

2.2.4 Partnership working

Developing good partnerships with those involved in the discharge process is important and closely connected with stakeholder engagement, as highlighted above. For instance, Sunderland's Health & Well-Being Scrutiny Committee (2012) recommend having good working agreements with the voluntary sector and other providers of care in the hospital area. In particular, they suggest:

Making available information about who does what in the organisation, whom to contact for different purposes; sharing training strategies and programmes; staff spending time "shadowing" partners in other sectors or short-term secondments; using the independent sector in formal monitoring mechanisms; sharing records.

This quote is important because it shows that a lot of the themes highlighted in this review, e.g. the importance of good communication practices, IT structures and patient-tailored plans, can have a positive impact for the organisation as well as across the wider health and social care system. The importance of improving partnership working is also stressed by Glasby (2004), who adds that the government should work to remove structural barriers that get in the way of co-operation and collaboration between different health and social care providers.

2.2.5 Information systems

Performance management is now monitored more easily thanks to the use of modern technologies. Information systems and good IT frameworks can support not only the monitoring activities described in section 2.2.2 above, but also the sharing of relevant information between health professionals to speed up the discharge process. A good example of how interventions on information systems can promote effective staff working is offered by Maloney, Wolfe, Gesteland, Hales, & Nkoy (2007). They analysed the use of Patient Tracker, a web-based tool accessible to all clinicians, which reports discharge information and allows clinicians to share information quickly. This achieved 100 fewer cancelled surgeries (20 down from 120) during the three winters following its launch.

2.2.6 Multi-disciplinary approach

The use of MDTs ensures that patients are assessed holistically, meaning that both their mental and physical wellbeing, as well as readiness to go home, are fully assessed. Additionally, involving staff from different professions promotes a seamless journey through different care settings, because non-hospital staff involved in the MDT can liaise with the intermediate care settings they work for and organise the transition.

The ward rounds should be timed properly and involve MDTs to ensure all people involved in a patient's care are kept informed and can give their input. Katikireddi & Cloud

(2008) confirm this when they recommend “close collaboration between the patient, the family, and the MDT” and stress that good handover between all professionals involved in someone’s care is crucial to passing the information needed for discharge correctly and promptly.

The King’s Fund (Gilburt 2016) has recently concluded that whilst some new integrated roles have emerged (notably care navigators and community facilitators) there is very little evidence regarding their impact on patient outcomes. They suggest that changes in the way staff work and integrate may be just as important as the creation of new integrated roles. However, the absence of reliable evidence makes this difficult to prove.

2.2.7 Integrated care, including intermediate care options

The importance of intermediate care has become much clearer in the last 10 years. The Department of Health (2009) identifies intermediate care as a crucial element to improving DTtoC, noting that systematic reviews of intermediate care services have found that they can offer suitable alternatives to treatment in an acute hospital. It also offers this useful definition:

Intermediate care: “a range of integrated services to promote faster recovery from illness, prevent unnecessary acute hospital admission and premature admission to long-term residential care, support timely discharge from hospital and maximise independent living.”

Intermediate care goes further than simply providing a place for people to stay in the form of step-down beds from acute care. For instance, Bryan (2010) shows that intermediate care can contribute to a patient journey even before discharge. Bryan recommends that intermediate care services and social services be involved in patients’ assessments, and that NHS and social care managers meet regularly to discuss discharge. This leads to a fuller and more co-ordinated integration of all care providers and promotes a seamless transition from one to the other.

An example of how intermediate care can successfully address the issue of delayed discharges comes from Crotty et al. (2005). They describe a randomised controlled trial to test the use of a transitional care unit to look after elderly people waiting for a long term care bed. In addition to the transitional care unit, the trial included an early multi-disciplinary assessment, weekly case conferences and family meetings to agree goals. Also, a nurse was made responsible for transferring notes from the hospital to the transitional care unit. The outcome was that, on average, patients spent 11 fewer bed-days in hospital.

