# Hospital Admissions and Delayed Discharge: Patient Needs and Support

June 2024

healthwatch Greenwich

# Contents

# Executive Summary

This study examined the experiences and perspectives of patients, their families, and stakeholders to understand the reasons behind potentially preventable hospital admissions and delayed discharges. The goal was to identify preventive measures to enhance community-based support and care, ultimately reducing unnecessary hospital stays.

We found that potentially preventable hospital admissions and delayed discharge is influenced by a range of social, environmental, and process factors with waiting periods for home modifications or transition to more suitable accommodation creating a significant challenge. In addition, communication between patients, families, and hospital staff can be lacking, leaving patients and families confused or in the dark about the reasons for prolonged hospital stays.

Gaps in awareness among patients and families about available community resources were noted, potentially missing opportunities for increased support that may have reduced the need for hospital admission. None of the patients and families we spoke to were aware of the extensive range of community resources that could assist in managing health and social conditions effectively at home.

A lack of trust in community resources was also identified. When patients and their families don't know the options available to them, they are less likely to feel trust and confidence in seeking out or using these services. Additionally, some patients and families perceive resources as less competent or less reliable than statutory services, further increasing reluctance.

Partially driven by personal preferences, cultural values, or previous experiences with health and care services that have not been positive, many patients prefer to manage their support needs independently within

their social/family networks. Reluctance to consider use of external community resources was expressed both by patients with strong support networks and by those who were isolated with little or no access to support networks. Interestingly, families were often more open and welcoming to the use of community support for their relative, particularly those who were unable to provide this support themselves.

Stakeholders providing access to community resources within Queen Elizabeth Hospital report opportunities to increase capacity and a desire for more referrals from hospital staff. Despite the availability of these resources, suitable patients do not always receive the referrals or information needed to access them. Stakeholders suggest hospital staff may have limited or inconsistent knowledge about the range of community resources available, leading to missed opportunities to increase support in the community.

Key findings emphasise the need for increased awareness of community-based resources amongst patients, families, and hospital staff, building trust by addressing cultural and personal concerns, and simplifying the process of accessing these resources.

# About

Healthwatch Greenwich (HWG) is an independent, statutory organisation representing people and communities who use NHS and publicly funded health and care services in Greenwich. We carry out qualitative and quantitative engagement and research on a wide variety of health and social care topics. Our mission is to drive change, campaign for, and influence commissioners and providers to ensure the design and delivery of services is equitable for all.

# Acknowledgements

Healthwatch Greenwich would like to thank the patients and their families who participated in this research study. We would also like to thank the staff on wards 14, 22, and 23 at Queen Elizabeth Hospital who helped with this project. Special thanks to Poornma Almas, and Pauline Rafferty and their teams for their input, guidance, and encouragement.

# Aims

1. To explore reasons behind potentially preventative hospital admissions and delayed discharge through the experiences and perspectives of patients and their families.

2. To investigate potential preventive measures that could have been implemented to avoid these admissions and promote community-based support and care.

3. To triangulate data and insight provided by other agencies to provide a rich source of information on patient support and needs post discharge.

# Methodology

## Data collection

Supported by ward staff, patients were recruited from wards 14, 22, and 23. Ward staff identified patients classified as "Pathway 0" discharge category for inclusion. "Pathway 0" refers to patients who can be discharged with no need for new or additional health or social care support.[1]

## Interviews

19 in-person/in hospital interviews with patients and their families were completed. The distribution was as follows:

- Eleven participants - patients only.
- Four participants - both patients and their families.
- Four participants - families speaking on behalf of patients due to language barriers or health issues.

Each interview took up to an hour and participants received a £40 shopping voucher as a thank you.

### Participants

Participants included twelve females and seven males.

Most participants identified as White British (12), followed by Black African (5), British Indian (1), and White European (1).

Participants were distributed across different age groups as follows: 25-49 (3), 50-64 (4), 65-79(7), 80+ (5).

[1] https://www.gov.uk/government/publications/hospital-discharge-and-community-support-guidance/hospital-discharge-and-community-support-guidance

# Findings

### Hospital admissions

Of those we spoke to, hospital admissions were due to a variety of medical factors. Reasons included accidental falls, respiratory conditions, gastro-intestinal difficulties, blood disorders, liver conditions, substance abuse, diabetes-related complications, and dementia. Some admissions were linked to poor self-management of health conditions at home. A proportion of families expressed concern that relatives were unable to manage their health conditions at home and needed more support to do so, examples given included help with wound care, medication management, and mobility assistance. Keeping up with daily tasks and maintaining a routine were identified as ongoing challenges.

