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REPORT
17

Seamless Care or Patchwork Quilt?

Discharging patients from acute hospital care

Linda Marks

King's Fund Institute

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Discharge policy is not virgin territory and many experts in the field contributed to the shape of this report. Special thanks go to Jackie Birmingham for her insights into US discharge policy, Sue Armitage for her perceptions of the role of liaison nurses and Steve Kendrick for information on readmission rates in Scotland.

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Any errors of fact or interpretation remain, of course, my own.

Summary

Discharge policy and practice in the UK are remarkable in at least two ways. First, is the consistency of research findings, stretching back over at least twenty years, which document the breakdown of routine discharge procedures. Second, is continuing evidence of major gaps in the discharge planning process, despite government guidance and a host of initiatives at local level. The goal of 'seamless care', for which the quality of discharge arrangements is a reasonable proxy, is not easily achieved.

Discharge does not take place in a vacuum, but reflects tensions between professional groups, between health and local authorities and between national guidance and local possibilities. Chapter 2 of this research report summarises three areas of discharge-related research: the experiences of elderly people and their carers; difficulties for those whose task is to manage acute beds; and communication between hospital and community-based professionals. These perspectives have all influenced the shape of the discharge agenda.

Chapter 3 draws attention to an emerging management agenda, documenting the impact of government guidance on discharge (in the form of the circular HC(89)5) as well as the additional demands of the NHS and Community Care Act 1990. Comparisons with discharge planning in the US illustrate that discharge policy in the UK could usefully be viewed as a discrete area for management concern and professional development.

Discharge policy is also influenced by changes in acute care. These changes include the continuing trends towards shorter lengths of stay; the decline of in-patient convalescent care; the reduction in long-term care beds in the NHS; and the development of numerous initiatives in providing acute levels of care in the home. Chapter 4 explores the effects of each of these developments on discharge practice in acute hospitals. It also discusses the usefulness of early emergency readmission rates as one way of monitoring the quality of discharge arrangements at a time of great changes in acute care.

By definition, discharge spans organisational and professional boundaries. While managerial changes within any organisation can address some of the problems identified, management fiat is by no means an adequate response. Chapter 5 of this report identifies areas of policy uncertainty, where joint approaches, sensitive to local options and individual circumstances, are required. Even here, however, conflicts between national policy and local opportunities can muddy the discharge process. It is therefore important to debate and clarify at national policy level rights of access to post-discharge care, and not to cast such fundamental questions as local management issues. The implementation of the NHS and Community Care Act makes it a matter of urgency that these issues are now resolved.

Introduction

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Hospital discharge arrangements involve bridging the gap between hospital and home. Discharge is a cipher for the organisational integrity of the NHS and indicates difficulties involved in implementing policies which span both hospital and community sectors.

Concern over the discontinuities of care across hospital and community services has characterised the NHS since its inception and is reflected in current debates over how best to achieve seamfree – or seamless – care. Historically, solutions have been sought as part of major administrative reorganisations, such as the first attempt to streamline the tripartite NHS in 1974. The Reorganisation Act of that year placed a statutory obligation on the new health and local authorities to cooperate with each other through Joint Consultative Committees, a clear recognition that such cooperation was both necessary and difficult to achieve. Subsequent reorganisations have reinforced managerial aims of clear lines of accountability within different sectors. However, they have been less successful in achieving coordination across different care frameworks, and therefore in ensuring the easy passage of patients who regularly cross administrative boundaries. In other words, problems of the discharge process have not been surmounted. Those pursuing the goals of seamless care in the new NHS of the 1990s can usefully found their endeavour on an analysis of the discharge process, its successes and its failures.

Ironically, the nature of health care delivery within a national health service has diverted attention from the need for managerial clarity throughout the discharge process. In-patient care is largely accessible and free at the point of delivery. Care is open-ended and referral from hospitals to primary care and social services has traditionally been routine rather than a subject for negotiation. This contrasts with health care systems such as that in the US where reimbursement criteria mean that hospital admission has to be justified, continuing in-patient care negotiated and discharge legally defensible. It is not surprising that in the US context, discharge has emerged as a discrete area for management action and professional development. This rather different approach is further discussed in chapter 3.

While in the UK management action in this area has been tardy, there has been no shortage of research on the discharge process. This is partly because of its intrinsic importance for patient well being and the quality of care, and partly because difficulties in the discharge process reflect organisational, professional and policy tensions within the NHS and have therefore been of interest to researchers in these fields. The large body of research, carried out over at least the last twenty years, is remarkable for the consistency of its findings. Problems of communication, coordination and information transfer have been routinely identified. Thus different professionals within a hospital may adopt different approaches to the timing and the process of discharge; communication between hospitals and primary care is often weak; and overlying these problems are differences in priorities, organisation and culture between health and local authorities. Chapter 2 provides a background to the discharge field outlining research findings from three different perspectives: elderly people and their carers; those concerned with the management of acute beds; and professionals at the receiving end of inadequate information exchange between the hospital and community sectors.

Central guidance on hospital discharge finally appeared in the form of the discharge circular HC(89)5 and an accompanying booklet. A detailed account of this circular appears in chapter 3. However, discharge-related problems are remarkably persistent, and are evident beyond the period of implementation of the circular.

The discharge process also reflects deeper concerns, less amenable to management action and administrative reform. Discharge from hospital often involves the transfer to another location for continuing care, and this is particularly true for frail elderly people, a group where the failures of discharge have been reiterated with depressing regularity. The ability to 'successfully discharge' this group implies clarity about the kinds of services that should be freely available for dependent elderly people, and at what level of need. In a discussion of ethical disputes in discharge planning, Abramson (1983) points out that policy disputes over elderly people and

> *... the amount of money that ought to be spent on their needs as opposed to other sub groups of the population and the nature of our obligations to care for the very old are macro ethical issues that get translated into micro ethical quandaries in clinical practice. Many of these quandaries surface in the discharge planning process where issues of access and equity; institutionalisation and deinstit-*

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THE PROCESS OF DISCHARGE

The process of discharge may start before admission and continue beyond in-patient care. As a minimum it encompasses screening, in-patient assessment and a discharge plan.

Pre-admission assessment

Possible for day cases and planned admissions through pre-admission clinics, or visits by health service staff, plus information from community services. It may include laboratory and x-ray tests.

Admission procedures/case finding/screening

This involves assessing needs for care during a hospital stay and after hospitalisation for all patients and identifying patients at 'high risk' for discharge planning. This includes the development of screening criteria for discharge planning in relation to diagnosis, disability, follow-up care needs, social support and home circumstances, age, home responsibilities, and multiple or recent emergency readmissions. There should be clear triggers for referral to social services, therapists, dietitians and other professionals. Information should be provided as early as possible to patients, families and carers about expected lengths of stay. Where discharge problems do not exist, this should also be documented.

In-patient assessment and preparation of a discharge plan

This is the most complex part of the process, and may require multi-disciplinary assessment(s), including the views of community staff, and should always involve the patient and family. Assessment instruments may cover functional needs, medical needs, readiness for discharge, rehabilitation potential, level of care need, resources available, available services and capabilities of patients, families and carers to carry out the discharge plan (see Birmingham, 1991). Discharge planning involves early identification of home support, pre-discharge assessments of the home and of the needs of carers, as well as communication between relevant professionals within the hospital, between hospital and community staff and between hospital staff, patients and their relatives. It requires coordination across acute and primary care as well as social services. There should be advance notice of the day of discharge for patients and relatives. The resulting discharge plan should be modified as necessary throughout the stay. Discharge planning information which may be contributed by many different professionals should be part of one discharge plan, incorporated within the patient record, often the most important vehicle of information between different health care professionals. It should be clear where responsibility for coordinating each plan lies.

Discharge from hospital and implementation of the discharge plan

This should be consistent with the assessment. In the US, for example, information on the discharge note may include a summary of the care plan, of instructions given to the patient and family, a note by the nurse of the mental and emotional state of the patient, nutritional intake, and functional limitation as well as information on referrals and services requested. All professionals who participate in the discharge process should write a note for the final phase of discharge. Transport, medication, communication with the GP with date of discharge, written discharge information for patients and carers (incorporating details on the treatment, the condition, follow-up medication and possible side effects, instruction for patients in self care if needed and for relevant carers) should be included. Details of the actual discharge, such as the person accompanying the patient home should also be recorded. All this information, including written instructions given to the patient should be included on the medical record.

Monitoring

Audit of discharge needs to be broad-based, and not limited to monitoring the administration of hospital-based procedures. First is the question of follow-up to ensure that the discharge plan has been implemented. More generally, there are a number of options for monitoring the quality of discharge arrangements. These include analysis of early emergency readmissions and special surveys of patients, GPs and other primary care and social services staff as well as routine mechanisms for obtaining feedback on unsuccessful discharges and the effects of hospital discharge policies on the workload of community services. Complaints can also play a part in monitoring discharge. From the perspective of implementing efficient bed management, regular bed utilisation reviews and discharge review groups are able to provide regular assessments of the contribution of discharge policy to the problem of delayed discharge or inappropriate use of hospital beds.

Crucial to each element of this process is accurate documentation. In the US, where the medical record – the legal business record of a health care institution – is used to evaluate the quality of care and to determine payment of services, accurate record keeping assumes a centrality not yet in evidence in the UK. (A detailed account of both the discharge planning process in the US and relevant documentation for discharge can be found in Birmingham, 1991.)

> *utionalisation; individual, familial and societal responsibility surface to present moral conflicts for those involved in the process* (p. 46).

While, as chapter 2 demonstrates, administrative problems of discharge have still not been overcome, the discharge process is constantly framed by wider considerations: important among these in the 1990s are changes in the boundaries of acute care, and the major policy reforms encompassed in the NHS and Community Care Act 1990. Changes conveniently subsumed under the rubric 'changing the boundaries of acute care' include the range of initiatives for providing hospital levels of care in the home as well as gradual and often unmonitored shifts in what is considered appropriate for acute in-patient care. As hospitals focus on specialised and interventionist care for acute phases of illness, so convalescence and long-term nursing care become displaced. This in turn raises questions about the rights of elderly people to free NHS nursing care on a longer-term basis and responsibility for providing and paying for alternative sources of convalescent care. Likewise, the NHS and Community Care Act 1990 renders local authorities responsible for the budget for publicly financed nursing and residential care. How will this affect equitable access to such care and how will the relationship between needs assessment and levels of provision vary across the country? The implications of these wider changes for the discharge process are explored in chapter 5.

It is worth noting that a number of issues are often separately identified and discussed: problems for professionals, managers and of course elderly people themselves when discharge procedures are poorly thought out or when they break down; the implications for discharge policy and practice of changes in the boundaries of acute care; and finally, arrangements for the discharge of highly dependent people. A major argument of this report is that discharge planning should be thought of as a process and that a comprehensive policy should encompass the spectrum from routine discharge to high dependency care. As a backdrop to this argument Box 1 illustrates the process of discharge. In recognition of their different histories, however, the structure of this report reflects and separately documents each of the three areas outlined above.

A further theme of this report is the importance of distinguishing the levels on which discharge problems should be resolved. There is much scope for management initiatives at local level and some of these are discussed. Likewise, the contract culture enables purchasers to stipulate standards of discharge and many hospital care at home initiatives show what imaginative discharge arrangements can achieve. However, ambiguity and lack of guidance at a national level on policy issues such as rights and access to care will be reflected in ambiguity in the discharge process. This inappropriately casts as a local level management concern issues of national policy importance and impacts on patients and carers at this time of great vulnerability. This report argues that the discharge process should be viewed as a discrete area for research and development and that links between discharge difficulties, local management problems and areas of wider policy concern be distinguished and clarified.

2 Discharge problems: three perspectives

There is a substantial literature on the failures of acute hospital discharge. Three main strands can be identified.

- One set of difficulties may be experienced by vulnerable groups, particularly frail elderly people, when they are discharged home with inadequate preparation or without suitable arrangements in place in the community.
- Another problem is that of delayed discharge, which results in the inappropriate or inefficient use of acute beds and can create further difficulties when pressure on acute beds is severe. This can, in turn, result in premature or precipitous discharge for patients.
- The final failing is the poor quality of communication between professionals in hospital and in the community, and more broadly, between health and social services.

This chapter summarises well-documented problems of discharge from these different perspectives and identifies possible solutions with regard to better administration and management of what are, by now, well accepted principles of discharge planning.

Elderly people at risk

Evidence of the ways in which discharge procedures fail elderly people has been collected for over twenty years (see Russell and Read 1986, for bibliography), and research findings have been strikingly consistent over the whole of this period – a point made by several commentators in the field (see, for example, Cass, 1978). Three groups took the lead in identifying problems encountered by elderly people as a result of poor discharge practice and inadequate post-discharge support: professionals involved in the care of elderly people; Community Health Councils; and voluntary agencies. Their different perspectives inevitably also influenced the solutions adopted. A summary of the main groups involved during the 1970s and 1980s follows.

Creating the discharge agenda

Professional concerns

Physicians concerned with the care of elderly people, and with developing progressive policies of patient care, were among the first to identify problems post-discharge (Brocklehurst and Shergold, 1968). From the late 1960s, too, departments of nursing research and hospital departments of social work carried out surveys of elderly people discharged from acute wards in order to identify unmet needs (see, for example, Hockey 1968; Skeet 1970; Hirst 1976). Pioneering research in this field was instigated by the Dan Mason Nursing Research Committee which commissioned Muriel Skeet to carry out a study of the home care needs of discharged hospital patients (Skeet, 1970). In 1980, the same author, in conjunction with the *Nursing Times,* produced an information pack on discharge procedures and the nursing process. This attempted to address the problems of poor communication between hospital and community sectors and the lack of awareness of the importance of early and continuous discharge planning. A further review of discharge practice by Skeet, under the auspices of the Continuing Care Project (1985), confirmed the persistence of these problems.

Despite the involvement of professionals in carrying out research and in framing discharge policies, few professional organisations have produced specific guidelines on discharge, although recommendations may be incorporated into broader statements related to quality assurance and standard setting. An important exception was the joint statement by the British Geriatrics Society and the Association of Directors of Social Services (1989) on the discharge of elderly patients into the community. They claimed that 'many people are discharged from hospital with inadequate arrangements for their future care'; that this could precipitate hospital readmission; and that the many occupational groups sharing some responsibility for discharge 'sometimes differ in their understanding of the needs of elderly people, how they can best be met, with often little evidence of shared values or common operational philosophy' (p. 1). They offered a series of proposals for preparing discharge plans, communicating with community services, and evaluating discharge procedures, along with a checklist of practical arrangements to be completed prior to discharge from hospital. They called for a clarification of responsibility for planning discharge in general, but there was no clear attribution of administrative responsibility nor was discharge planning separately identified as a discrete activity.

Community Health Councils

Particularly throughout the 1980s, CHCs carried out surveys to assess the quality of discharge planning on acute wards and the adequacy of care post-discharge. These focused mainly, but not exclusively on the care of elderly people (see, for example, Williamson 1985; Adams 1985; East Birmingham CHC 1981; Leigh-Smith *et al.* 1991). There are difficulties in comparing these studies partly because they are not routinely framed in terms of a process of discharge and therefore differ in the questions asked, and partly because of differences in the samples. However, they are remarkably consistent in their assessments of the problems experienced by elderly people during the discharge process and on returning home.

Voluntary organisations

Throughout the 1970s and 1980s, voluntary organisations played a key role in highlighting and attempting to bridge the gaps between home and hospital care. Among the earliest studies in the field was Geraldine Amos' work for Age Concern on the needs of elderly people discharged from hospitals in the Liverpool area (Amos, 1973). This formed part of the programme of the Continuing Care Project, which analysed problems of organisation and communication which riddled the discharge process (Age Concern, 1975; NCCOP 1978 a,b). This influential voluntary organisation tried to promote the coordination of aftercare arrangements for elderly people on discharge; foster greater understanding about needs post-discharge and encourage closer links between voluntary and statutory providers. In particular, it promoted the role of 'aftercare coordinators' as the most practical solution to fragmented discharge procedures given the time lag routinely exposed in research studies between discharge from hospital and the arrival of statutory services. The involvement of the voluntary sector in this field was further strengthened by the (then) DHSS 'Helping the Community to Care' programme (1985-8). This funded 12 projects in post-discharge support and enabled voluntary organisations, mainly Age Concern and the Red Cross, to work closely with health and local authorities to demonstrate models for providing such care. (See Box 2 for a summary of the involvement of the voluntary sector in this field.) It is clear that the activity of voluntary organisations has been extremely important, both in highlighting issues which were relatively neglected by management, and in framing possible solutions. However, it has done little to shift attention towards statutory responsibility for discharge arrangements or towards the management responsibilities of providers. Burgeoning activity in the voluntary sector implicitly underlined ambiguities over which statutory authority was responsible for managing the transition from hospital to home and for meeting immediate post-discharge needs.

In summary, therefore, there was much concern, and many initiatives in discharge planning throughout the 1970s and 1980s, often based in units specialising in the care of elderly people and bolstered by the contribution of myriad voluntary projects. Within districts, discharge planning, where it was separately identified, might be incorporated within the wider areas of audit or quality assurance.