More general evidence for the effectiveness of a variety of step-down options from acute care comes from Gaughan, Gravelle & Siciliani (2014):

An increase in the number of care-home beds in a Local Authority by 250 (10%) reduces the number of hospital bed-days lost per month due to delayed discharges by 17 (6%). The number of delayed days is also reduced by an increase in care-home bed levels in neighbouring Local Authorities. There are more delayed days in Local Authorities with higher prices for long term care. An increase in the number of people aged 65+ by 1% increases the number of delays by 1.7%.

2.2.8 Interventions tailored to patients' needs and wishes

As highlighted by several government and Department of Health documents, care should be tailored to each patient's needs. The NHS has acknowledged how important this is and incorporated it into the slogan "*No decision about me, without me.*" This underlying philosophy has a series of important consequences relating to the discharge process. The most important is that patients, carers and their families should be involved at various stages of the admission-discharge process and be given relevant information promptly. According to Scott (2010), staff should also have the opportunity to design, feedback and contribute to the discharge process in order to improve it if necessary.

"No decision about me, without me" also impacts on how staff should communicate to patients and how resources should be invested. This is part of a concerted shift towards focussing on patient centred care.

2.2.9 Clear and efficient patient pathways

In this section we use the term 'pathway' broadly to refer to the movements of patients throughout the hospital, not just the steps identified by hospitals' discharge policies.

It should be clear to a hospital who does what from when a patient arrives at the hospital to the moment when they leave. The discharge process should be simple and follow the Department of Health guidelines highlighted in section 1.3.3.

Reviewing staff timetables to make sure staff are available when demand is higher can ensure assessments are carried out promptly. This has been tested and generated positive patient outcomes at South Warwickshire NHS Foundation Trust and Sheffield Teaching Hospital NHS Trust ([The Health Foundation 2013](#)).

It is also very important that staff act proactively and start planning discharge as soon as possible. This includes assessing patients who are at particular risk of spending a long time in hospital, and several parts of the system can contribute to achieving this. Katikireddi & Cloud (2008) recommend that staff focus on "*anticipat[ing] potential problems by good information gathering and timely referral to the MDT*" and "*taking a comprehensive social history.*" This shows that information systems, partnership working, MDTs and a holistic view of care all play a role in assessing risk and planning discharge properly.

Scott (2010) compared the outcomes of different types of interventions on readmissions and found that the most successful ones were integrated pre- and post-discharge multicomponent interventions. Multicomponent interventions were those that involved discharge planning, patient-carer education, post-discharge services, instruction sheets, home visits and phone calls.

There is also the possibility of bypassing some of the hospital process through schemes such as *Discharge to Assess* ([NHSE 2016](#)). The idea here is that the default pathway is the patient returning home to be assessed, thus allowing them to be in their most comfortable environment, and reducing pressure on hospitals to rush assessments before discharge. Through using this model, DToC were reduced by 25% in three months in Medway, and in Sheffield there was a 37% increase in patients who could be discharged on their day of admission or the following day ([NHSE 2016](#)). The implementation of

discharge to assess can require substantial cultural change in a local healthcare system, again requiring strong leadership and effective partnership working.

2.2.10 Clear and effective communications

When it comes to discharge, it is particularly important that staff and patients communicate clearly about what the patients' needs are, how medications have changed and what help the patient will need after discharge. Staff should also communicate clearly to colleagues and all others involved in someone's care, so that appropriate post-discharge arrangements can be made.

Staff response to patients' needs is a fundamental channel of communication ([Glasby 2004](#)). Communication enhances patients', carers' and families' understanding of what is happening and what needs to be done. This enables them to make choices about their future and necessary arrangements to leave the hospital safely. This level of communication also reduces patients' stress in going back home, because they know they can get support elsewhere. The Agency for Healthcare Research and Quality ([2013](#)) makes detailed suggestions on how to communicate with patients effectively:

Include the patient and family as full partners in the discharge planning process. Discuss with the patient and family [the] key areas to prevent problems at home. Educate the patient and family in plain language about the patient's condition, the discharge process, and next steps [...]. Assess how well doctors and nurses explain the diagnosis, condition, and next steps [...] to the patient and family and use teach back². Listen to and honour the patient and family's goals, preferences, observations, and concerns.