Overall, families can and do help, but while some are able to offer additional support, many cannot as they do not live locally and/or have their own life/work/other commitments. In addition – for those families able to offer support, the effectiveness of this support depends heavily on their knowledge and skills, with many suggesting they themselves were confused or did not know enough to be able to help and they felt limited in their ability to support relatives effectively at home.

In addition to the primary medical reasons for admission, patients and families told us they faced challenges related to their living environments. The need for home modifications or more suitable housing, mobility issues, and other practical day-to-day challenges exacerbated health problems, with some suggesting poor or unsuitable housing led to hospitalisation.

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*"She's on the 5th floor, there are lifts that sometimes aren't working. As she opens her door, there are stairs to get up into her actual flat. And that's where she was falling… "*
*-Family of Patient 16*

*"I'm so angry because all of this has been caused by the housing association [boiler breakdown, no heating or hot water for 2+ months], they have caused this issue. If they had sorted this out, my daughter would not be here."*
*-Family of Patient 13*

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**Delayed discharge**

At the point of our interview, duration of hospital stays varied greatly from a few days to weeks, and some were further extended by delayed discharge. Reflecting housing challenges, common reasons for extended stays and delayed discharge included waits for necessary assessments or information, particularly for housing needs or home modifications. Many of the patients we spoke to required specific assessments to determine the suitability of their living conditions. These assessments are essential for identifying what changes are needed and ensuring changes are made before the patient can safely return home. However, the process of scheduling and conducting assessments, followed by the actual implementation of any changes, can take some time. For those requiring placement in accommodation such as assisted living facilities, nursing homes, or specialised housing, the process can be complex. The availability of accommodation is often limited, and the administrative processes involved in securing a spot can be lengthy.

Lack of communication between patients, families, and hospital staff can add further complexity. Many of those we spoke to felt 'in the dark' about the reasons for delay. This can lead to confusion and frustration, as they

are uncertain about what steps are being taken, what is causing the hold-up, and what they can do to help expedite the process. This communication gap can further extend delays by contributing to misunderstandings, missed appointments, or incomplete preparations for discharge.

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*" ...no one's really said very much about when I'm going home or what's happening."*
*-Patient 16*

*"My sister got a call from the discharge team saying that they was gonna discharge her [mum] the next day. We were then told you can call back and speak to a doctor, which we tried to do several times...and then we were told, oh, no, they're not discharging her. And then last week, another nurse said that she [Mum]was going to be discharged. So, it seems like a lot of miscommunication as well, which is obviously really stressful"*
*-Family of patient 16*

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**Role of family and the need for community support services**

The need for home modifications to reduce accident risks and improve health and mobility was frequently mentioned. Lack of assistance with domestic tasks like cleaning, shopping, cooking, and gardening was also a concern both for patients and for families unable to give this support. In addition, some raised needing help to manage and coordinate multiple health and care appointments/assessments.

Families, rather than patients themselves, frequently raised social isolation as a worry. For example, they noted that relatives living alone often lacked daily social interaction needed to maintain mental and emotional well-being. Families spoke about isolation contributing to neglect of personal care, increasing the risk of falls or other health concerns that may necessitate hospital visits.

Moreover, families expressed concern that without greater social interaction, health outcomes after discharge were likely to be poorer. For instance, they suggested that relatives who returned to an isolated environment were less likely to stick to medication schedules, organise follow-up appointments, or actively keep themselves fit/healthy.

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*"I could go out if someone takes me to the bus stop. I can get on the bus provided I haven't got to walk anywhere in the other end and that's it. I haven't been to the shop for five years. I mean, I can't go out and buy a birthday card."*
*-Patient 14*

*"...I think [day centres] would help him a lot. Because when he's indoors, he's just sitting, watching telly. But then at the end he got fed up with that. Yeah, he's finding everything boring."*
*-Family of Patient 12*

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Patients often rely on their families and informal support networks for help, turning to familiar and trusted sources for assistance during and after their hospital stay. This reliance is driven by several factors, including trust, close personal bonds, cultural norms, and the immediate availability of support that family and friends can provide.