Problems identified

Whatever the origin of the research, six problems with the discharge process commonly recur:

- elderly people in acute wards are not routinely asked about their home circumstances nor how they will cope after discharge;
- there is little information about medication and its side effects and practice in self-medication is not routine;
- information on discharge policy and procedures is not widely available on wards;
- there is often inadequate notice of discharge;
- transport arrangements are often poor;
- there are often delays and inadequacies in the provision of community services.

It would appear self-evident that elderly people in acute wards and in Accident and Emergency departments should be asked about their home circumstances. Such is not the case. For example, as far back as 1976, Hirst found that under half the elderly patients in her study were asked by hospital staff if they needed help at home. Little seems to have changed over the last fifteen years. The recent study on the process of discharge carried out by the National Institute for Social Work (Neill and Williams, 1992) found that one in three people over 75 reported little or no pre-discharge discussion of this topic. Similarly, a discharge review carried out at Northwick Park hospital (Hurley and Chapman, 1991) showed that just under half the study population had not discussed with hospital staff how they would manage at home.

Elderly people are still given little information about their medication or about their condition. In a study of the process of discharge planning on geriatric wards, Waters (1987) found that of the 32 patients studied only 10 knew what their tablets were for. Only nine recalled being given any advice.

More generally, there is little attempt to inform people about discharge procedures or to involve elderly people and their carers in making discharge plans (Young *et al.*, 1991). In relation to particular conditions, a recent study of stroke survivors some three years after discharge showed that patients and carers felt 'abandoned' after

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DISCHARGE PROJECTS: THE VOLUNTARY SECTOR

There is a wide range of schemes designed to provide short-term support for frail elderly people after their discharge from hospital. Most provide support for between three to six weeks using some combination of paid and volunteer staff. There are various funding combinations, and the blend of project and other funding may change over time within any one project. Although aims vary, most schemes seek to provide the kind of personal, domestic and social support which might be provided by a neighbour or relative for people (largely those over 75) who are vulnerable after a hospital stay. Their existence reflects, to some extent, the inadequacy of mainstream services in providing flexible support which is swiftly coordinated: volunteers regularly become involved in encouraging closer cooperation and liaison between support services; monitoring discharge procedures; and ensuring aftercare arrangements are in place. Between 1984-9 the (then) DHSS funded three year demonstration projects exploring the different ways of providing extra care for elderly people. The 12 projects were run by voluntary organisations working with the NHS and social services. Some of these subsequently attracted full local funding. A number of discharge schemes are described below.

South Glamorgan Care for the Elderly Hospital Discharge Service (Russell, 1988)

This voluntary organisation, which began in 1985, was funded by the European Poverty programme, the Welsh Office, South Glamorgan Health Authority and South Glamorgan County Council. It provides two levels of care. Paid 'settlement aides' provide support for the first few days after discharge and this may be followed by less formal volunteer support. The aim is to prevent readmission for social reasons.

Age Concern Brent: Hospital Aftercare Scheme

An Age Concern scheme was funded from 1985-88 under the 'Helping the Community to Care' programme and subsequently funded under joint finance to provide emergency or 'bridging' domiciliary support for elderly people. Most referrals are from acute care and made by hospital staff. Increasingly, longer-term support is being provided so that it is changing into a general hospital aftercare service.

Age Concern Stockport: Hospital Aftercare Service

This project was established in 1985 to provide a volunteer aftercare service for elderly people discharged from the Accident and Emergency Department. It provides care and comfort, a services check and a safety audit of the home. It was initially funded under the 'Helping the Community to Care' programme.

Age Concern Solihull: Hospital Discharge Scheme

Initially funded in 1985 under the 'Helping the Community to Care' programme via Age Concern, this scheme is now joint financed. It provides short-term domiciliary care for elderly people when first discharged from hospital, mainly through paid care assistants.

Age Concern Staffordshire: Hospital Aftercare Service

This was set up in 1989 to help vulnerable elderly people leaving hospital who might otherwise be in residential care. As well as providing friendship and support, the volunteers liaise with statutory services.

Age Concern York: Hospital Aftercare Scheme

Again funded through the DHSS via Age Concern and subsequently from York Health Authority and Age Concern, this provides a volunteer aftercare service for elderly patients.

Ogwr Hospital Discharge Scheme (Jones, 1986)

This discharge scheme was established in Ogwr in 1984. Volunteers visit at risk elderly people discharged from hospital.

These projects reflect just some of the schemes which have arisen to support elderly people discharged from hospital. There are also examples of collaborative schemes between the voluntary sector and health and social services. Their proliferation reflects a recognition of the gaps in statutory services after discharge from hospital, in particular the lack of a speedy and flexible response and the resources to provide a wide range of personal, domestic and social support. At best they can be described as a vital link in the community care chain, demonstrating creative collaboration between the statutory and voluntary sectors, and exploring the benefits of 'hybrid' care assistants. However, there are also real difficulties:

- assessment procedures and referral routes for such schemes may be unclear;
- links with primary care services, particularly GP services, are often weak;
- there is some concern that volunteers infringe on the work of nurses and home helps; training of volunteers is variable; and
- it may be difficult to monitor the quality of care.

Schemes are not routinely used in a planned way as part of a total package of care; often the initial intention of providing short-term care merges into longer-term support. More fundamental, however, is the uncertainty of funding. A number of projects folded after three years when the DHSS 'Helping the Community to Care' funding ceased; many are dependent on joint finance. There has been no organised response to the problems which such schemes attempt to address, no policy about the level or quality of support to which elderly people should be entitled immediately post-discharge or of the separate responsibilities of both health and social services in arranging for such support to be provided. It remains to be seen what impact the NHS reforms will have on the particular needs of this most vulnerable group.

hospital discharge and did not know where to apply for help. The authors recommend an agreed policy for providing detailed information to stroke survivors before leaving hospital (Greveson and James, 1991). This is a suggestion that could equally well apply to many other conditions.

A further persistent problem is the failure to provide adequate notice of discharge. Bath CHC (Leigh-Smith *et al.*, 1991) found that 62 per cent of patients in the study (all of whom were over seventy and lived alone) were given less than 48 hours notice of discharge and 37 per cent were told of their discharge date on the day that it happened. Bowling and Betts (1984a) found that 24 per cent of their study population were given no prior notice, and Victor and Vetter (1988) found that 39 per cent of patients over 65 were given less that 24 hours notice of discharge. These problems are typically more widespread in acute wards, and Victor and Vetter, among others, have pointed out that people discharged from departments of geriatric medicine are consistently better prepared for discharge.

The day of discharge is often mishandled, with delays and confusion over transport arrangements. For example the Northwick Park study (Hurley and Chapman, 1991) showed that 53 per cent of patients experienced transport problems on the day of discharge. Neill and Williams (1992) found that 'it was not unusual for a patient to wait on the ward from early morning until evening for an ambulance for the journey home' (p. 152). They also point out that patients were often not accompanied indoors, that many could not negotiate stairs and would effectively be trapped on one floor until someone called and that carers who were themselves elderly and disabled might be put under great physical strain through having to assist their spouse.

Finally, research has consistently documented delays in the arrival of community services. Skeet (1985) highlighted the critical gap of three to five days post-discharge, when the patient is most vulnerable and when a lag in service provision may occur. Neill and Williams (1992) pointed out that one quarter of the elderly people in their sample experienced delays in the arrival of services which meant that they received little or no help in the first few days following discharge. Likewise, Harding and Modell (1989) found that 33 per cent of elderly patients interviewed post-discharge were not visited by family, friends or professionals within three days of discharge. Moreover, when services did arrive, they were often inadequate. Hospitals often underestimate the extent of community support required: one study showed that the number of community services called on within two weeks of the discharge date were double those arranged by hospital staff (Skeet, 1985). Not surprisingly, a number of studies have shown that some elderly people felt they had been discharged too early, with this proportion increasing once the difficulties of coping at home became apparent (Neill and Williams, 1992).

There have been numerous initiatives to ease the discharge process. For planned admissions, discharge planning may begin before admission. Home visits can be carried out by members of the primary care team to assess the home situation. Skeet (1985) describes an initiative where those awaiting admission to orthopaedic wards attend a pre-admission clinic three to eight weeks beforehand. Here their home requirements are assessed by an orthopaedic manager, a physiotherapist and an occupational therapist and patients are given an idea of what to expect as a result of their treatment. For in-patients, functional assessments can be more meaningfully carried out through home visits with occupational therapists. Information booklets for patients have been prepared (Vaughan and Taylor, 1988) and Neill and Williams (1992) suggest a 'Going Home Folder' where professionals, patients and carers could record facts relevant to discharge. However, solutions to many of the problems outlined above are synonymous with the implementation of effective discharge process – as outlined in Box 1: early discharge planning; screening for vulnerable patients; regular assessment; information for patients and carers; well coordinated aftercare; and regular audit.

Prioritising the use of acute beds

Concern over the use of acute beds for social reasons is almost as old as the NHS. During the 1970s, at a time when numerous reports highlighted the failings of aftercare, including the premature and poorly planned discharge of many elderly people, problems of delayed discharge gained prominence. With increasing specialisation and rising costs, the need to maximise the resources of the hospital inevitably meant that attention was increasingly focused on the appropriate use of acute beds. This involved avoiding both inappropriate hospital admission on the one hand, and delayed discharge on the other. Although early studies had explored reasons for unnecessary hospital stays by looking at home circumstances and the availability of residential care, during the 1970s studies 'tended to consider only the fact that such delay prevented the admission of a further case to the bed, hence the use of the term "blocked bed" ' (Ashley *et al.*, 1981, p. 2) – see Box 3. More recently debate has shifted from 'bed-blockers' to wide-ranging reviews of the use and misuse of acute care. Changes arising from the NHS and Community Care Act 1990 are likely to exacerbate the inappropriate use of acute beds if

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'BLOCKED BEDS'

The term 'blocked bed' is notable for being widely used yet lacking an agreed definition or official recognition in the form of routinely available statistics. The blocked bed was typically associated with elderly patients, with the typical 'blockers' being 'women over 75, living alone, or with one relative, who had been admitted to hospital in an emergency with a fractured femur, head injury or other trauma' (Murphy, 1977, p.1395). An indication of the size of the problem in the late 1970s was achieved through a postal survey of the 98 Area Health Authorities (AHAs), carried out in 1979. Only four of the 94 AHAs which responded to the survey denied a blocked bed problem (Ashley *et al.*, 1981). Twenty two had carried out special studies, made necessary by the absence of routine information on the extent of blocked beds. Respondents at this time commented on the difficulties of setting up any special studies or monitoring exercises due to a lack of cooperation between departments and among health professionals and a lack of established procedures for monitoring discharge-related information. As an example of this, it was pointed out that there was often no waiting list for those in acute wards awaiting alternative accommodation. However, the authors of the review also point to the lack of an adequate theoretical framework for discussing and measuring misutilisation of services for the elderly. Since then, numerous studies have documented the irrelevance of routinely available statistics to identify the scope of the problem.

Throughout the late 1970s and 1980s studies attempted to assess the extent of inappropriate placement in acute wards. One day censuses, cohort analyses, subjective judgements by medical and nursing staff, and attempts at the objective assessment of functional ability by independent observers were used singly or in combination. Estimates of blocked beds ranged from 14 per cent (Coid and Crome, 1986) to 8 per cent (Victor, 1989) of acute beds. The need to carry out special studies underlined the lack of routine data on dependency levels, as well as on the relationships between dependency, discharge planning and discharge destination. For example, Coid and Crome discovered that for 18 per cent of the bed blockers in their study no plans for transfer of discharge had been formulated and a second opinion from a geriatrician had been sought for only 49 per cent of bed blockers.

Numerous studies of inappropriate bed use touch on the reasons for discharge delay. These vary from factors within the control of the hospital – discharge procedures, ward management and transfer arrangements – to factors related to delay in being admitted to residential or home care. For example, Murphy's (1977) study of surgical and orthopaedic beds found that for 28 per cent of the bed blockers in the study there were no plans for discharge, and that, for the whole group, referral to a medical social worker took place 12 weeks after admission. In a study of a cohort of admissions to the Radcliffe Infirmary, Oxford, where a broader approach to inappropriate bed use was adopted, Anderson *et al.* (1988) used a bed study instrument to determine bed use and found that for only 38 per cent of bed days were patients considered to have positive reasons for being in hospital. They identified several routes for reducing this percentage, such as increasing the frequency of ward rounds at which discharge decisions might be made, delegating responsibility for discharge decisions to other staff and providing diagnostic-related protocols. It has also been shown that feedback of information to physicians over the inappropriate use of beds reduced inappropriate bed use.

Many of the studies imply a lack of formal discharge planning. Farag and Tinker (1985) found that ambulance delays, the pattern of consultant ward rounds and investigations accounted for almost one third of the delay. Delays were also due to lack of timely information about residential care. These studies herald increasing concern over better management of acute beds. Attempts to identify inappropriate placement can also highlight difficulties in agreeing criteria over fitness for discharge, which in turn take their cue from changes in the boundaries of acute in-patient care and between health and social care. In other words, definitions of blocked beds are partly a function of prevailing perceptions of the role of acute hospitals as well as the availability of alternatives (Holloway and Marshall, 1981).

Ways of assessing clinical and nursing dependence in order to identify the rational use of acute in-patient care are not well developed in the UK, yet even small differences in the criteria adopted to assess inappropriateness can yield large changes in the numbers of patients judged to no longer require acute care – a fact which, incidentally, makes it difficult to compare studies on bed blocking levels based on subjective staff assessments. At a national level, too, it is still the case that information on discharge destination is minimal, with the same level of detail being provided on discharge to prison as on discharge to private nursing and residential care, despite the fact that information on patterns of discharge and levels of dependency is a useful planning tool and is now an essential part of the implementation of the NHS and Community Care Act.

arrangements for discharge are not in place in the community, or if resources are inadequate.

A number of themes emerge from studies of blocked beds. For the most part, bed blocking is itself the focus of analysis: its extent; changes over time; clinical and social characteristics of bed blockers compared with other longer-stay patients in need of acute care; and possible solutions. By far the longest tradition of research is concerned with elderly people who have remained in acute wards for periods exceeding 28 days (an arbitrary, but commonly adopted definition). This has meant that the study of the appropriate use of acute beds has typically been identified with one 'problem group' rather than with more general issues of ward management, administrative procedures or discharge policies. A focus on the extent of bed blocking masked the importance of developing discharge review procedures for particular wards, patients or conditions even though such procedures could minimise inappropriate placement and routinely identify sources of delay. By implication, too, the focus was on the misutilisation of hospitals rather than on the disservice done to patients inappropriately placed. Solutions to the problem of blocked beds became increasingly framed in the context of policies for the in-patient care of elderly people and particularly on the management and organisation of services for elderly people in acute hospitals. Innovations included:

- the redesignation of acute medical beds for rehabilitation and assessment (McDonald, 1989);
- the implementation of age-related admissions policies, with all those over a certain age, usually 75, being admitted into geriatric beds (Coid and Crome, 1986);
- an integrated approach, where beds in geriatric and general medical wards were pooled;
- policies for 'progressive patient care' and easy transfer of elderly people from acute to rehabilitation to continuing care;
- the involvement of geriatricians in managing elderly people with acute illness (Whitaker *et al.*, 1989).

There is great variation, and different admission policies may obtain in the same district (Brocklehurst *et al.*, 1989). All these approaches have been beneficial through helping to overcome the problem of delayed referral to geriatricians and psychogeriatricians from acute wards and through speeding up rehabilitation by promoting active early involvement of therapists and social workers. It has been argued that different ways of working in geriatric and other wards have hampered the development of integrated approaches (Coid and Crome, 1986) and it has been noted that 'despite (evidence) of the contribution of geriatric medical services to the efficiency of acute hospital care for old people, geriatric medicine has not been universally accepted by other areas of medicine' (Lewis and Wattis, 1988, p. 191). However, the extensive use by elderly people of hospital services means that the multi-disciplinary approaches of a kind already well developed in care of elderly people will need to be more generally adopted in acute wards. The lack of a multi-disciplinary approach to discharge planning in acute wards, combined with difficulties in sustaining the momentum for discharge were highlighted by initiatives such as the discharge review group at the Royal Free Hospital in London which was set up to review delayed discharge on a regular basis (Sadler, 1990).

The 1990s have seen a shift from the emphasis on 'bed blockers' to more general management issues. The report from the Audit Commission on the management of acute medical beds (1992) identified inefficiencies in clinical and hospital management in five areas: admission; placement; stay; discharge; bed availability and management. In relation to discharge, the report highlighted (pp. 18-23):

- consultant timing of ward rounds which may lead to poorly planned discharge;
- haphazard methods of identifying those in need of rehabilitation;
- delays in 'ordering, dispensing and distributing take-home medicines';
- transport problems;
- poor communication with patients, GPs and outside agencies;
- delays in arranging packages of domiciliary support;
- lack of clear responsibility (in about half of acute hospitals) for finding places for those unable to be discharged home;
- problems of liaison between health and local authorities and a lack of incentives for social workers to facilitate prompt discharge.