Kripalani, Jackson, Schnipper, & Coleman ([2007](#)) show how good communication can have a positive impact on medication. Medications often change following an admission: this needs to be shared with a patient's GP and clearly explained to the patient. Clarity relating to medicine adherence can promote a patient's confidence to go back home.

2.3 What are the barriers to effective hospital discharge?

This section outlines the key barriers to effective hospital discharge as identified by empirical research, policies and government reports, organising them against key themes from the section above.

2.3.1 Ineffective leadership

The importance of leadership and stakeholder engagement at all levels and across organisations is highlighted by Anthony et al. ([2005](#)) who attribute delayed discharges to the lack of clarity on discharge responsibilities. This is also related to a lack of clear escalation procedures and processes to monitor the performance of all those involved in the discharge process.

² This means asking the patient to repeat back the instructions they have been given, to check that they remember and understand them. The importance of including an element of education in the discharge process is stressed further by (Shepperd, et al., 2013).

According to a report on unsafe discharge from hospital by the House of Commons Public Administration and Constitutional Affairs Committee ([2016](#)), good leadership also involves instilling certain values and priorities throughout an organisation. For example, while staff in many hospitals may feel under pressure to discharge patients quickly, clear leadership can ensure this doesn't take precedence over patient-centred care. Leaders must also allow for clear mechanisms by which staff can raise concerns over the discharge process.

2.3.2 Lack of resources

One important barrier to effective hospital discharge is scarce resources (e.g. funding). An example of how low funding can hinder effective hospital discharge is offered by Bryan ([2010](#)), whose research shows that DToC is often exacerbated by the unavailability of step-down beds, e.g. when domiciliary care is not available, there are no sub-acute NHS beds, or when it takes a long time to find a placement in a care home. She adds that another reason why a step-down bed might not be promptly available is waiting for decisions about social service funding.

The scarce availability of resources can also have a negative impact on staff. For instance, the Department of Health ([2003](#)) links delayed discharges to staff shortages, which result in patients' readiness for discharge not being assessed frequently enough. Bryan ([2010](#)) thinks that staff shortages may also lead to staff feeling pressurised to discharge quickly, and this sometimes means that there is not enough time to do assessments properly.

As an example of how understaffed wards may lead to delayed discharges, Anthony et al. ([2005](#)) show that delays are sometimes due to clinicians not ordering discharge and failing to see the patients, because they have too many patients to see and priority is given to those who are acutely ill. Additionally, they point out that in a significant number of cases mistakes are made with prescriptions; stretched and overworked staff can only make this problem worse.

A lack of resources also affects how many interventions and training programmes human resources departments can put in place. Bryan ([2010](#)) highlights that staff often lack the ability to address systemic issues, and thus delivering training to help them face this challenge could lead to staff being more effective in re-designing discharge processes.

Katikireddi & Cloud ([2008](#)) offer an interesting example of a human resource initiative which is in principle a positive development, but is hindered by a lack of resources and training. They talk about the introduction of a new post (the discharge coordinator) which provides a single point of contact for patients, families and clinicians. However, in practice it is often the junior doctor who takes care of the process. Junior doctors must see a high volume of patients in a small amount of time, and this may have a negative impact on the quality of their assessment input and its timeliness ([The Health Foundation 2013](#)).

Furthermore, we see examples of how a lack in staff and system resources impacts the most vulnerable patients, for instance those with dementia or mental health needs. Due to their condition they require special care, but their discharge is often delayed due to a lack of specialist assessment or finding suitable accommodation post-discharge ([Department of Health 2009](#)).

Moreover, Jasinarachchi et al. ([2009](#)) highlight that country-wide variation in funding to domiciliary care arrangements partly explains variation in DToC rates and the quality of

service received by patients. This regional variation is noted in a session report by the House of Commons Committee of Public Accounts (2016), which calls on NHS Improvement to do more to spread good practice in this regard.