The immediate and flexible nature of family support often makes it more adaptable to evolving needs compared to community resources. However, there is also a belief that community resources are not readily accessible or are unlikely to meet their specific cultural, linguistic, or religious needs. Moreover, within some communities it is expected that families will take on this role. Cultural expectation can be a significant influence. For some, seeking external help might be seen as a failure or might carry a stigma. As a result, patients rely more heavily on family support networks, even if doing so is not always ideal. While family support networks are invaluable, they also face challenges.

The burden of providing support can lead to physical, emotional, and financial strain on family members, particularly if they lack adequate support and resources themselves.

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*"it's largely around dropping in and seeing her [Mum] or seeing if there's anything she needs or food prep and stuff like that. But I mean, I work full time. My sister works part time and has two autistic kids. So it's it's not really easy for us to find, you know, time to [support]."*
*-Family of Patient 16*

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Expanding community resources or making available community resources more accessible by raising awareness may address some of the concerns of both patients and families. Targeted and tailored public awareness campaigns may help destigmatise the use of external resources for some communities and increase knowledge about available resources, encouraging seeking assistance without feeling a sense of failure. In addition, reviewing the cultural sensitivity of community services and demonstrating their ability to meet cultural, linguistic, and religious needs might reassure patients and families and rectify assumptions.

## Stakeholders: Key insights

### Stakeholder Group 1

This stakeholder provides a discharge 'take home and settle' service. Patients unable to use public transport, or transport themselves in their own vehicle, or without friends/family to transport them, are escorted home by a support worker in a private car.  On arrival a brief check is made of the environment for safety and comfort, for example to ensure that electricity is available and that a telephone and TV remote control is within reach.

Small domestic tasks are carried out, if needed, such as buying a few food items, provisions for the patient to make a drink/snack. In addition, handy-person tasks such as installing a raised toilet seat are also completed at the drop off. A follow-up call is made a day later, to check-in with the patient and to ask if any further help is needed for which patients are either supported directly or referred/signposted on to other organisations.

The take home and settle service is an important resource for patients as it provides immediate reassurance during the transition from hospital to home. By escorting patients, the service ensures they get home safely and are not left to struggle to make the journey alone. Safety and comfort checks at home remove worry about immediate necessities. The follow-up call the next day offers further reassurance and identifies any further needs. Internal monitoring by the provider suggests this service reduces patient anxiety, minimises potential hazards, and creates a comfortable transition back to home life.

For hospital staff, the take home and settle service reduces delays in discharge created by a lack of transport options. Moreover, knowing that immediate in-home needs and safety checks are taken care of, allows staff to discharge patients with greater confidence and peace of mind.

**Stakeholder Group 2**

The second stakeholder uses motivational interviewing[2] to offer/encourage use of a social prescribing service, linking patients with projects and community groups to get involved with. They also carry out small household tasks, if needed, such as food shopping, and handy-person tasks like installing key safes and moving or installing furniture. They also check-in with patients after discharge and assess any further needs.

[2] Motivational Interviewing is a way of talking with people to help them find the motivation to make positive changes in their lives. https://www.educationalwave.com/pros-and-cons-of-motivational-interviewing/

Those they cannot accommodate within their social prescribing network are referred or signposted on to other organisations.

By linking patients with community projects and groups, this resource addresses the some of the social determinants of health, such as loneliness and lack of social support. Practical assistance with tasks like food shopping and installing key safes enable patients to function independently at home.

For hospital staff, social prescribing facilitates a more holistic discharge process that goes beyond addressing immediate medical needs and looks at the broader aspects of a patient's life that influence health outcomes. By encouraging patients to engage in healthy behaviours and participate in community activities, this service begins to tackle key contributors to many health issues.

**Collaboration between hospital and community support services**

Stakeholders explained the steps they take to make sure that hospital staff know about their services/resources available to patients. One of the main ways they do this is by giving leaflets to staff directly and leaving leaflets for staff on wards.  These leaflets provide an overview of the resources, and the criteria for referral.  Regular updates through emails and newsletters to hospital staff are also used to try to keep the resources front of mind.

Another important strategy is directly engaging with specific wards and/or giving regular presentations at staff meetings. Stakeholders visit wards to explain their services in person, answer questions, and address any concerns. This was identified as the most effective method in generating referrals from hospital staff.