The debate over blocked beds is now subsumed within the broader topics of the management of acute beds, the boundaries of health and social care and the appropriateness of hospital or home (or nursing home) care.

Communication and co-ordination: hospital and community

A third major area of discharge-related research is communication and coordination between hospital and community-based professionals. Three areas of concern are described here:

- links between hospital consultants and GPs;
- communication between hospital and community-based nurses;
- and coordination of health and social services at both professional and administrative levels.

Communication between consultants and GPs
Discharge-related communication between consultants and GPs has been the subject of extensive research and concern, despite its apparent simplicity from an administrative point of view. The common practice is for hospital doctors to send a short discharge letter to GPs followed by a longer discharge summary. In a survey of discharge summaries from geriatric wards, Black (1990) found that 87 per cent of districts responding to a survey adopted this pattern. There has been much debate over the kinds of information that discharge summaries should contain and over the ways of reducing delays in communication between hospitals and GPs. Penney (1988) found that only 11 per cent of discharge summaries had reached GPs within one week of discharge and only 39 per cent within 14 days. Twenty five per cent never arrived. Black (1990) found that the discharge summary could take between one day and four months to arrive, with the main delay being due to a lack of secretarial support rather than method of delivery. In contrast, Penney found that over 80 per cent of discharge letters, the initial and less detailed communication between consultant and GP (in this case delivered by hand by the patient), arrived within one week.

Other studies confirm these findings. In relation to the content of letters, Harding (1987) found that GPs were dissatisfied with the content of 29 (20 per cent) of discharge communications and this lack of detail affected their management of care in 20 cases (13.8 per cent). She notes that GPs were particularly concerned that letters did not always contain sufficient information about drug regimens, especially where drugs had been discontinued in hospital and new ones started, about results of investigations carried out in hospital, about symptoms or detail of follow-up plans. Beck and Wilton (1988) comment that even for patients with cancer, discharge information is unlikely to mention what information has been given with regard to the diagnosis, creating an ambiguous situation for GPs providing follow-up care. A further area of dispute is that of hospitals requesting that GPs prescribe drugs which are administered and monitored by hospital staff, or of prescribing less than seven days supply on discharge. (The DoH issued guidelines in this area in 1991.)

Numerous solutions to the slowness and poor content of consultant letters have been suggested. It has been demonstrated that it is quicker for patients to deliver discharge letters to GPs than for them to be posted (Sandler and Mitchell, 1987). Combining prescription forms with the discharge note for patients to take home is quicker than posting a separate discharge note (Kendrick and Hindmarsh, 1988). Much of the delay is due to lack of secretarial support: increased use of computer technology; electronic mail systems; and fax machines can facilitate the processing of discharge summaries.

It has been suggested that the cumbersome two-tier system of discharge note followed by discharge summary be replaced by a single summary to arrive within three days. Howard (1986) introduced a discharge letter combining features of both discharge notification and discharge summary in a handwritten version accompanying the patient with a typed copy sent later. Attempts to improve the quality of information in discharge summaries for elderly people have included the development of a new discharge form which reflects the objectives of geriatric assessment. This includes information about mobility, dressing, continence, cooking and feeding, mental state, hearing and vision as well as information on the services and equipment ordered for patients (Philp *et al.*, 1988). Harding (1987) emphasises that 'it may be possible for local hospital and community staff to agree on the content, format and routes of communication about discharge' (p. 495).

There appear to be few initiatives where GPs can routinely provide feedback to hospitals on their discharge policies, although views of GPs have been sought in a number of specific studies (see for example Bowling and Betts, 1984b). Clearly, there is great variation in the discharge practices of different hospitals. It would, however, seem important to review GP reactions to discharge communications. As mentioned earlier, the contracting process provides a way for standards to be influenced by GPs, either directly, through fundholding, or indirectly through liaison with DHAs.

Continuity of care: hospital and community nurses
In practice, much of the coordination for discharge has been carried out by nurses, hence studies on the continuity of care have largely focused on communication between hospital and community nurses. It has been argued, for example, that discharge should be considered part of the systematic and holistic approach to individual nursing care embodied in the nursing process (Gilchrist, 1987). However, research has identified a number of problems. Discharge-related information is often poorly documented in hospital nursing records and reflects the fact that problems

related to acute in-patient care and treatment take priority over problems of assessment and discharge planning. In her study of discharge planning, Waters (1987) found that 'none of the records studied contained as much information as had been obtained by the researcher during interviews with the respondents' (p. 79). Work still continues in an effort to develop appropriate nursing referral forms (Armitage, 1991). There is little evidence of pre-discharge instruction or of involving relatives in care.

Studies of district nurses show that there is often little warning of discharges from acute wards, information may be of poor quality and that discharge letters to community nurses often arrive between one and three weeks after discharge (Bowling and Betts, 1982). In particular, phone messages may be incorrect and lacking in detail. The timing of discharge may be poorly planned and post-discharge planning in terms of services and equipment may be inadequate. There appears to be little knowledge among hospital nurses of the ways of working of community staff or of the range of voluntary agencies in the community which may be able to provide help and support, and there is little opportunity for feedback from community staff to those in the hospital.

These problems of the interface between hospital and community have been addressed in a number of ways, including exchange schemes and job sharing. Departments caring for elderly patients may employ hospital-based community nurses who liaise with community teams and who may follow up patients after discharge (Horrocks, 1987). Jowett and Armitage (1991) suggest the introduction of joint hospital/community management posts; staff exchange programmes; the introduction of integrated clinical posts and directories of local services on all wards. Innovations in hospital nursing care, allowing ward nurses to contribute to home assessments and district nurses or care assistants to visit wards (McMahon, 1988) can ease communication between hospital and community staff for patients requiring complex discharge arrangements.

Since the 1970s there has been an expansion in the number of liaison posts, initially developed in general wards and care of the elderly units, and intended as a link between hospital and community. Often educational and fixed term there was nevertheless some uncertainty over the nature of their task. In response to this, some liaison nurses developed their screening role, determining which patients needed discharge planning. This development has met with varying degrees of enthusiasm. The Welsh community nursing review (Edwards, 1987) recommended that liaison staff with community experience be attached to acute hospitals. In contrast, the community nursing review for Northern Ireland (DHSS, 1986b) took quite a different approach, stating that it was not considered necessary for the post of liaison nurse to be continued, emphasising instead that discharge procedures should themselves ensure continuity of care. (See Armitage, 1991 for discussion.) In a formal evaluation Jowett and Armitage (1988) highlighted the dangers of liaison nurses 'removing some of the responsibility for communication and discharge planning from hospital nurses' (p. 584). There is also some overlap with the role of social workers (Armitage, 1991) in particular in relation to the provision of counselling and support. In these ways, liaison nurses serve to add further complexity to the information transfer process.

Clearly, liaison nurses can facilitate communication across nursing boundaries. To the extent that discharge planning involves crossing numerous professional and organisational boundaries however, developments which are profession-specific remain a partial solution to the problem.

Health and social services

The third major area of concern in professional communication and coordination over discharge is that of the relationship between health and social services. The recognition that social aspects of discharge were part of the role of an acute hospital was reflected in the role of almoners and continues through the statutory responsibility of social work departments to provide social work support for hospitals. This may take the form of on-site social workers or support from locally-based area teams. Given this long tradition of involvement, the relative lack of research on social work in health care is striking. At the most basic level, there are no routine statistics collected in England and Wales on the number of social work staff working in health service settings.

> *It is remarkable ... how little published material there is in Britain to guide decision makers and practitioners in the effective allocation of social work resources in hospitals* (Connor and Tibbitt, 1988, p. 3).

Although there are few studies of hospital discharge from a social services perspective, a study of the views of a range of health and social services professionals involved in discharge, carried out by Brent Social Services in 1991, highlighted problems of communication and coordination. There were no formally agreed procedures between social services and the hospitals; no procedures for informing social services regarding admission of their clients; lack of notice of discharge; and no feedback channel from social services to health authorities. Hospital staff found home care to be inflexible; a lack of hospital social workers meant that ward sisters and occupational therapists were having to carry out tasks they considered more appropriate to social work; there were difficulties in getting social workers and occupational therapists to carry out assessments; and there remained a degree of confusion over the roles of district nurses and home care staff on the one hand and hospital and social services occupational therapists on the other. Assessments of hospital social workers were not always accepted by local authorities and there were difficulties in contacting social services by telephone.

Many of the problems identified in this section are open to management action in the context of the implementation of the discharge process outlined in the introduction. This will involve close involvement of health and local authorities in drawing up discharge policies in order to negotiate procedures for social services assessments in acute wards, to agree how voluntary agencies are used, to share criteria related to 'fitness to discharge' and to avoid duplicate assessments. However, many of the discharge-related issues between health and social services are not simply questions of communication and are not always open to solution through management fiat. Problems relate to:

- the separation of responsibility for assessment for services from the capacity to guarantee the delivery of these services;
- the clash between the local authority's duty towards its local population and its statutory responsibilities and the concern of staff in acute wards to release acute beds;
- and ambiguities over the extent and level of post-discharge support that can and ought to be supplied, reflected in wide variations in the levels of such support across the country.

Likewise, many discharge delays are due to the lack of suitable alternatives to in-patient care. Nevertheless, many of the deficiencies identified in this section are open to management action, and one of the hallmarks of discharge-related research has been the relative neglect of a strong management approach in this area.

The management task emerges

3

In 1989, the management task gained prominence as specific guidance over discharge was published by the Department of Health, albeit prompted by the continuing concern of the Select Committee on the Parliamentary Commissioner for Administration over the lack of properly defined procedures, rather than by the decades of concern voiced by professional organisations, CHCs and voluntary bodies. In February 1989, the Department of Health Circular HC(89)5, the Department of the Environment Circular, LAC(89)7 and an accompanying booklet *Discharge of Patients from Hospital* placed discharge squarely on the management agenda. In 1990, *Caring for People* refocused attention on discharge of highly dependent people. These are discussed in turn.

Discharge of patients from hospital (HC(89)5)

Discharge of Patients from Hospital replaces a circular published 26 years previously (HM(63)24), a surprising gap given the research summarised in chapter 2. It reiterates the importance of: early discharge planning; written procedures and good communication between hospital and community services; rigorous checking before the patient is finally discharged; and audit. It emphasises the centrality of patients, families and carers in the discharge process. Main themes of the circular are summarised in Box 4.

4

HC(89)5

Establishing discharge procedures:

discharge procedures to be agreed with all those involved in their implementation;

all wards and departments (including A and E departments) to agree up to date discharge procedures which should be issued to all concerned;

procedures to be monitored by district health authorities in collaboration with social services;

regional health authorities to be informed of action taken by the end of March, 1990.

Creating effective arrangements:

doctor responsible for the patient to agree discharge;

doctors to have agreed and managers to be satisfied that arrangements for home care are comprehensive, as far as is possible;

one member of staff to hold responsibility for checking that 'all necessary action has been taken' prior to discharge;

information from those at the receiving end of discharge procedures to be incorporated into review of discharge policies;

consultants to play an important role in the review of procedures although a range of other professionals will also have a part to play;

details of procedures to be circulated to 'GPs, the ambulance service, local authority social services and housing departments and any voluntary bodies who may provide help'.

The accompanying booklet was designed to help those responsible for drawing up discharge procedures in the light of HC(89)5. The booklet highlights the special needs of twelve different vulnerable groups such as terminally ill patients, homeless people and people living alone; describes some general requirements, in a little more detail than the circular; and then separately discusses discharge responsibilities of different professional groups.

Widely agreed and written procedures along with clearer accountability arrangements are clearly a sine qua non of discharge planning and the discharge circular and booklet were generally welcomed as much needed guidance in a long neglected area. Age Concern, for example, publicised extracts of particular relevance to the needs of elderly people (Age Concern England, 1990a).

A number of themes emphasised in the circular were particularly welcome. First, consultants were to discuss with staff, patients and carers the likely length of stay. In addition, discharge was not to take place until doctors and management were satisfied that arrangements were in place. This implied that doctors could not request discharge while remaining unaware of the difficulties which those arranging discharge might be facing. Interestingly, the remit of other professional groups in these decisions was not addressed. The timing of discharge was therefore to be decided by the same groups experiencing pressure to admit urgent cases. Furthermore, it was not clear whether, as Thomas (1989) puts it, 'members of the multi-disciplinary team will be able to appeal to managers when they disagree with a medical decision to send a person home' (p. 10).

Second, the patient was considered central to the discharge process. In particular, in what became one of the most quoted passages of the booklet, where patients were not returning to their own homes, arrangements 'must be made in good time and be acceptable to the patient, and where appropriate, the patient's carers or relatives ... No NHS patient should be placed in a private nursing or residential home against his/her wishes if it means that he/she or a relative will be personally responsible for the home's charges' (para. A2(ii)). *The Patients' Charter* (DoH, 1991) also states in relation to discharge that 'you and, with your agreement, your carers will be consulted and informed at all stages' (p. 15). That carers should be integral to the discharge process is not just a part of good practice; a prospective study (Roudot-Thoraval *et al.*, 1987) demonstrated that the opinion of the patient or family (or both) was the best measure for predicting transfer to long-term care after acute care.

Third, the key role of nursing staff in discharge is recognised (in the booklet rather more than in the circular). It has been argued, however, (Waters and Booth, 1991) that the circular underemphasises the nursing role in discharge planning and exaggerates that of medical staff. The authors comment that 'the contribution of the consultant to preparing the patient for discharge is negligible once the patient is declared fit for going home' (p. 35).

The booklet emphasises the roles of different groups both within and outside the health service in promoting effective discharge and this has meant, in some cases at least, that such groups have worked together in drawing up agreed guidelines – a first step to making such guidance work. Finally, accountability and monitoring arrangements are emphasised with the implication that regional health authorities are responsible for monitoring that action has been taken.

Limitations of HC(89)5

Inevitably, with the sea changes in health and social care since 1989, certain aspects of the circular and accompanying booklet seem outdated. However, it is open to criticism within its own frame of reference and, in addition, attempts to monitor its implementation have been fragmented. These criticisms raise broader questions that remain relevant to discharge policy, which are discussed here in the context of the process of discharge planning, described in the introduction of this report.

The process of discharge planning and the discharge circular

Discharge planning is a process that can be initiated before a patient is admitted, or at any time during a hospital stay. Government guidance concentrates less on this process than on professional accountability for discharge. This is consistent with a reluctance to treat discharge as a discrete activity, which is greater than the sum of the separate tasks of the various professionals involved.

As Box 1 demonstrated, discharge planning represents a wide spectrum of activity. In acute wards, most patients leave hospital needing little home support. For some, however, discharge will involve many different professionals in multidisciplinary assessments and the coordination of a wide range of hospital and community staff. The complexity of this process is masked by the generality of the circular and booklet which place less emphasis on what needs to be done than on the separate responsibilities of different professional groups in implementing guidelines to be agreed within districts, departments or wards. In this way, discharge planning is viewed as an integral part of existing professional roles and responsibilities; extra demands are implicitly assumed to be readily accommodated within these responsibilities. There is a safeguard in the circular that a specific member of staff is to be responsible for completing the final discharge check-list, although this could be a time consuming task, and particularly difficult if information relevant to discharge arrangements is scattered amongst the records of different professional groups. It also implies clear responsibility at the end of the discharge planning process which is not matched by clarity at each stage. The success of discharge policy hangs on effective links between acute care, primary care and social services and therefore on ways of organising professionals so that gaps can be bridged. Some health authorities had already tried, in different ways, to meet the additional demands of discharge planning through employing liaison nurses, specialist discharge coordinators, or administrative discharge officers; such initiatives are neglected in the circular.

While the patient is described as central to the discharge process, there is relatively little discussion of the rights of the patient or of the tensions in negotiating the difficult path between managing a flow of acute beds and the (possibly) conflicting needs of in-patients or their relatives. There is no obligation for discharge arrangements to be subject to the agreement of the patient: instead, the booklet stresses that the ward sister and nursing team are to 'discuss with patients, responsible relative(s) or other carer(s) before decisions are finalised' (para. C2). As there is no separate discharge function, there may be no reference point for discharge-related information, which is not simply patient-based. Where, as is often the case, patients are transferred from ward to ward as bed managers juggle with available beds, continuity of responsibility for discharge is broken as the patient moves to a different nursing team.

The circular and the booklet also remain vague over one of the most crucial aspects of discharge – the transfer of responsibility from hospital to community services. At which point does the responsibility of the hospital end and that of the community services begin? Who is accountable for non-appearance of services or service delay? What guarantees are there that services arranged in the hospital will materialise and who should be contacted to remedy shortfalls in arrangements? Inevitably, given the brevity of the circular, there is little specific guidance and no discussion of problems of implementation.

Monitoring the circular

The publication of HC(89)5 added a further dimension to discharge-related research. How have discharge policies been translated into effective action at ward level? What problems have been experienced in trying to implement new discharge policies?