2.3.3 Poor partnership working

Glasby (2004) and Kripalani, Jackson, Schnipper, & Coleman (2007) show that health and social care staff do not always work together as well as they could. Moreover, health and social care often have different ideas about what good practice looks like and work towards different goals. There are a few explanations for this: the distinct financial arrangements for health and social care; the professional silos and boundaries between health and social care staff; and the complexity and bureaucracy of NHS procedures, which often hinder quick and effective discharge.

On the topic of finances, there is a tension between the short-term financial incentive to discharge patients more quickly, and the ability of social care organisations to receive them (House of Commons Committee of Public Accounts 2016). According to the same report, while acute hospitals may fine local authorities for causing delayed discharge, fines are often not enforced and are viewed as an ineffective way to improve incentives by NHS Improvement and the LGA. It is hoped that the Better Care Fund will more effectively promote closer joint working between health and social care organisations.

Further evidence of poor partnership working comes from the dissatisfaction of patients with how their new medication has been explained. A specific lack of partnership between hospital staff and patients/family carers is an issue, as well as poor communication between the hospital and community pharmacists (The Queen's Nursing Institute 2015). This is part of the wider issue of information sharing, which remains a problem between health and social care organisations. Despite having a statutory duty to share patient information, only up to a quarter of hospitals said that they had sufficient access to information for older patients (National Audit Office 2016).

2.3.4 Unclear patient pathways

Clarity and proper planning of the discharge steps are crucial elements for effective discharge. The Department of Health (2003) identifies that the timing of ward rounds can be a cause of delayed discharges, for instance when the round happens at a time when some members of the MDT cannot attend or when patients are away for tests.

The Health Foundation (2013) reinforces this point. This report offers a comprehensive analysis of the problems related to patient flow. It shows that it is very important for a hospital to analyse, track and monitor when patients come into A&E, when they are admitted into hospital, when they are (not) assessed and when the bulk of relevant staff are available. This analysis brings to light if there are any mismatches between demand and capacity.

For instance, as mentioned in section 2.2.9, South Warwickshire NHS Foundation Trust used these data to find out that there was a mismatch between the number of staff available to make discharge assessment, and when such assessments were needed: this meant that capacity could not meet demand at all times and explained why patients' assessments were delayed.

2.3.5 Ineffective communication

The Department of Health (2003) argues that a contributor to delayed and ineffective discharge is the lack of patient and carer involvement in the discharge process. It is often the case that communications between different professionals, patients, carers and their families are not timely and/or clear. For example, a survey quoted in Katikireddi & Cloud (2008) indicates the prevalence of poor communication with patients and carers on discharge: it found that 43% of 2.3 million carers in the UK feel unsupported at discharge, receive no information on what to do and do not know what benefits are available to them.

Poor communication can lead to misunderstandings about when a patient is going to be discharged and the details of the discharge plan (e.g. medication), causing patients stress and worsening their quality of care (see The Agency for Healthcare Research and Quality (2013), Anthony et al. (2005) and Kripalani, Jackson, Schnipper, & Coleman (2007)). For example, Bryan (2010) found that patients are often anxious about being discharged because they are not fully informed about their condition and worry about going home too soon.

Anthony et al. (2005) show how patients and/or staff not being native English speakers can be a barrier to communication and therefore affect discharge. Patients may struggle to understand the clinicians' instructions and if no extra help is provided, such as written instructions, or clear handover of information to the patient's GP or other carer, this can lead to medication mistakes or adherence problems.

Another example of the impact of poor communication is offered by Bryan (2010) and Glasby (2004): when a patient, their carer and family are notified late of discharge, this can lead to delays because they did not have the time to prepare, from both a practical and psychological point of view. For instance, a family may not have had enough time to make the necessary adjustments to welcome the patient back home.

It is worth noting that, while their involvement is crucial to ensuring smooth discharge, families sometimes also present obstacles to discharge. Specifically, this can occur when they see hospitals as providing respite care, or have unrealistic expectations of services available (Connolly et al. 2009, Connolly 2010).

Technology can create much more efficient systems of communication, but can also create barriers to effective discharge planning when fragmented. The situation for many healthcare professionals on the ground is a range of different information systems, creating frustration and making planning and paperwork difficult (QNI 2015).