Relationship with the discharge team was identified as critical and both stakeholders noted very positive and collaborative relationships with discharge staff. Indeed, one stakeholder was based in the discharge

lounge allowing for rapid referral of patients. The other stakeholder, not based in the discharge lounge, used regular calls to the discharge team to remind staff about their service and identify referrals.

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*"[We] expand [hospital staff] knowledge about what we do - plus expand our knowledge of what they [hospital staff] need us to do… Our staff being on site, our brand being present, and people getting to understand what we do."*

*-Stakeholder 2*

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Despite promotional efforts and ongoing marketing, challenges exist and both stakeholders shared similar concerns that resources were not always fully utilised and they had capacity for more referrals from hospital staff.

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*"…lots of people say, 'Yep, we know you're there', but not everybody uses us. I think people are so used to doing what they're doing, which is to pick up a phone for hospital transport, which I understand might be the best thing for them, but it's not always gonna be the best thing for their patient."*

*-Stakeholder 1a*

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Staff movement was identified as a challenge. Staff turnover made it harder for stakeholders to ensure key hospital personnel were always aware of available community resources. New staff members were not always briefed or familiar with the support available to patients. Stakeholders worried that lack of awareness could lead to missed opportunities to refer patients to their services.

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*"High turnover of [hospital] staff is the problem really, to be honest. It's our main issue.....recently we had somebody leave on one of the wards and you know, they were a real champion of us. And they used us a lot and then nothing had been sort of passed on to the new staff member, so we just stopped receiving referrals from that ward."*

*-Stakeholder 1a*

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For hospital staff, the presence of two resources with some overlapping similarities may create uncertainty. Staff may find it difficult to differentiate between them, adding to their administrative workload. For patients, being offered two similar resources could be confusing and may contribute to a sense of being overwhelmed during an already stressful time.

**Communication and preparation issues during discharge**

Stakeholders shared examples of challenges with the hospital discharge process. These included, waits to collect medication, delays in patients receiving discharge paperwork, poor communication between patients/families and staff, and a lack of clarity regarding responsibility for patient care post-discharge. Patients ready to leave hospital but unable to do so because their prescriptions had not been filled or essential discharge documents had not been completed was not uncommon. While these delays are multiple hours rather than days and are inconvenient for patients, they also contribute to inefficiencies for stakeholders as their capacity to deliver their service is reduced while waiting.

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*"So you're sitting around waiting to go, and the patient is sitting around waiting to go, but the paperwork is not ready, so we can't go. I've told this to a number of people in the hospital..."*

*-Stakeholder 1b*

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In addition, stakeholders suggest their conversations with patients sometimes revealed poor communication between patients/family and staff. Not all patients understood their discharge plans, medication instructions, or follow-up care arrangements. In addition, a lack of clarity regarding post-discharge care created confusion.

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*"...biggest issues we face, cause you've got somebody who's just left hospital - so now the hospital say they're now community responsibility, so the hospital won't deal with them. So then you go to community and they say, well, they've just come out of hospital, so it's the hospital's responsibility." Stakeholder 1a*

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# Conclusion

While hospital admissions amongst our small sample resulted from a wide range of medical conditions, interestingly, a significant portion of these admissions were attributed, by patients or their families, to poor self-management of chronic conditions at home. In their view, this often stemmed from a lack of appropriate support and resources, leaving patients vulnerable to health crises, and needing hospital care.

Environmental factors, particularly unsuitable housing, and a need for home modifications, played a role in exacerbating health problems. Patients and families told us that inadequate living conditions, such as the absence of functioning lifts in blocks of flats, a lack of internal maintenance, and unsafe environments, directly contributed to poor health.

Perhaps unsurprisingly, a large proportion of delayed discharges amongst those we spoke to were due to waits for necessary assessments and

home modifications. Patients requiring specific housing adjustments or placements elsewhere faced delays. Delays were further compounded by a lack of clear communication between hospital staff, patients, and their families. Patients and families reported feeling uninformed about discharge plans and the reasons for delays, leading to confusion and frustration.

Community resources facilitate the transition from hospital to home and offer continued support afterwards. Community resources offer practical assistance and begin to address some of the social determinants of health, such as loneliness and lack of social support. While robust outcome evaluations are yet to be produced, these services suggest initial benefits in reducing anxiety, and encouraging participation in healthy behaviours.