One of the requirements of the circular was that districts should report action taken to their regional health authority. As part of this study, attempts were made to ascertain activity at regional level in relation to the discharge circular. Reorganisations and changes of staff in regional health authorities made this task difficult. However, it became clear that some of the ambiguities inherent in discharge planning were reflected in fragmented responsibilities for monitoring the circular. Public health, health policy, quality assurance, nursing and community care implementation were some of the departments or directorates involved, though in some cases it appeared that no single person or department held overall responsibility. Few regions appeared to have systematically followed up their districts with regard to implementation. Where, as in North West Thames, a review of district discharge policies had been carried out, and active attempts made to assess progress, there was great variation between districts, with monitoring arrangements for discharge the least developed area.

This trawl of regional monitoring arrangements underlined the fact that where many departments and professionals are involved, the responsibility of all slides into the responsibility of none – a situation which has served to delay progress in clarifying accountability for discharge. In addition, just as monitoring is the least developed part of district discharge policy, so, at regional level, monitoring of the circular appears to have been minimal. There is therefore no national picture of discharge policy, of successful initiatives, or of problems in carrying out the circular.

At local level, various studies have shown that implementation is patchy. Even where policies have been agreed there may be little detail on the procedures to be carried out and, in any event, staff and patients may remain unaware of their existence. There may be variations in discharge policies between hospitals in the same district and between specialties within the same hospital. For example, a study carried out by the Helen Hamlyn Research Unit over eighteen months after the publication of the circular (Young *et al.*, 1991) showed that two thirds of the hospital staff in the three hospitals studied had no knowledge of a standard discharge procedure although the report notes that 'staff on specialist medical wards for older people and orthopaedic wards were more likely to report the existence of specific ward protocols than their counterparts in general medicine or surgery' (p. 18). A study carried out by Brent Social Services early in 1991 noted that there had been no routine involvement of the social services department in drawing up discharge policies, despite this recommendation forming an important plank of the circular.

An analysis of the implementation of the discharge circular in one district pointed out that 'no resources were allocated for procedures to be written, carried out or monitored ... and the separation of each professional's task means that the idea of a process which is integral with the flow of the treatment programme will be hard to achieve'. In addition, the author points out the differing priorities of social services in relation to aftercare (Sutcliffe 1991, p. 58).

This does not imply a dearth of discharge-related activity at local level, however. Increasingly, new research takes into account the views of different groups with a say in implementing and evaluating discharge procedures. For example, researchers at the Helen Hamlyn Research Unit (Young *et al.*, 1991) based their evaluation of the care of older people 'at the interface' on the views of a range of professionals as well as of patients. They carried out a GP survey, a survey of health and local authority staff in the community; a survey of staff on hospital wards in the acute units; in-depth studies with older people recently discharged from hospital, their informal carers, GPs and ward managers; and group interviews with hospital and community staff. Such an approach not only brings out the interface problems which depend on cooperation across agencies for their solution but also reflects the complexity of the discharge process. Their study highlighted a lack of clarity over responsibility for discharge among professional and managerial groups. They also found that patients were not informed of a discharge policy and staff often seemed unaware of its existence. The study confirms, for one district at least, that written official policies do not always permeate to ward level.

Many districts continue to refine their discharge policies. In Northwick Park hospital for example, and as a direct result of the circular, discharge was the focus of a project for developing good practice in discharge planning where the process was evaluated from the perspectives of ward staff, patients and community staff (Hurley and Chapman, 1991). New discharge guidelines were prepared by a multi-disciplinary discharge policy group. Standards for discharge were agreed and included the preparation of an individualised discharge plan, to include the name of the person (usually a nurse) with responsibility for coordinating the planning for that particular patient, the setting of a discharge date within 48 hours of admission and full involvement of patients and carers in the planning process. A new standard discharge planning form was introduced for all patients, with supplementary information being collected for patients at risk. Information was provided about criteria for referral to the various community agencies, with information about how to contact them. Following the framework of the booklet *Discharge of Patients from Hospital* (and adapted from it) the guidelines then itemised specific responsibilities by professional group. Finally, there were guidelines for wards and units to develop discharge plans for particular groups.

This project clarified those aspects of discharge under the control of hospital staff. Not surprisingly, questions related to the transfer of care to the community services remain problematic. For example, the nurse with responsibility for coordinating discharge is advised to 'ensure that for frail, disabled or elderly patients living alone, arrangements have been made for their home to be heated and food provided, where necessary' (Discharge Policy Group, para. 4.2.11). It is not clear, however, whose task this is nor how statutory services can achieve this level of flexibility.

In summary, therefore, the publication of HC(89)5 seems to have had limited impact on the discharge process with implementation being both partial and patchy.

A new emphasis on discharge: Caring for People

The implementation of *Caring for People* has raised the profile of discharge and underlined the importance of jointly agreed discharge arrangements. With local authorities as the lead agency for assessing and arranging social care outside hospitals, the timeliness and rapidity of in-patient assessments, particularly for those on the boundaries between home care and nursing or residential care, has taken on a new urgency. An Executive Letter of 11th March, 1992 (DoH, 1992a), to health and local authorities from Andrew Foster, then Deputy Chief Executive of the NHS ME and Herbert Laming, Chief Inspector of the Social Services Inspectorate – the first of the two Foster/Laming letters – identified eight interdependent key tasks in implementing *Caring for People.*

1. Agreeing the basis for assessment systems for individuals.
2. Agreeing arrangements for new clients in residential/nursing homes.
3. Ensuring robustness and mutual acceptability of discharge arrangements.
4. Clarifying the roles of GPs and primary health care teams.
5. Ensuring adequate purchasing and charging arrangements for residential/nursing home clients.
6. Ensuring adequacy of financial and other management systems.
7. Ensuring staff are suitably and, wherever appropriate, jointly trained.
8. Informing the public of arrangements for assessment and care provision.

Monitoring the implementation of agreed hospital discharge arrangements was also included as an essential objective for regional health authorities for 1992-3 corporate contracts with the NHS ME. Indeed, it could be argued that most of the eight key tasks are premised on effective discharge, such as agreed assessment systems; arrangements for new clients in residential homes; and clarification of the role of GPs and the primary health care team. The first Foster/Laming letter (DoH, 1992a) asks that discharge arrangements be reviewed in order to 'take full account of the new requirements for LAs to introduce needs based assessment' with a 'clear understanding of the services to be made available to the individual following discharge'. The second letter (DoH, 1992b) emphasised the active role health authorities were to play in implementing the eight key tasks.

The importance of discharge policy became increasingly apparent as implementation of the reforms loomed. The community care Support Force, set up in September 1992 to provide practical advice to health and local authorities in delivering the key tasks of community care implementation by April 1993, issued guidance for agreeing strategies for nursing home placements and for integrating assessment and hospital discharge arrangements. This advice, issued in November 1992, was just in time, as evidence of such agreements, along with existing community care commitments was required by a DoH memo of 2nd October 1992 to be available by December

31st, 1992. This was a precondition for local authorities' eligibility for the Special Transitional Grant for community care. As part of this, authorities had to identify which areas they would fund; commit funds for care packages; agree on how discharges would be monitored; identify current discharge routes and services available and have agreed procedures for implementation of the policy. The need for this advice, and at such a late stage, highlights the neglect of discharge planning: it is difficult to see how rigorous discharge planning could ever proceed without joint agreements over such issues for people in the community who already receive complex packages of care.

While it is clearly essential that the reforms are integrated with discharge planning, a focus on the assessment and funding of care packages for elderly people who would otherwise have entered residential care underlines the partial approach taken in the guidance, and reflects the finance-led nature of the reform. Information, monitoring and joint agreements are relevant across the whole spectrum of discharge planning. As in the blocked bed debate (see chapter 2) emphasis is on a 'problematic' group rather than on the implementation of effective procedures across the board.

Discharge planning: still a partial approach

It is clear that, despite recent changes, discharge planning is not seen as a discrete task. Historically, the provision of an extensive domiciliary care network in the UK has also meant that less responsibility is taken by the hospital sector in arranging discharge than might otherwise be the case. Assessments are often carried out by social services or district nursing staff after discharge has taken place. In this way, the links between discharge and a given level of post-discharge care, on which the date of discharge may have depended, can be severed. The general practitioner then becomes the lynch pin for promoting continuity of care, rather than the hospital. In contrast, in the US, where referral from hospital to community services or home care has not been automatic but a transfer to be negotiated between different organisations and subject to the constraints of insurance companies, the hospital role in discharge planning has become more prominent, as described in Box 5.

The tendency to treat discharge functions separately in the US combined with a hospital-based approach has important effects in terms of the kinds of research which are carried out and the information at hospital level which is routinely available. Different approaches to discharge planning have been evaluated with reference to post-discharge care and patient outcomes. Mamon *et al.* (1992) found, for example, that having a formal case manager reduced the risk of unmet treatment needs post-discharge. A well organised discharge planning department can identify trends in referrals, chart changes in the complexity of discharge planning over time, and document changes in workload related to discharge planning overall as well as in relation to specific departments. Services requested at the time of discharge can be monitored as well as destination on discharge. Conversely, clear criteria for discharge form part of equally clear criteria for remaining in hospital. Severity of illness and/or intensity of service are factors taken into account in order to justify continued hospitalisation. This is particularly important as, if the patient no longer requires a hospital level of care, the insurer may refuse to pay for additional in-patient days. Workable discharge plans therefore have to be in place at the time when the patient is ready for discharge. This is in sharp contrast to the UK where clear criteria of this kind are not routine with the result that certain kinds of information are not easily available. Changes in levels of dependency and the effects of these on workloads of people providing discharge planning in the hospital, or of those providing care post-discharge, have proved difficult to chart as has the relationship between levels of dependency and destination on discharge. The implementation of the NHS and Community Care Act 1990 has now focused attention on these issues.

In the US, the emphasis has been on discharge planning in acute hospitals and there has been less incentive for evaluating discharge planning in nursing homes. However, a study evaluating the effects of financial incentives on discharge patterns for Medicaid patients in nursing homes found that such incentives increased the proportion of patients being discharged to lower levels of care. Importantly, the longer the gap between admission and the onset of discharge planning, the less effective the process became (Jones and Reiners, 1986). For the UK, this raises the question of ongoing assessment and discharge planning when people are transferred from hospital to other institutional settings.

Comparison between the US and UK highlights some of the tensions in discharge planning, tensions which will increase in the UK with the creation of more trusts in both hospital and community sectors and the further development of GP fundholding. In time, there may be a choice of agencies each providing different levels of home care and there will be a discrete discharge task in deciding which agencies can provide appropriate levels and intensity of care. How this task will be apportioned between

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US APPROACHES TO DISCHARGE PLANNING

In the US, discharge planning is mandated and negligence charges can be the upshot of inadequate discharge planning on the part of the hospital.

Discharge as a process

Emphasis on discharge as a process has been developing over the last twenty years in the US. For example, as far back as 1974, the American Hospital Association provided detailed information on the principles and process of discharge, and in particular outlined criteria (including admitting diagnoses) that might be useful for screening patients to allow for early identification of those who required discharge planning (American Hospital Publishing Inc., 1983). The relative sophistication of discharge planning takes its cue from the complexity of regulations governing eligibility and standards of care. In particular, the introduction of the prospective reimbursement system, in 1982, raised the profile of discharge planning as hospitals sought to reduce costs per case. Hospitals may develop standard packages of follow-up care for specific diagnosis-related groups of illnesses, the categories used in the prospective payment system (Punch, 1985).

The rise of discharge planning

The rather different approach adopted in the US is witnessed by the rise of discharge planning units and discharge planning managers. While all health professionals have some responsibility for discharge planning, the main professionals who become generic discharge planners are nurses or social workers, who may be known by a variety of names, including discharge planners, home care coordinators, placement specialists and, continuity of care coordinators. There may be managerial, staff, clerical and liaison grades and the department acts as a single agency for referral. Specific discharge planning rounds may be used to discuss continuing care needs of patients, while those at low risk will be followed up by the health care professional with primary responsibility for the patient. Where multi-disciplinary assessments take place, the discharge planner analyses the impact of the various assessments on the discharge plan – again a clear indication of the separateness accorded the function of the discharge planner as opposed to that of other professionals. A concern for costs, reflected in the activities of departments of utilisation review, and the monitoring of admission and continued in-patient stays, has promoted the recognition of discharge planning as 'a concept and as a process' (Birmingham, 1991) – a skill which is more than the sum of independent professional contributions and which is considered as a separate task.

Setting standards

These activities operate within standards which are specific to states, institutions and to different professional groups. There are also guidelines laid down by regulatory and monitoring bodies. For example, the Health Care Financing Administration (HCFA), which lays down conditions of participation for hospitals in Medicare and Medicaid programmes, includes guidelines for discharge planning as part of quality assurance, which is part of each institution's internal programme. Arising out of the HCFA are Peer Review Organisations (PROs), established in 1982 as part of the mandate to review care for Medicare patients. They contract individually with the HCFA and each state usually has a specific PRO. Guidelines issued for PROs emphasise that all patients should have a discharge plan and part of their remit is to evaluate the care received by a proportion of patients readmitted to hospital within 31 days of discharge. Specific standards are laid down by the Joint Commission on Accreditation of Hospitals whose Accreditation Manual includes guidance on dietetic services, emergency services, hospital-sponsored ambulatory care services, medical records, pharmacy and patient rights. It emphasises the importance of documentation of the discharge plan in the medical record which should include an assessment of the availability of appropriate services. Standards for the internal utilisation review committees are also set by the JCHAO and reviews are usually carried out for admission, continued stay and discharge. Finally, there is the range of contracts and agreements between institutions and third party payers, including HMOs.

The existence of multiple regulatory bodies is less daunting than would appear, simply because many of their standards overlap. Ironically, however, it is the very fragmentation of the US system, combined with the centrality of hospital-based care that has made discharge planning and its extensive documentation of such importance. This is combined with concern over the pressure for earlier discharge which is part and parcel of the reimbursement system. In turn, the complexity of the discharge agenda has not been matched by a decline in the accusation that people are discharged too quickly from in-patient care.

primary care, social services and hospital services, or even between purchasers and providers is yet to emerge. The links between discharge planning and care management will also need to be clarified. In the US, hospitals, as the lynch pin of the health care system, have developed an outreach approach to discharge planning, bearing responsibility for short-term needs – deemed the recuperative phase of illness – but also including information on likely long-term needs. In the UK, a plan that enables discharge to take place is clearly a (minimal) hospital responsibility, but the subsequent responsibility of community services for planning and providing ongoing care, often within different organisational frameworks and with differing priorities, leads to confusion. It also affects the success of discharge. For example, if a hospital institutes an early discharge policy, where highly dependent patients need short-term nursing as well as social care, will the local authority provide social care as envisaged in the NHS and Community Care Act? Or will this be a situation where, in order to guarantee care, the hospital will provide its own outreach service, as already sometimes happens in the US and in some of the early discharge schemes in this country? The NHS reforms are likely to bring into prominence demarcation decisions in discharge planning and the provision of post-discharge support.

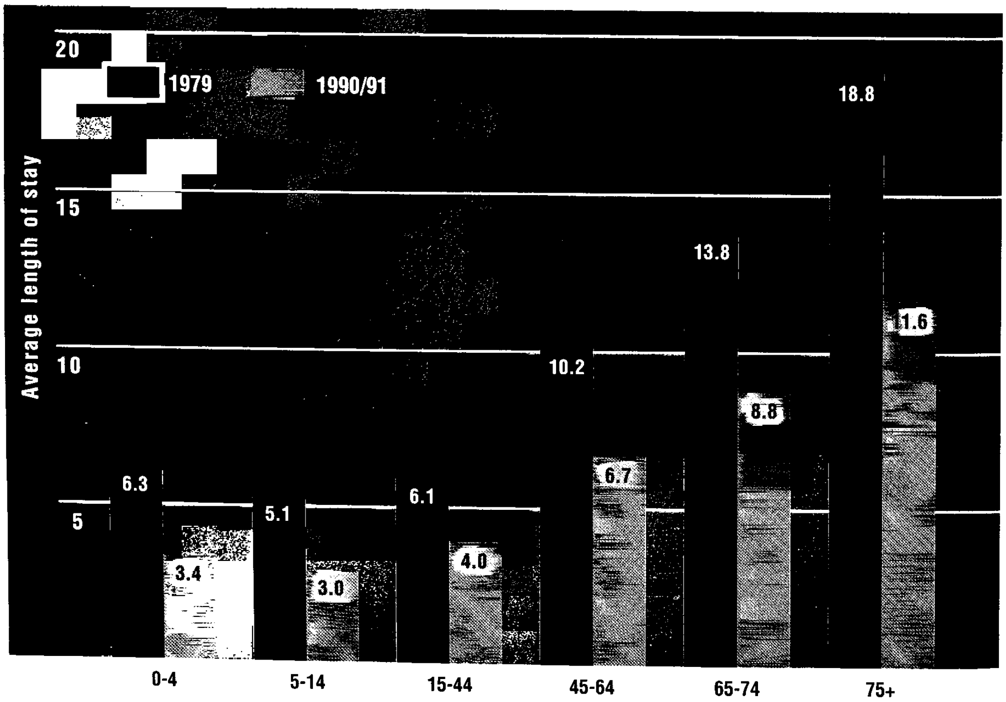
4 Discharge policies and changing boundaries of acute care

This report has documented the emergence of discharge policy in acute hospitals as a discrete area for management concern and policy development. This has encouraged the creation of effective discharge policies and systems for implementation and audit. Better information related to discharge will help chart the changing dependency of patients when they leave hospital and the increasing complexity of discharge arrangements. In this way, planning for community-based health and social care can be placed on a more secure footing. The substance of discharge procedures and the nature of post-discharge arrangements are, however, framed by wider considerations. This section looks at the implications of one major influence on discharge policy, the changing boundaries of acute care. This is reflected both in declines in lengths of stay and in the various implications of current realignments in the balance of acute hospital-based and home-based care. These are discussed in turn.

Declines in length of stay

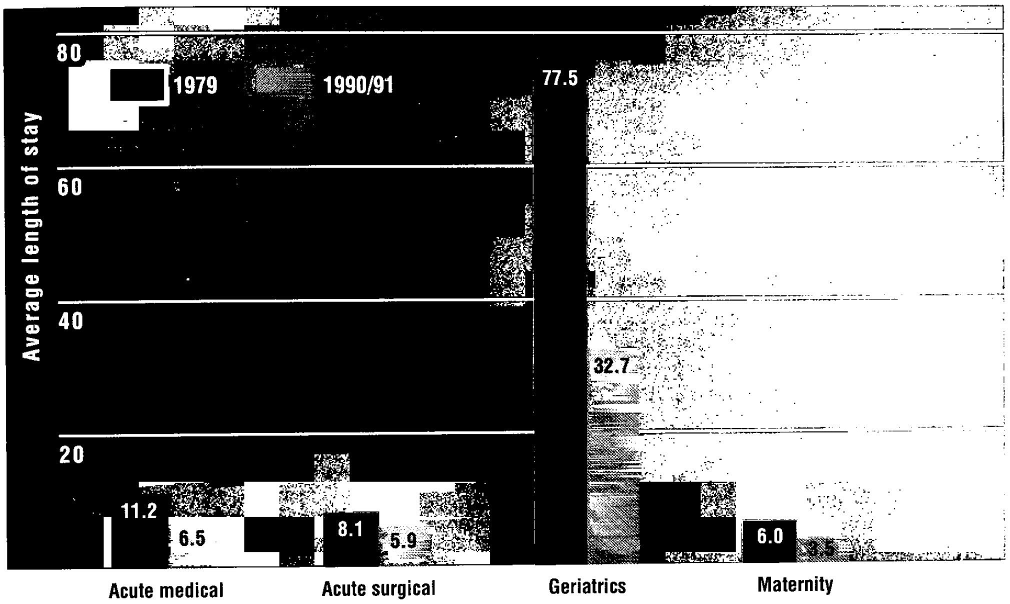
A consistent trend in acute hospital activity is the decline in average lengths of stay across all age groups and all specialties (Figures 1 and 2). There have been numerous attempts to identify reasons for reduced lengths of stay overall, to map the wide geographical variations in lengths of stay for similar conditions and to identify the relative importance of possible determinants. Reimbursement systems, bed management policies, differences in supply factors, (availability of beds, consultants, day surgery, out-patient facilities, nursing and convalescent care) and factors affecting demand such as age, morbidity and socio-economic characteristics have all been considered. Whatever the overall trends, much remains to be discovered about the factors affecting length of stay for particular specialties and sub-groups of patients – see Box 6.

Figure 1 Average length of stay – Acute sector (medical and surgical), England, by age, 1979-1990/91



Sources: Department of Health (1992), Statistical Bulletin, 2/1. Department of Health (1993), Statistical Bulletin 1993/2, February.

Figure 2 Average length of stay – NHS non-psychiatric hospitals, England, 1979-1990/91



Sources: Department of Health (1992), Statistical Bulletin, 2/1. Department of Health (1993), Statistical Bulletin 1993/2, February.

Rethinking hospital-based care

Hospitals exercise a powerful appeal as the dominant institutional representation of health care. They inspire local loyalties and act as a focus for public support. Attacking the organisational integrity of these institutions has often been identified with attacking the availability of health care itself. Although numerous commentators have argued that many of the activities carried out within acute hospitals owe more to historical accident, local politics and consultant privilege than to the rational allocation of functions across the health care system, it is only since the late 1980s in the UK that efforts are being made to marry these observations with organisational changes.

Various reasons have been put forward for this shift in emphasis, and these are discussed in turn:

- changes in medical technology;
- increased specialisation of hospital care;
- resource constraints;
- renewed emphasis on community care.

Medical advances reduce lengths of hospital stay and enable more diagnosis, treatment and monitoring to take place outside hospitals. (See Stocking, 1992, for review.) Clearly, in surgery there are major technological advances such as endoscopes, lasers and lithotripsy which allow for less invasive diagnosis and treatment. Safer anaesthesia has increased the potential for out-patient and day case surgery. Developments in biotechnology have resulted in diagnostic kits and monitoring devices which can be used outside hospitals and the development of portable drug delivery systems likewise extends the conditions that can be cared for at home. With more complex care taking place at home, and the decentralisation of laboratory technology, distinctions between primary and secondary care are becoming increasingly blurred. Technological developments also include devices to assist personal functions and sophisticated monitoring systems. In a review of home health care technology, Banta (1992) argues that the greatest potential for future technology is to support functioning and activities such as moving, bathing, toileting or dressing. However, this has not so far proved a priority either for the health care system, or for the technology industry.

The increasing specialisation of acute care has led to a reconsideration of the role of nursing care within hospitals. While the voluntary hospitals initially cared for the sick poor, and continued to provide longer-term intensive nursing care in the absence of publicly funded community-based alternatives, the decline in the extent to which both longer-term and convalescent care are considered part of the hospital role are evident. Lengths of stay continue to decline across the board, and the extent to which hospitals now provide longer-term nursing care is variable and reducing. The main

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VARIATIONS IN LENGTH OF STAY

Research has tended to concentrate on variations in lengths of stay for common surgical procedures. For example, Morgan and Beech (1990) point out that developments in clinical practice including 'changes in surgical techniques, as well as in suture material, anaesthesia, methods of pain control, the availability of new antimicrobial drugs and types of implant' (p. 92) have all contributed to reductions in lengths of stay. An earlier US study came to similar conclusions after drawing on data from over 500 hospitals observed annually from 1971-1981 in order to identify and evaluate trends in mean length of stay for eleven surgical procedures (Sloan and Valvona, 1986). A number of potential reasons for decreased hospital stays were operationalised and assessed, including degree of competition, service intensity, case mix, reimbursement mix and technological change. The authors concluded that developments in surgical technique were the most important influence, with major reductions taking place before Medicare's new prospective payment system was introduced in 1983.

However, these findings for surgical procedures cannot be extrapolated to acute care in general, where, in the US at least, it appears that cost containment measures have exercised a significant and independent influence on lengths of stay. For example, a review of over 400 US studies on the effects of the prospective payment system across all specialties (Schramm and Gabel, 1988) showed that the length of hospital stays which had been falling for a decade at an annual rate of one to two per cent fell by nine per cent in the first year of implementation. A decline in hospitalisation in the preoperative period was the most important factor in this demonstration of the independent influence of reimbursement systems on mean lengths of stay. Discharge of patients to skilled nursing facilities and home health agencies increased. There was no evidence that readmission rates were affected, however.

More detailed information is available through a Massachusetts-based (1982-6) study of Medicare patients (Epstein *et al.*, 1991). This aimed to test the effects of the prospective pricing system on length of stay and readmission rates over a four year period, albeit in the context of a state where limits were already imposed on hospital total revenues. Importantly, the study controlled for case mix and other confounding influences, such as severity of illness, and made a special study of those conditions where readmission might be affected by quality of in-patient care. Lengths of stay (adjusted for DRG) decreased by about 25 per cent between 1983 and 1986 and one fifth of this decrease was attributed to the introduction of prospective payment. The authors point out that the impact of prospective payment would have been larger if measured in a state where cost-based hospital payment had previously obtained.

While these studies suggest that developments in surgical techniques, and the introduction of cost control mechanisms have influenced overall trends, average lengths of stay for particular groups and within specific hospitals are influenced by age, case mix, decisions over the boundaries between geriatric and acute medical care and the existence of 'outliers' – those with a length of stay far above the mean. These factors need to be taken into account in interpreting the 'performance' of any health authority in relation to this indicator (Sudell *et al.*, 1991). For example, an analysis of factors predicting length of stay for elderly patients in acute wards (Maguire *et al.*, 1986) showed that diagnosis was of greater importance than social factors in predicting length of stay, with stroke, confusion and falls as the main reasons for admission associated with prolonged length of stay. Length of stay as a 'performance indicator' and reasons for change over time in length of stay are therefore complex phenomena. Moreover, it cannot be assured that trends towards shorter lengths of stay will continue unabated. Evidence from a US study of the effects of cost-containment policies by both private sector and federal government shows that declines in average lengths of stay were steepest in the two years following the implementation of the prospective pricing system in 1983, but that subsequently, average length of stay increased slightly (Schwartz and Mendelson, 1991).

group affected are very elderly people, particularly those over 85, and the combination of demographic changes, increasing needs for care and the contraction of nursing within the NHS provides an explosive mixture.

Resource constraints and financing mechanisms are crucial in influencing the boundaries of acute care. The split between purchasing and providing health care highlights areas where the provision of acute care has been least influenced by local circumstances and the need to win contracts will inevitably fuel drives for efficiency. This means that the use of acute in-patient care will come under increased scrutiny, in terms of admission and discharge policies and of performance in relation to lengths of stay for specific conditions.

Finally, policy objectives for health care delivery are moving away from institutions to primary and home care. Since the 1970s, the World Health Organisation has argued that health care systems need to be reoriented so that primary health care becomes the mainstay of the health care system. It also argues that care should be provided locally to patients, and wherever possible, at home (WHO, 1985). British health policy increasingly echoes this concern and recent white papers emphasise health promotion and community-based approaches.

The result of these pressures is to promote, for the first time, a radical rethinking of the role of the acute hospital and of its relationship to other health care services, an activity at its most controversial in the current debate on the future of hospitals in London and other major cities.

As one example of this radical rethinking, a review of acute services carried out by South East Thames Regional Health Authority (1991) took as its starting point the functions carried out under acute care, rather than a concern with bricks and mortar or organisation around specialties. It identified four main functions of acute hospital care: low dependency out-patient work; low dependency in-patient care which does not require elaborate investigation; lower risk elective work for patients with no concurrent illness; and emergency, trauma and other urgent work. The review argued that each of these holds different implications for degrees of specialist care available within a single location and for decisions over the siting of services. In relation to the interface between acute and primary care, they made the observation that

> *there is a direct relationship between the optimal use of hospital beds and out-patient clinics and the capacity of primary care, social services and other agencies to support convalescence and undertake follow-up* (p. 36).

In their review of the changing interface between acute and primary care services, Hughes and Gordon (1992) illustrate ways in which these boundaries are being redrawn. Their review of the interface between primary care and acute care reveals a woeful lack of shared information, with consultants often unaware of basic information such as the range of services offered in specific GP practices. Despite this, there are a number of initiatives demonstrating shared care between consultants and GPs for diabetes, asthma, hypertension and antenatal care, where GPs undertake routine management and monitoring with specialist diagnosis and back up from the hospital.

One of the effects of pressures from both within and outside the hospital sector has been to create a new area for debate and dissemination – hospital care at home (Marks, 1991 and see Box 7).

Medical advances and technological developments need to be harnessed to new systems of delivering and organising care. Changes in the ways of thinking about acute hospital care have important implications for discharge policy and practice and these are explored below.

Changing boundaries: discharge implications

Discharge policy and practice reflect, implicitly or explicitly, the parameters of acute care in general and views over the best management of specific conditions in particular. These include assumptions over appropriate lengths of stay, decisions over whether follow-up is via GPs or out-patients, and over the intensity and kinds of nursing care which need to be hospital-based. Each of these factors may vary from hospital to hospital, or even from one consultant to another. Discharge policies thus reflect not only the management guidelines of any particular hospital or ward but also the extent to which the boundaries of acute hospital care are being redrawn. Discharge options locally are also framed by alternatives available within the community, including the provision of residential and nursing care; GP beds for convalescence and rehabilitation; the organisation of care including acute care for elderly people; and community-based alternatives. The content of discharge therefore reflects options available to any hospital in arranging for community or residentially-based health and social care.

This section focuses on aspects of changing boundaries which are of particular significance to the development of discharge policies. First, is the contribution of discharge practice to reducing lengths of stay; second, is the change in the funding and location of longer-term nursing care for elderly people; third, is the deliberate substitution of hospital levels of care with home care; and, fourth, is the renegotiation of the responsibility of acute hospitals in providing shorter-term convalescent care.

Discharge practice and length of stay

There is increasing interest in assessing the influence of discharge practice on length of stay. While pressures on acute beds and cost-containment policies can be translated into inadequate discharge planning or premature discharge, the same pressures may also act as incentives for the implementation of comprehensive policies and the development of extensive domiciliary support which, at their best, may reduce lengths of stay, be cost-effective and increase patient choice. As already mentioned, for specific groups of patients, selected technologies or particular surgical procedures, carefully administered hospital care at home schemes have successfully combined earlier discharge with reduced costs for the hospital sector. In these cases of the deliberate relocation of acute hospital care into the home, careful assessment and appropriate discharge arrangements form the hub of successful initiatives. The same emphasis on discharge planning is evident in the relocation of frail elderly people from longer-term nursing care in hospitals into supported home care. One example of this in the UK is the Darlington Community Care Project, which provided a successful model for integrating discharge planning within the wider care

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HOSPITAL CARE AT HOME

Hospital care at home involves bringing together disparate initiatives ranging from early discharge from acute hospitals to alternatives to hospital admission, along with studies of the cost-effectiveness of transferring selected hospital-based procedures into the home. Developments in information technology and advances in treatment and rehabilitation technology can also facilitate certain kinds of home care.

Hospital care in the home is a blend of the old and the new; both comparative policy analysis as well as an examination of initiatives within the history of the NHS show that experiments in home care are legion. However, dissemination has been patchy and the overall significance of these developments for changing the boundaries of acute and home care have been poorly exploited to date.

Although the kinds of care provided clearly differ over time and across different health care systems, there are many examples of organisational innovation. For example, since the inception of the NHS there have been attempts to reduce the trauma for young children of hospital stays by promoting paediatric home care. The first schemes were developed in the 1950s, but in 1987 there were still only 23 schemes in existence in England (While, 1991). Initiatives in providing hospice care at home were begun in 1969, and there is a wide spectrum of home-based terminal care. In 1991 there were 321 home care teams working from hospital, hospice or community bases (Clark, 1991). Domiciliary terminal care provides a microcosm of the ways in which care spanning hospital and community can be provided and of the types of cooperation that can exist between hospital teams, primary care and specialist advisors.

In the UK, certain people requiring ventilatory support have been cared for at home since 1965, and home total parenteral nutrition was first established in the 1970s. In the UK, too, haemodialysis for end-stage renal disease has been carried out at home since the 1970s. Again dissemination has been slow, and incentives weak. Continuing care for diabetes has taken place in some GP practices since the 1970s, and here too there are different models for apportioning responsibility between GPs and out-patient care.

Clearly such developments could not take place without certain 'enabling factors' such as the general improvement in home standards, technological developments and initiatives both in providing complex packages of care in the home and in spanning home and hospital care. Nevertheless, the directions in which hospital care at home are now developing are also influenced by reimbursement policies, financial incentives, the search for cost-effective alternatives to acute in-patient care and the increasing involvement of major supply and drug companies (McNerney, 1985) in providing home care services in conjunction with their home care product businesses. Successful innovations in HCH are likely to encourage further critical evaluation of the boundaries of acute and home care.

management process, where a multi-disciplinary team carried out screening procedures, assessment, care planning and discharge. The package of home care was regularly monitored and reviewed (Challis *et al.*, 1989).

Discharge-related initiatives have often formed part of special projects and have been separately evaluated. Discharge planning has been shown to be effective in reducing lengths of stay even when lengths of stay are already short. For example, an experimental study carried out within a single medical unit in a US hospital (Farren, 1991) showed that the length of stay for patients receiving early discharge planning was reduced by half a day in stays of under five days. As a result, discharge planning was made mandatory, and no longer depended on a physician's order; the discharge screening tool was used on every unit, and discharge conferences were made mandatory for all patients. Studies carried out in the UK, too, have shown that initiatives incorporated within the day to day running of hospital departments can reduce length of stay. Early discharge planning combined with regular review of those occupying acute beds for longer periods (see, for example, Sadler, 1990) has proved particularly valuable. The Audit Commission's report on managing acute beds (Audit Commission, 1992) emphasised the importance of integrating discharge planning into preadmission, admission and assessment procedures.