However, awareness of community resources was low amongst patients and families and many patients showed reluctance to engage with community resources. Patients, when needing help, preferred to call on their family and informal support network. Reliance on these networks was driven by trust, cultural norms, and immediate availability.

# Recommendations

1. **Housing Safety and Home Assessment**

- Review the home assessment and modification processes to identify bottlenecks and inefficiencies. Review should be driven and shaped in collaboration with residents/patients and families.

2. **Community Resources**

- Information on community resources and how to access them to be provided to patients/families as part of the discharge process.
- Increase information available to all patient facing hospital staff on community resources. Information should include details on how to refer or signpost patients/families, and the benefits of doing so.
- Collaborate with community leaders and influencers to promote community resources by demonstrating the cultural sensitivity of these services and their ability to deliver support that meets cultural, linguistic, and religious needs.

3. **Discharge and Communication**

- Review discharge procedures, including medication fulfilment and paperwork completion, to reduce unnecessary delays.
- Review written discharge information provided to patients and families. Review should be driven and shaped in collaboration with residents/patients and families.

4. **Evaluation**

- Evaluate the effectiveness of community resources: Measure impact on patient outcomes, such as readmission rates, patient satisfaction, and overall health and wellbeing improvements.

# Limitations

- Most participants were White British. Patients/families from other ethnicities/backgrounds may have distinct experiences not captured within this report.

- Age distribution skews towards older adults (65+), potentially overlooking the perspectives, experiences, and needs of younger patients.

- Grouping mix of health conditions together could obscure the specific challenges, needs, and experiences associated with each health condition.

- Recruitment process was challenging due to a lack of familiarity among hospital staff with the terminology "Pathway 0."

# Response from Provider

Healthwatch was established in 2013 in accordance with the Health and Social Care Act 2012. Within this legislation Healthwatch has a right to a reply within 20 working days to reports and recommendations submitted by Local Healthwatch to a service provider/commissioner.

Report & Recommendation Response Form

| | |
|---|---|
| Report sent to: | Kirsty Price <Kirsty.Price@royalgreenwich.gov.uk> |
| Date sent: | 19/6/24 |
| Title of Report: | Hospital Admissions and Delayed Discharge: Patient Needs and Support |
| Date response required by: | 18/7/24 |
| **Response** | If there is no response, please provide an explanation for this within the statutory 20 days.<br>**Please note: This form and its contents will be published by Healthwatch Greenwich.** |

| | |
|---|---|
| Date of response provided | 5/7/24 |
| General response to the report[3] | This report from Healthwatch is invaluable in understanding the experiences of people being discharged from hospital on Pathway 0 and those who are attending hospitals, sometimes ending up being admitted. The report highlights that it is not always about gaps in service provision but how we ensure we connect people to services and community based resources and ensure they are having meaningful impact. It also highlights the importance of staff awareness of those resources, communication methods and tailoring to different resident needs and how they can use their knowledge to advise residents in the best way possible. |

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|---|---|
| Response to recommendation 1. **Housing Safety and Home Assessment** | Connecting people with support to improve their home environment is a key priority to ensure people are able to stay at the place they call home for longer and reduce the need for more dependent settings. The Local authority has begun work to review the Housing Adaptations policy and its processes for ensuring people can access which aims to ensure more people have access to minor adaptations to improve their home environment. |
| Response to recommendation 2. **Community Resources** | Part of the Greenwich Home First communication strategy is to ensure people and stakeholders can be connected to support, by enabling staff to make sure every opportunity to connect people is made. Work is also ongoing to ensure we have the right community resources in the right places to meet our residents needs. |
| Response to recommendation 3. **Discharge and Communication** | The recommendations in this report will be shared with our Home First partners including the hospital to ensure a collective response and actions are taken forward against the recommendations where these are not already underway |
| Response to recommendation 4. **Evaluation** | The recommendations in this report will be shared with our Home First partners including to ensure there is a collective oversight of the effectiveness of community resources and that we build in time and resources to evaluate what is working and what changes need to be made where we find areas for improvement We also recognise the importance of hearing our residents views and we continue to build on our approaches to hearing peoples lived experiences and working alongside them to review, design and implement local services. |
| Signed: | |
| Name: | Kirsty Price |
| Position: | Head of Integrated Commissioning & System Development |

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