It is clear, therefore, that routine discharge planning should form an integral part of the efficient management of hospital beds and that specific discharge protocols can reduce lengths of stay for selected conditions and groups of patients.

Discharge and longer-term nursing care

NHS continuing care beds have traditionally been provided for patients dependent on longer-term nursing care. The extent to which patients receiving continuing nursing care occupy beds in acute, rehabilitation and assessment wards varies from hospital to hospital, influenced both by local policies for managing the care of elderly patients and by the availability of suitable local alternatives in the community or in residential care. In recent years, consumer organisations and CHCs have voiced concern over a poorly documented and, until recently, poorly debated decline in the number of NHS continuing care beds. In the appropriately named *Dis-continuing care* (1991), Age Concern England documented the results of their survey of English health authorities on this issue. Despite difficulties in interpreting the figures, given the lack of a common practice for recording bed numbers for elderly people for acute, respite and continuing care, and rehabilitation, there was a clear trend for a large decrease in the number of continuing care beds. Reflecting similar concerns, the Association of Community Health Councils for England and Wales carried out a survey of CHCs on this topic in 1990 (ACHCEW, 1990). Seventy seven per cent of respondents reported a reduction in the provision of continuing care beds over the previous three years.

These changes can be linked to a number of different factors. The first is a major shift in thinking about the role of acute care. While ministerial pronouncements echo a commitment to a continuing care role for the NHS, the Management Executive is more cautious while health authorities often unambiguously state the opposite. Thus Virginia Bottomley wrote to the Patients' Association in August 1990 that 'It is not government policy to encourage health authorities to reduce the number of long stay beds in favour of the private sector' (quoted in Age Concern, 1990b). However, in correspondence (dated 5.4.91) with Sally Greengross, director of Age Concern England, Duncan Nichol commented that 'whilst health authorities and units are expected to act reasonably in all the circumstances, this does not include keeping the patient in hospital where there is no clinical need to do so', and that discharge procedures were a matter for 'local management'. Taking a more extreme view are some local health authorities which consider that hospitals are solely about medical emergencies and acute care. Thus a (1987) plan for one district (quoted in *Dis-continuing Care*), stated that 'no hospital provision should be set aside for those elderly people who require continuing care other than beds being always available to cope with medical emergencies' (para. 7.6(d)). This combination of clear policies at national level, ambiguity at management executive level and contradictions at local level, inhibit the implementation of clear discharge procedures for frail elderly people, who are increasingly unsure of their rights to free nursing care. Often this confusion means that the spirit and letter of the discharge circular HC(89)5 and the accompanying booklet are contradicted at local level. For example, the CHC survey showed that there was often little consultation before discharge, a lack of information about rights to nursing care and of financial contributions towards private care and alternatives were not offered (ACHCEW, 1990).

One of the factors which enabled district health authorities to reduce long-stay beds was the proliferation of private nursing home care from 1983 onwards. This provided hospitals with a sense of security over the placement of frail elderly people in receipt of income support. The result is that many hospitals are now losing their capacity to provide longer-term care for frail elderly people. This is worrying given the growth in numbers of very elderly people requiring high levels of support and the results of surveys which demonstrate that geriatric medical long-term care patients are a highly dependent population (see, for example, Ward *et al.*, 1992). Even where suitable private alternatives are available many private nursing homes would not be able to cope with patients with severe behavioural difficulties. NAHAT (1989) has stated that the most likely effect of the increase in numbers of people aged over 85 between 1988 and 1995 will be the increased demand for long-stay care and various studies have shown that patients in long-term beds are more physically and mentally frail than those in nursing homes or residential care (see chapter 4).

There seems, therefore, to be little relationship between the increasing demands of an elderly population and the provision of long-term care within the NHS. Joint planning for community-based alternatives is sporadic and subject to changing priorities within local authorities. Where there are joint plans with the NHS and the independent sector it is often not clear who will pay for that care. In her recent review of community care and elderly people, Henwood (1992) argues that the belief that long-term care of frail, elderly people can largely be provided in 'the community' is based on an article of faith rather than on an assessment of the available evidence.

Reducing the availability of free long-term care for elderly people within the NHS, and replacing it with means-tested local authority services raises a number of issues of wider policy concern. Age Concern has been active in highlighting four major problems:

- increasing inequity in the access to longer-term care, depending on local provision;
- a lack of comprehensive care for frail elderly people;
- organisational tensions over 'bottom line' responsibilities of health and local authorities;
- and the introduction of means-testing for longer-term nursing care. Age Concern comments that 'we believe that the issue of means-testing for continuing nursing care must be openly debated. At the moment, it is an implicit but crucial factor in many regional and district plans' (Age Concern, 1990b, p. 7).

Reliance on the private sector for the most frail and vulnerable has important drawbacks. The private sector can pick and choose its residents, and there are already examples of people on income support being refused places. There is no security of tenure; fees can go up and individual homes can of course be closed. The extent of local authority provision varies between different localities, and is framed by local priorities, resources and demands. This guarantees, at the very least, a degree of inequity from district to district. Research has already demonstrated (Harding, 1992) geographical variation in the provision of local authority services and this is now extended to the provision of what was formerly considered to fall within the province of the NHS. The changing boundaries between health and social care mean the right to free care is exchanged with a duty to purchase care. It is no accident that an area where health care costs are rising dramatically – longer-term care – is one of the first to be means tested. The emphasis placed by the NHS ME on local flexibility, while encouraging innovative and flexible responses also means that these tensions will be resolved (or not) at local level, with services being allowed to find their own level in a sea of competing demands.

Against this backdrop, the NHS and Community Care Act 1990 made provision for the transfer of the residential care element of the income support budget (from April 1993) to local authorities for new patients. The purpose of this was to reduce the incentive for providing institutionally-based care through the availability of an open-ended budget for those on income support. The many difficulties inherent in this transfer have already been aired. The size of the budget is difficult to estimate as no record has been kept of local residents' entry into private nursing care; there is no statutory provision to provide certain levels of service, and initially money was not ring-fenced, raising questions of the priority such care would receive against the many other competing demands on resources. (This latter element was later revised as a result of pressure from local authorities.) Lack of targeted funds is a fundamental problem in a reform intended to create a wider range of community alternatives for elderly people.

In relation to discharge procedures, this change compounds many of the problems outlined earlier. The ambiguity surrounding responsibility for long-term care permeates discharge procedures for this group. Assessment for long-term care is partly a process of elimination of all available alternatives. Age Concern (1990c) notes that:

> *in some authorities assessment procedures include an initial investigation of the financial resources of the patient. Those who remain in NHS care do not have enough resources of their own and live in areas where no nursing home care is available within DSS limits* (p. 7).

With the introduction of the NHS and Community Care Act, health authorities will not have easy access to income support and will be dependent on the local authority for providing alternatives to NHS accommodation, whether this is in a nursing home or in the community. It is not yet clear what the effects are likely to be on the need for long-term care beds, if these are to remain a safety valve. In addition, it is unclear who has bottom line responsibility for providing long-term care for the increasing number of frail elderly people with dementia who personify the impossibility of separating health and social care.

In summary, therefore, both continuing care beds and the use of income support have been important safety valves in the absence of comprehensive strategies for the care of elderly people. Both those safety valves are being removed and alternatives are not yet in place. Neither are there joint information systems on which to plan alternatives. There is a strong body of opinion that the demand for long-term care is unlikely to diminish. However well managed the discharge procedures within hospitals, there is little that can be done to prevent blocked beds if community-based alternatives for frail elderly people are not in place.

Hospital care at home

Hospital care at home is the term generally adopted to describe changes in the boundaries of acute and home care, where levels of care associated with acute hospitals are relocated at home (see Box 7). Although the deliberate and carefully planned substitution of hospital with home care should be clearly distinguished from the general trend towards earlier discharge, this section argues that the principles of discharge planning which have proved essential to developing hospital care at home schemes illustrate issues which are central to discharge policy in acute wards. Earlier discharge and the reassessment of the location of non intensive nursing and convalescent care reflect a gradual reshaping of boundaries, the effects of which have been largely unanalysed and the implications for discharge policy largely unexplored.

Attempts to establish cost-effective home care schemes have inevitably formulated careful plans so that discharge can take place safely and effectively. Unlike many of the professional guidelines or HC(89)5, these are formulated around particular conditions or treatments, reflecting the fact that while the principles may be generalised, discharge planning is essentially a detailed activity organised on an individual basis. Because there is no margin for error in the quality of post-discharge arrangements, the delivery of supplies or the monitoring of care arrangements, great attention has been paid to the organisational routes for spanning the gap between primary and secondary care. Such initiatives point to some of the inadequacies in current organisational arrangements and indicate ways forward.

The creation of feasible and cost-effective HCH programmes involves a number of first steps: the choice of suitable conditions; selecting suitable patients from the patient population who suffer from these conditions; implementing programmes to prepare and instruct patients, families and carers; identifying the acceptability of the programmes to service providers and service users and establishing efficient management procedures pre and post-discharge. This is less straightforward than might appear. For example, choosing suitable conditions depends on an assessment of different levels of need for nursing, rehabilitation and other care in a hospital stay and an evaluation of the point at which it is clinically safe and organisationally feasible to transfer care into the home. Many hospital at home schemes are fundamentally early discharge schemes reflecting the fact that nursing and rehabilitation are often the main reasons for being in hospital once the early interventionist period is over.

One example of an initiative which attempted to measure hospital and community inputs was a pilot study carried out in Sweden in order to explore the potential for replacing part of the hospital stay for total hip replacement with a programme of home rehabilitation (Moller *et al.*, 1992). This involved plotting the type and length of care and rehabilitation activities that each category of staff provided for each in-patient day, an assessment of those that could take place at home and cost projections for hospital and home care. It was found that 'most of the hospital stay beyond five days after surgery seemed to be entirely devoted to such physical training and physical therapy treatments as motion and walking exercises' (p. 96). These were similar to those provided to older patients through home care services. It was considered cost-effective to reduce lengths of stay in favour of early rehabilitation at home, although individual discharge times would, of course, vary. The analysis of each 'component' of hospital-based care by condition is an important way of exploring the potential of hospital care at home. It is an extension at ward level of the functional approach increasingly applied more generally to the location of services currently concentrated in the acute hospital.

While it would be difficult to construct a cost-effective service without these stages, they are not in themselves a guarantee that hospital care at home is cost-effective. Subsequent evaluation would have to assess total costs for both hospital and community services, for patients and carers, should measure outcomes and ideally be based on an experimental design. Few studies conform to these requirements. However, various reviews of high technology care at home have shown that cost-effective care is most clearly demonstrated where there is no multiple pathology, where there is an element of non-professional help and where training is not too complex. In other words, home care for specific conditions with relatively predictable prognoses are cheaper. To the extent that remaining hospital beds are occupied by more acutely ill patients, however, skill mix on acute wards may need to be modified. It is often difficult to establish cost-effectiveness in studies of early discharge for elderly people with multiple pathology. It may even be difficult to establish that home care is a substitution for acute in-patient care, as opposed to terminal care, geriatric care, home care or no care at all. However, home care schemes can deliver high quality services, are often preferable for patients and their families and can be argued for on grounds of quality and patient choice.

Other hospital at home initiatives show the benefits of discharge planning which starts at admission and often reflects better management of in-patients. Thus, in the Peterborough scheme for early discharge of elderly people with hip fractures, management has been tightened up from the point of admission in order to avoid delays in casualty, assessment and decisions over the capacity to discharge early (Pryor *et al.*, 1988). Criteria for selecting patients have been developed and a team assesses the mental function of the patient, pre-injury levels of mobility inside and outside the home and the extent of support required. Such an approach contrasts with common clinical management of such patients. For example, one survey of the care of elderly patients with fractured neck of femur showed: long waits in casualty; that mental function was not routinely assessed; the lack of readily available senior medical care; delays in carrying out the operation; and delays in planning discharge (Pearse and Woolf, 1992). Ninety-three per cent of the hospitals in this survey did not have an effective policy for ensuring that patients spent no more than one hour in casualty. This demonstrates how effective discharge planning is inseparable from good clinical management of specific conditions.

Hospital care at home schemes which involve high technology care such as intravenous therapies, need to ensure a degree of participation, emotional stability and dexterity among patients or their carers. Careful instruction has to be carried out in hospital, and possibly reinforced in the home setting. This will include written instruction and clear indications of how to seek emergency aid. Given the increased demands of looking after acutely ill people at home, or of carrying out complex procedures where mistakes may be life threatening, full understanding of the patient and family is required, as is a realistic assessment of the emotional and financial burdens which may ensue. In general, for acute home care, there is no margin for error in the transportation of supplies or in the arrival of services for the home. The time lag so often identified in traditional discharge arrangements is not an option. Therefore discharge arrangements are in place before the patient leaves the hospital and follow-up is immediate.

There are different ways in which the gap between hospital and home care may be bridged. In keeping with the fact that it is often perceived to be in the interests of hospitals to discharge patients early, many schemes are initiated by hospitals. Post-discharge care may be provided through hospital outreach, teams spanning hospital and community, expanded community services, autonomous home care agencies, and for certain kinds of intravenous therapies, equipment manufacturers. Where agencies outside the hospital contract to provide home care they will often need to be involved in the discharge process within hospitals. Common to all these organisational permutations, however, is a guarantee of the kinds and levels of care which will be provided at home. Thus there is prior understanding and agreement both of the duration of care and of the kinds and levels of services required by the hospital care at home service. It is not possible to discharge to autonomous authorities who accept the referral but will provide levels of care determined by the priorities of their organisation, as currently happens with routine arrangements in the UK.

Schemes are not limited to early discharge from acute hospitals and some involve the successful expansion of community nursing services to provide a wide range of hospital level care, enabling earlier discharge and also preventing admission. There are a number of these schemes in operation in the UK (for example in Pembroke, Derby, Croydon and Peterborough) and the Peterborough scheme is the best established UK initiative. The Pembrokeshire hospital at home scheme, set up in 1990, provides acute nursing and rehabilitation, and takes referrals not only from orthopaedic surgeons and general surgeons, but from GPs and district nurses where it is considered that the service can prevent hospital admission. Medical care is the responsibility of the GP. Other condition specific initiatives have been described. Butters *et al.* (1991) describe care of people with HIV/AIDS through community teams, one of an increasing number of services developed to provide a wide spectrum of care in the community

Some of the most dramatic, and cost-effective forms of hospital care at home, involve the transfer of procedures associated with hospitals such as intravenous antibiotic therapy and nutritional support. However, changing the boundaries between acute and home care will depend on the extent to which lengths of stay can be reduced for more common conditions such as myocardial infarction, cancer, stroke, orthopaedic care, and paediatric care, and on better provision for home-based terminal care. It will in part depend on the extent to which elderly people with multiple pathology can be safely cared for at home.

Hospital care at home represents and reflects new thinking about discharge and the boundaries of acute care. Instead of discharge arrangements being considered in terms of 'when the patient is ready to leave hospital' or needs of patients after discharge, the quality of discharge arrangements can themselves inform what is considered to be essential or appropriate lengths of stay. It demonstrates the importance of each aspect of the discharge process (outlined in the introduction); underlines the importance of transfer arrangements and of agreement over guaranteed levels of care outside the hospital. Unmonitored early discharge is not an option for this kind of care. In passing, it has demonstrated that various organisational arrangements and new kinds of staff can all help to make early discharge a possibility even for complex cases. It thus raises questions about length of stay and the integration of discharge policy with clinical protocols for specific conditions.

As already mentioned, hospital care at home needs to be clearly distinguished from the trend towards earlier discharge. However, early discharge of frail elderly people itself reflects a change in the role of the acute hospital in providing convalescent care.

Whatever happened to convalescence?

A report from the Industrial Society demonstrates the importance previously attached to convalescent care.

> *The (NHS) has made a period of convalescent home treatment available to patients who have been hospitalised if the case is considered suitable by the hospital medical staff. However, there are cases where a period of convalescence would be beneficial for someone who has been working under pressure, suffering strain through domestic problems or debilitation through a succession of minor illnesses. Firms and Unions who provide facilities for convalescence in such circumstances are contributing to the establishment and maintenance of the highest possible degree of physical and mental well being of the workers and ensuring for themselves a healthier and more contented workforce* (The Industrial Society, undated, p. 9).

The Industrial Society showed that many firms and unions ran their own convalescent homes; hospitals often employed 'convalescent secretaries' to arrange recuperation in convalescent homes, which catered for people of all ages, helping in the transition from hospital to home. Such posts are now rare and there are few convalescent homes. While it is accepted that many rehabilitation and convalescent needs can be met outside hospital, there has been a drift away from the institutional provision of convalescence, and from the responsibility of hospitals, among others, to arrange it. GP beds and hotel services provided by hospitals are now the only recognition of the need for intermediate care or for institutionally-based care which is transitional between home and hospital. GP beds, whether in general or community hospitals, traditionally provide low technology care at a level intermediate between home and hospital for patients unable to remain at home. One influential and recent example is the Lambeth community care centre (Henderson and Tarpey, 1992). There have also been initiatives in providing community nursing beds. With developments in community-based care some have considered this anachronistic, though there are signs that the pendulum is swinging back. Hughes and Gordon (1992) point out that fundholding may provide an incentive to increase the numbers of GP beds.

The more recent trend towards closer analysis of the functions carried out within acute hospitals and on wards, and the concern to provide cheaper locations for as many as possible of those functions is evident not only in accelerated discharge for certain conditions and treatments but also in the interest over the last two years in separating 'hotel' functions from other aspects of in-patient stays.

The patient hotel originated in Sweden, and in 1991 the first designated patient hotel was opened in Kingston Hospital (although currently housed within the hospital). The cost per bed per day is estimated at £51 compared to £230 in an acute bed (Meara, 1992). Patient hotels are now being planned by a few districts for day surgery and day treatment, where patients are not to be left alone for the 24 hours following treatment, and for oncology and ophthalmology patients recovering from operations. There is also the possibility of using hotels as half way houses to allow for earlier discharge. It has been pointed out (Anon., 1991) that there is a sense of unease that hotels may be used as a stop-gap and as a 'substitute for the much neglected art of discharge planning' (p. 3).

The declining capacity of acute hospitals to meet needs for recuperation creates problems as the care needs of elderly people make it unrealistic to use hospitals purely as 'technical treatment centres'. In her review of acute services, Stocking (1992) highlights the tension between technological developments which enable patients to be discharged earlier and the increasing population of elderly people 'who may require longer to recover physically and psychologically than they would have done when younger' (p. 8). While demographic and social changes have been reflected in the pattern of use of acute services, they have not prevented a continuing trend towards shorter lengths of stay in acute wards. Neither have they been reflected in comprehensive strategies for community-based post-discharge services.

The need for post-discharge care, or convalescent care, has never been prominent in welfare legislation. Russell and Brenton (1989) compare the experimental rest homes established in the 1950s and the community-based hospital discharge schemes, often provided by voluntary agencies and which became established during the 1970s (see chapter 2). Both forms of provision were designed to ease the transition between home and hospital and provide time for services to be arranged. Both, however, remained peripheral to mainstream service provision. It is of interest to note that the four rest homes set up by the National Corporation for the Care of Old People had patients who were supported by either the hospital or welfare authorities, depending on the nature of care needed. Clearly the health and social divide in this area has a long heritage. Russell and Brenton comment that discharge schemes masked the inadequate levels of statutory service provision and that

> *it is the social position given to elderly people that perhaps ultimately explains why solutions to the problem of their hospital discharge and aftercare have usually taken the form of temporary measures tacked on to the statutory services from the voluntary sector, rather than specific services geared to their needs ... It contrasts, for example, with the statutory aftercare arrangements for mothers and their newly born babies on return from hospital* (1989, p. 225).

New thinking about discharge is an inevitable consequence of these changes in the boundaries of acute care. Where changes are planned and deliberate, as in hospital care at home, or the provision of home-based terminal care, the discharge process itself rarely poses problems. In other words, when discharge, or home care is the focus, organisational barriers can be surmounted. Difficulties arise when the discharge process reflects ambiguities, tensions and organisational mismatches between hospitals, social services and primary care, particularly in relation to unplanned changes in the boundaries of care or in the ability of any of those organisations to meet the demands made of them.

Monitoring the effects of changing boundaries

Monitoring the effects of the changing boundaries of acute care on the quality of that care is of great importance. While a range of methods may be deployed, including surveys and patient interviews, early emergency readmission rates have been considered as one possible indicator of changes in the quality of in-patient care. It has been tempting to draw parallels between the trends towards earlier discharge and increased rates of early emergency readmission, which are particularly marked for frail elderly people. However, relationships between length of stay, discharge procedures and early emergency readmissions are complex, and merit careful examination.

Emergency readmissions: a meaningful indicator?

One indicator of 'unsuccessful discharge' is when an emergency readmission takes place soon after discharge, and where the reason for readmission is linked to the original admission. In such cases there is a strong argument for assessing the quality of in-patient care, discharge planning and post-discharge support – see Box 8.

The increased rate of emergency and elective readmissions after both planned and unplanned admissions can be demonstrated through analyses of routinely available hospital statistics, given the existence of an unified medical record system. For example, data collected through the Oxford record linkage study for 1968-85, and covering all hospital discharges except psychiatry and obstetrics, demonstrate that age-standardised readmission rates (within 28 days of the first, index event) had risen for all specialties over this period. Between 1968 and 1985, readmission rates for elective readmissions after elective index admissions rose from 3.5 per cent to 7.1 per cent, reflecting a pattern of acute care that increasingly favours repeated planned admissions over extended lengths of stay. Less predictable was the rise in emergency readmission rates, from 4.0 per cent to 7.0 per cent over the same period. The authors are cautious over the interpretation of these trends commenting that 'on one hand, the results are consistent with the suggestion that pressure on resources and decreasing lengths of stay may have led, in certain cases, to inappropriately early discharge necessitating emergency readmission' (p. 712). However, on the other hand, the authors had found no increase in readmissions after planned day case surgery (Henderson *et al.*, 1989). More recent data from the Scottish linked data set confirm this trend. The emergency readmission rate (within 28 days) after an initial emergency admission was 7.5 per cent in 1983 rising to 9.6 per cent in 1990 (see Figure 3). Standardisation by age and sex made little difference to these readmission rates. Emergency readmission rates after an emergency index stay have risen for all age groups.

As a group, elderly people are vulnerable to a pattern of repeated emergency readmissions, setting up a cycle of chaos. This pattern was demonstrated in a study of 903 patients aged over 75 (Townsend *et al.*, 1992). It was found that patients initially admitted as emergencies were significantly more likely to be readmitted than those with a planned admission – and these readmissions were significantly more likely to be emergencies. Eighty nine per cent of first readmissions within two weeks were emergencies as were 78 per cent of first readmissions within eighteen months of discharge. Notably, there was a high rate of multiple readmissions, with 10 per cent of patients who lived alone and who did not benefit from an aftercare scheme (which this study was designed to evaluate) having four or more readmissions within 18 months. The aftercare scheme led to a significant reduction in emergency readmissions.

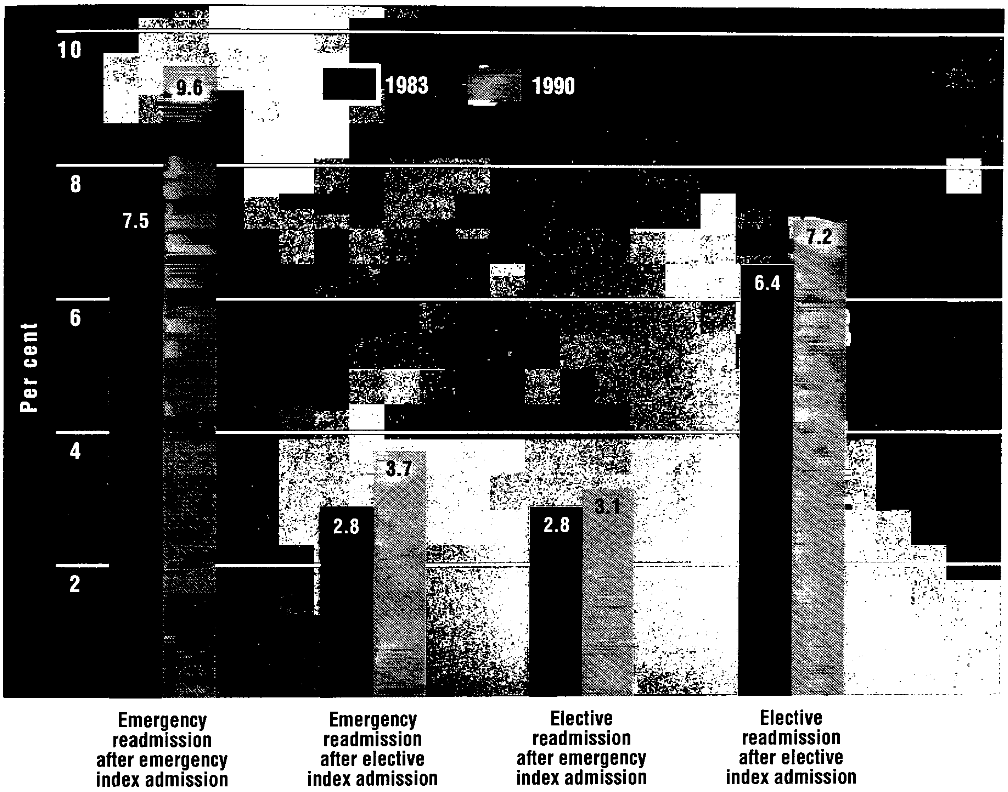
The authors point out that:

> *with increasing pressure on hospital beds, general practitioners, patients and carers often find that requesting an emergency admission is the only way to get a patient a bed. Patients are then denied the possibility of making their own plans for admission and discharge care, and so a potential cycle of disorganisation begins ...* (p. 138).

More planned care and supported discharge are suggested for vulnerable groups such as the elderly living alone, or for those with two or more emergency admissions within six months.

While analysis of readmission histories may provide a useful pointer for discharge planning, caution in using readmission rates as a general indicator of the quality in-patient care is routinely recommended: methodological difficulties involved have led some commentators to reject their usefulness altogether. For example, Victor and Jefferies (1990) argue that 'readmission has little future as a general indicator of outcome, despite the strong attraction of the increasing ease with which this indicator may be calculated by using computerised patient admission data' (p. 20). Planned readmissions, emergency readmissions which arise from a largely unpredictable deterioration and readmissions unrelated to the initial admission are clearly poor candidates for assessing the quality of in-patient care. However, analysis of readmission rates is gaining prominence given the importance of auditing acute services, combined with the availability of readmission data in those systems which have developed patient-linked data sets. The US Health Care Financing Administration, for example, takes for granted the importance of readmission as a

Figure 3 Trends in readmissions, Scotland, 1983-1990



Source: Information and Statistics Division, Scottish Health Service (1993), *Trends in hospital readmission rates in Scotland 1983 to 1990*, Health Briefing No. 93/23, July.

possible indicator of the poor quality of in-patient care and has mandated that Peer Review Organisations (at a cost of some $50 million per annum) review the care provided during the initial hospitalisation for a 25 per cent sample of readmissions that occur within 31 days of discharge (Epstein *et al.*, 1991).

While the benefits of avoiding early emergency readmission and the cycle of disorganisation that follows for elderly people and their families may seem self evident, further research is needed to assess the levels and types of discharge planning which can reduce the need for repeated hospital readmission.

This chapter has demonstrated how changes in acute care have affected the process of discharge and the options available for care. Conversely, developments in discharge planning, particularly in hospital care at home, have demonstrated the potential for shifting the boundaries of acute care, the importance of protocol development which encompasses discharge and the benefits of managed change.

Discharge inevitably involves negotiation. However, it is increasingly the case that good discharge planning is also a right for patients, and rights are not simply a function of whatever happens to be available locally. Whereas problems over the continuity of care have prompted research about the nature of professional negotiation, organisational culture and the problems and benefits of multi-disciplinary working, it is the more recent approaches to bed management and hospital care at home that have raised questions about methodologies for establishing patient dependencies, for establishing the cost-effective cut-off between home and hospitals and for developing ways of spanning hospital and community care.

8

EARLY EMERGENCY READMISSIONS

Attempts have been made to unravel the significance of readmission rates not just in relation to the quality of in-patient acute care but also in order to better target discharge efforts. These studies include explorations of the predictors of readmission ranging across:

- patient-related characteristics (age, gender, living arrangements, case severity);
- aspects of health care organisation (hospital size, competition);
- in-patient stays (length of stay, quality of in-patient care);
- and the quality of discharge arrangements (Thomas and Holloway, 1991).

Readmission and the clinical case

A consistent and unsurprising finding of studies both in the US and the UK is that readmission is linked to the severity and complexity of the clinical case. Victor and Vetter's (1985) random sample of patients over 65 discharged from acute hospitals showed that 17 per cent were readmitted within three months; the readmission diagnosis was the same as the admitting diagnosis in 77 per cent of cases and people with chronic disabling conditions were at a higher rate of readmission. They found no links between length of stay and readmission rate. Thomas and Holloway (1991) found that readmission rates among the DRG groups studied ranged from 5.2 per cent to 29.5 per cent and that within DRG groups severity was the most consistently important indicator. While demographic variables were important, this was generally due to association with demographically-related mortality patterns. Adopting a rather different approach to the same issue Anderson and Steinberg (1985) attempted to develop a predictive model. Of the twenty influences considered, the most important variables were clinical (number of discharges in the 60 days before admission; whether the condition was chronic and whether surgery had been performed). The study emphasises that even a small decrease in readmission rates could have a substantial financial impact.

Clinical severity and readmission

A number of researchers have further explored the relationships between clinical severity and readmission rates. From a clinical perspective, there are difficulties in deciding on appropriate time gaps between initial admission and subsequent readmissions for particular procedures. Henderson *et al.* (1989) point out that 'in monitoring the success of hip arthoplasty a much longer time period for readmissions would be appropriate than in monitoring readmissions for infection after abdominal surgery' (p. 713). Also, as patterns of readmissions differ across diagnostic groups, it is important for planning purposes to analyse repeated readmission rates across specific groups of conditions. Gooding and Jette (1985) looked at four diagnoses – cerebrovascular disease (excluding stroke), hip fracture, congestive heart failure and stroke (considered separately), analysing the six month hospital readmission rates among over 65s. The overall readmission rate within this six month period was 24 per cent. Importantly, however, readmission rates varied widely across the four diagnostic groupings. Patients with congestive heart failure (CHF) were at particularly high risk of being readmitted and of repeated readmissions. The authors comment that 'neither age, gender nor the complexity of concomitant illness appear to affect this CHF group's risk for rehospitalisation' (p. 600). In addition, they were more likely to be readmitted after short lengths of stay and if they had been discharged directly home than if they had been discharged to alternative care. This study is important for its attempt to unravel the relationship between diagnostic group and readmission rates. It is also a strong argument for attempting to target and refine discharge planning based on better information about the groups most at risk of repeated readmissions.

Readmission rates

While analysis of readmission rates from routinely collected data may provide important insights, cohort studies, randomised control trials and retrospective analyses of case notes are all methods that have been used to chart readmission rates and to answer the crucial questions of the post-discharge circumstances associated with early readmission, the extent to which early emergency readmissions are avoidable, as well as the kinds of interventions that might lead to their reduction. A number of prospective studies have illustrated the rates and timing of readmissions, although differences in the populations studied, in whether all readmissions or just emergency readmissions, are included, and in the time scales adopted to measure readmissions, can make comparison difficult.

- In a four per cent random sample of patients aged over 65, admitted into NHS non-psychiatric hospitals in Wales and followed up for 3 months, Victor and Vetter (1985) found that seventeen per cent were readmitted within three months of their original discharge.
- Hodkinson and Hodkinson (1980) followed up patient discharge from a department of geriatric medicine for one year and found that the proportion readmitted was 26 per cent within the first year of discharge.
- Williams and Fitton (1988) found that 6 per cent of over 65s were readmitted as emergencies within 28 days.
- In a study of readmission rates of over 75s, Townsend *et al.* (1992) found that of those initially admitted as emergencies, 12 per cent were readmitted within 4 weeks.
- In a study of admissions to a geriatric unit of people over 65 over a six month period McInnes *et al.* (1988) found a readmission rate (all specialties) of 29 per cent among men and 15.9 per cent among women in the first 100 days after discharge.

8

continued

These studies reveal interesting variations in critical periods for readmission and how they differ for both men and women and across different age groups. It is likely too, that there will be variations in the period of time within which the greater proportion of readmissions take place even among groups of similar age and case mix due to differences in clinical practice and in the appropriateness of post-discharge and longer-term domiciliary support.

Post-discharge influences

While it is clear that readmission rates for elderly people are high, particularly after an initial emergency admission, more important is information which tells us to what extent early emergency readmissions can be avoided. Two important factors are the quality of in-patient care and the appropriateness of post-discharge support. For example, in a study of readmission for people with chronic disease, Ashton *et al.* (1987) found that non disease specific discharge data were useful for predicting early readmission. The benefits of a community support scheme post-discharge for elderly patients was demonstrated in an experimental study of the effect of providing care attendants post-discharge for people over 75 (Townsend *et al.*, 1988). There was a significant difference in the number of readmissions in the control and study groups over an eighteen month period, with 6.7 per cent of the former being readmitted more than twice compared with 13.9 per cent of the latter. The control group receiving standard aftercare spent an average of 25 per cent more days in hospital. This study shows that a minimal level of post-discharge support – up to 12 hours a week for two weeks in this instance – was effective in reducing readmission rates in the longer-term. In this study, particular benefit was gained by those living alone and those over 85. Most analyses of readmission rates do not share the methodological rigour of this study but rely on retrospective or prospective analyses of patients who have been readmitted in order to try and identify whether the readmissions were avoidable.

In a prospective study of readmissions to a geriatric medical unit over a twelve month period, Graham and Livesley (1983) found that 25 per cent of their patients were readmitted within one year. They categorised these patients into five groups according to the principal reasons for readmission: unavoidable clinical deterioration; inadequate medical management (which included falls); non compliance; social problems; and inadequate rehabilitation. Only 32 per cent of patients were readmitted due to unavoidable clinical deterioration and the authors claim that as many as 47.7 per cent of readmissions could have been prevented. They found that readmission was most common in groups with inadequate rehabilitation, where 80 per cent returned within seven weeks, and low patient compliance. The proportion of readmissions within two weeks of discharge was higher for those originally discharged from non geriatric units, underlying the need for all acute care to respond to the rehabilitation and post-discharge needs of an ageing population. Using the same categorisation, McInnes *et al.* (1988) found that 73.6 per cent of men and 53.0 per cent of women were readmitted due to unavoidable clinical deterioration. However, 39.4 per cent of women were defined as receiving inadequate medical management, with just over half of these being readmitted because of falls.

Williams and Fitton (1988) attempted to isolate principal and contributory factors for readmission – possibly a more fruitful avenue for exploration given the difficulties in separating medical and social reasons for readmission. In a study of 133 patients (all specialties) who were readmitted as emergencies within 28 days, they argued that over half the readmissions could have been prevented if more effective action had been taken in: preparation and timing of discharge; attention to carers' needs; timely and adequate information to the GP; nursing and social services support; and management of medication. Of particular significance were differences between carers in the control and study groups.

In summary, further analyses of readmission rates is important not only for auditing in-patient care but for developing sophisticated and properly targeted discharge planning.

5 Discharge and the reform of community care

The NHS and Community Care Act 1990 has profound implications for the management of discharge procedures across health and social services. It requires the integration of (social services led) assessment and (largely hospital-led) discharge planning in hospitals, the speedy implementation of complex packages of domiciliary care on discharge and agreed procedures between health and local authorities for nursing home entry and the funding of nursing home care. This section examines discharge policy in the light of the community care reforms, focusing on three major areas:

- organisation of the professionals involved in discharge;
- the match between dependency and discharge destination;
- and assessment and care management in the discharge process.

First, however, this section takes a general look at the Act and discharge policy.

The 1990 Act

From April 1993, hospitals will no longer be able to discharge patients directly to private residential and nursing care where public funds will be used to pay for their care. Instead, social services will be responsible for organising assessments of those requiring intensive support and will hold the budget (for patients not already in nursing home care) which may be used to provide residential or nursing care or to provide packages of domiciliary care. In making publicly funded nursing home and residential care contingent on an assessment organised by social services departments within a cash-limited budget it is hoped to stem the drift towards institutional care as a solution to the dependency needs of frail elderly people, curtail costs and encourage innovative approaches towards community-based care. Assessment and care management in the context of joint agreements between health and local authorities are seen as the key to achieving these changes. However, as previous chapters have made clear, in theory this should already have been happening. All but the simplest discharge planning has always relied on effective collaboration between health and social services. For example, HC(89)5 emphasised that 'wards and departments have up to date discharge procedures agreed with those within and outside the authority who will be involved in their implementation' and that furthermore 'it is the responsibility of Health Authorities in collaboration with social services departments to monitor the way in which discharges from hospital are being undertaken ...' (para. 13). Therefore, HC(89)5 should have set the framework for discharge procedures which were jointly negotiated and agreed, where good working arrangements were not already in place.

As chapter 2 of this report demonstrated, official policy in the form of HC(89)5 was widely welcomed, often ignored and largely unmonitored. The rush to implement the NHS and Community Care Act exposed the tardy implementation of HC(89)5, highlighting the parlous state of discharge planning, particularly within many acute wards, and the lack of meaningful jointly agreed assessment and discharge procedures across many health and local authorities. The integration of social services assessments and discharge procedures is essential for all complex discharge planning. Now that local authorities are the lead agency in assessing and managing social care any failures on their part to agree and implement swift assessment and discharge procedures in acute hospitals will result in the blocking of 'elderly' beds in the first instance. This will swiftly be followed by the increased use of other adult medical and surgical beds for elderly patients admitted through Accident and Emergency departments. Commenting on the potential for delay via social services, a chief executive writes:

> *What if social services department officers do not agree with the consultant? What if the social worker is on holiday? What if the budget for new nursing home placements has become over committed? Even if another solution acceptable to the professionals can be found, what if the patients' relatives refuse to agree?* (Sargent, 1993, p. 25).

The interface between acute hospitals and social services in relation to discharge procedures, including information on discharge patterns from acute wards and the role of hospital social workers, all received scant attention in early discussion of the reforms and these issues were emphasised by few authorities in their first community care plans. However, recognition of this crucial aspect of the reforms gained momentum towards the end of 1992. Agreement over discharge arrangements was included as one of the key tasks for implementing *Caring for People* (DoH, 1992). Subsequently, health and local authorities were to agree their arrangements for integrating the assessment and discharge of people from hospital by the end of December 1992 if local authorities were to be eligible for the Special Transitional Grant for community care. As already mentioned, guidance on the elements of these agreements was made available by the Department of Health community care Support Force, just two months before the deadline. While this may have speeded up the paper work, it is unlikely that the timescales allowed a fundamental reworking of discharge arrangements.

As outlined in previous chapters, those implementing the Act have inherited a complex pattern of discharge planning and variable access to immediate and longer term post-discharge support. They have also inherited unresolved problems in relation to the health and social services interface. Underlying many of these issues is the more fundamental problem of the health and social care divide, its inappropriateness in terms of the blend of services which need to be commissioned for particular individuals, demarcation disputes for professionals spanning these boundaries and the convenience of this ambiguous boundary for cost shifting. The success of the act partly depends on how these problems are tackled.

This section dicusses in more detail areas of uncertainty in discharge planning, on the basis that clarity over the boundaries of what can be achieved by management action has to be developed alongside a recognition of areas of deeper uncertainty and conflict. This is particularly the case where discharge decision making becomes a playing field for policy conflicts which remain unresolved at a national level.

Professional issues

Chapter 2 summarised some of the long-standing problems of coordination and communication between professionals involved in discharge. While the health and social divide exacerbates these problems it is not solely responsible for them. Hospitals work through formal structures and hierarchies and there are few formal structures running across professional groups, even though multi-disciplinary approaches are fundamental to complex discharge planning.

Four professional issues of particular relevance to the reforms are discussed here:

- the role of social work in hospitals, given the crucial role that hospital-based social workers have traditionally played in discharge both to the community and to residential care;
- the emergence of new professions in the community to undertake the blend of domestic and personal care that might be provided by a relative;
- the impact of the reforms on professionals who have largely been hospital-based but who will increasingly be required to carry out community-based assessments;
- questions of demarcation and professional autonomy at a time when roles and responsibilities in the field of community care are undergoing rapid change.

Dispute and confusion in each of these areas can hamper the implementation of effective discharge procedures.

Social work and hospital care

Social services have been required to provide social work support to hospitals since 1974, when hospital social work was transferred from the hospital service to local authorities. Social workers may be on site, attached to particular wards or groups of patients or, at the other extreme, social work support may be drawn from local area teams which may be patch-based or organised according to client groups. In the latter case, they will respond to referrals from health professionals from a number of different hospitals. There are no routinely collected statistics on social work in hospitals but a survey carried out by the Department of Health in 1989 (DoH/SSI, 1991 para. 1.1) estimated that in 1989, there were 5,000 health related social services staff of whom roughly 80 per cent were based in hospitals. There is, however, little information to guide the allocation of social work resources in hospital and this has resulted in great variation between authorities both in the level of coverage and in the seniority of staff.

Various problems of social workers in hospitals have been identified. Working in health authorities while being employed by social services departments creates a number of professional tensions, and the priorities of hospital-based staff may clash with those of area teams. This may be reflected in differing assessments for domiciliary support, where the views of hospital-based staff may not be reflected by area teams operating within a locally determined system of priorities. The less 'local' the hospital, the sharper the problems, and there have been bitter disputes over the funding of hospital social workers for hospitals serving wide catchment areas. The provision of social work support to Trusts remains unresolved. Although all these factors have served to undermine the role of on-site social work, studies have found that a number of important tasks are less likely to be attended to in the absence of an on-site presence. Connor and Tibbitt (1988) found that home circumstances of those admitted as an emergency were less likely to be checked; discharge arrangements were started later and there was less counselling of elderly people and their relatives about future care options. There was also little opportunity for providing hospital staff with information on the levels of service likely to be available in the community. This information is of particular importance where patches have different priorities and eligibility criteria for the various services. Delays in assessment were marked in hospitals without social workers; access to medical records and key staff was more difficult and where social workers relied on referrals from hospital staff rather than on case finding, a number of potential clients fell through the net. Connor and Tibbitt concluded that hospitals with input from hospital-based social workers provided a better response to social care issues than hospitals without this input.

More recently, a report for Brent social services (1991) commented that reliance on social work sector offices to also take on the servicing of hospitals has not been a success, since the latter did not have time to spare from their existing community caseload.

Nevertheless, hospital social work has been vulnerable to cutbacks in the UK (Loxley, 1988), in sharp contrast with the US where there has been increased involvement of social workers in discharge planning, risk management, ethical decision making and research on reducing length of stay (Anon., 1985). It is clear that the changes in community care coincide with a decline in hospital-based social work despite its important contribution to discharge-related activities. While discharge planning for the needs of highly dependent older people has been the focus of much of the assessment and care management effort as far as the acute hospital/social services interface has been concerned, less attention has been placed on discharge of frail elderly people more generally. The community care plans produced by April 1992 often completely neglected the interface between social services and acute hospitals, as well as the potential contribution of hospital social workers. There are exceptions, however. Some plans closely linked the changes inherent in the community care act with the 1989 directive on hospital discharge procedures and saw both as closely linked to the development of hospital-based social work. For example, Dudley's community care plan (Dudley Metropolitan Borough Council, 1992) highlighted the fact that the needs of many individuals for social care arose from illness requiring hospital admission, and estimated that no less than one in twenty patients receiving a service from the hospital received help from the hospital social work service. The upshot in this case was an expansion of the hospital social work department. In the same way, Guy's and Lewisham Trust (1992) expressed the view that social work input in hospital would need to be increased, though not at the expense of multi-disciplinary assessments. The community care plan for Oldham (Oldham Metropolitan Borough, 1992) argues that if they were to achieve a target to reduce admission to nursing homes by 17 per cent as recommended, then strengthening of the hospital social work team would be essential.

There is, however, a different view which argues that the process of agreeing joint assessment procedures, the implementation of a care management model and the fact that a number of professionals may undertake these assessments may serve to further undermine the particular contribution of the social work profession to discharge planning, and in particular the role of on-site social work. To the extent that assessment and care management become generic activities, and to the extent that local authorities accept the assessment of health professionals carrying out jointly agreed procedures, the link between specific professionals and discharge planning will be diluted. However, unless the arrangements for complex assessments are integrated into the spectrum of discharge planning, there is a danger of two tier discharge, with good procedures in place for the few requiring complex assessments while 'routine' discharge planning remains unchanged.

The emergence of new professions in the community

As far back as 1985, the Darlington Community Care Project recognised the importance of a 'hybrid worker' to realise its aim of providing home care for frail elderly people who would otherwise need continuing hospital care. These workers combined the roles of home help, nursing auxiliary and auxiliary to paramedical staff. It was noted that:

> *it was our belief that the problem of coordinating services within and across the boundaries of health and social services could only be achieved by creating a worker who was able to receive instruction from professionals in different parts of the care system according to the needs of the client* (Darlington Health Authority and Durham County Council Social Services Department, 1987).

In this way, the health and social divide is spanned through the activities of a particular role, and this model has been reflected in the 'community care assistant' originally proposed in the Griffiths Report of 1988.

Projects which have sought innovative approaches to hospital care at home, to community care or immediate post-discharge support have all required staff, or sometimes volunteers, to provide a blend of personal and domestic care. As one example of this, the South Glamorgan Care for the Elderly Hospital Discharge Service, a voluntary sector project which aimed to prevent hospital readmission for social reasons of recently discharged elderly people, employed 'settlement aides' for the first few days after discharge.

> *Settlement aides will assist with all the routine tasks that many elderly people have difficulty with at first: ensure that the heating is adequate; do all the shopping; prepare a meal; air and/or make the bed up; liaise with other services; help with errands, phone calls, letters, appointments, bills, pensions, prescriptions etc ... The role of the settlement aide can be viewed as being similar to that of a good neighbour or relative* (Publicity leaflet, South Glamorgan Care for the Elderly Hospital Discharge Service).

The recognition that a gap needs to be filled between the health functions carried out by community health staff and the traditional social care provided by social services has been fundamental to many of the post-discharge schemes set up by voluntary agencies, such as Age Concern and the Red Cross, who have attempted to provide flexible care (see Box 2). In the same way, hospital care at home schemes which aim to prevent admission or promote earlier discharge through the provision of home support have also created new posts – patient aides, care attendants, home care assistants and the like. For a number of years too, the recognition of the importance of providing personal as well as domestic care has promoted the reassessment of the traditional home help role towards providing flexible, personal care.

These developments have a number of implications for professional roles. First, the creation of generic community care workers both reflects the continuing ambiguity and debate about health and social care and provides one solution to it. While much of the debate has been couched in professional terms, in particular in relation to the demarcation between district nurses and home helps, in reality many of the community care tasks could be performed by either and are routinely performed by carers where they have the responsibility for providing community care. It is not surprising that along with the development of community care workers is the demand for greater recognition of the similar community care tasks routinely performed by unpaid carers.

In their community care plan, St Helen's Metropolitan Borough (1992) made explicit the responsible authority for each of a total of nearly 150 tasks performed by either health or social services staff. Roughly one third of the tasks could be provided by either. These tasks mainly related to mobility, toileting, eating, washing and dressing and personal care. This exercise, replicated in social services departments elsewhere, is a strong argument for joint initiatives and different kinds of community-based workers. It underlines the problem facing care managers of whether to provide district nursing or social services home care oriented solutions, where the former is free at the point of delivery and the latter involves a charge for consumers.

Second, the greater involvement of staff without health-related qualifications in personal care is not without its problems. For example, the care assistant in Pembroke's hospital care at home scheme is to provide bathing, care of eyes, teeth, hair and nails, pressure area care, catheter care, dressing and undressing and incontinence care. This is a clear example of how boundaries between care assistants and nursing staff are becoming blurred, although in this case the assistants operate under the supervision of qualified nurses. Twigg (1986) argues that the:

> *medical model offers ... the means for negotiation of ... boundaries through the restructuring of the social body into the medical body* (quoted in Henwood, 1992, p. 23).

Personal care offered as part of nursing care does not jar with individuals' needs for privacy and Twigg argues that home helps have to resolve these difficult issues through the quality of their personal relationships with individual clients. As Henwood points out:

> *such an approach is highly discretionary and idiosyncratic and does not provide a reliable foundation on which to build a consistent approach to the management of personal care* (p. 23).

Analysis of the effects of the creation of paid non-professional nursing helpers on debates about the role of nursing itself is likely to be relevant in the creation of new professions and their relationships to existing roles, in particular, those of district nurses and home helps. Dewar and McLeod Clark (1992) point to the trained nurse paradox that 'while nurses accept the fact that mother and relatives can nurse, this is not translated to a paid helper' (p. 114). New roles will create new demarcation disputes, which themselves reflect not just professional sensibilities or profession-specific technical skills, but more fundamental beliefs over the relationships between certain kinds of professional training and the provision of intimate personal care.

From hospital to community: the relocation of professionals

A further issue affecting the organisation of professionals is where they provide care. It has long been argued that geriatricians and psychiatrists should forge closer links with general practice, both in terms of advice to primary care professionals and in the provision of out-patient services. In the same way, it has been suggested that the roles of community psychiatric nurses and social workers in primary care are expanded. Of particular importance is the changing role of geriatricians as more frail elderly people remain in the community receiving complex packages of care and where continuing assessment is required for elderly people requiring publicly-funded residential or nursing home care. Currently, residents of private nursing homes receive medical care from GPs rather than hospital doctors and the form this care takes varies, with some GPs visiting routinely while others visit on request. This has raised the issue of whether there is a role for specialist community-based geriatricians to work directly with the staff of homes and to provide readily available advice for GPs. For example, an initiative in Halton Health Authority (Adamson, 1988) transferred responsibility for the admission and aftercare of elderly people in elderly persons' homes to the Department of Medicine for the Elderly working in partnership with providers of care in the home. There is also the wider issue of ensuring that appropriate assessment and rehabilitation is available to private nursing homes. Currently, health authority employed community staff such as district nurses, physiotherapists and occupational therapists are not allowed to provide services for residents of private nursing homes. With care being provided through a range of voluntary and private agencies, it is important to clarify the role of health authority employed staff, as well as the location of staff such as geriatricians, where traditional professional locations no longer completely match the changing boundaries of care.

Demarcation disputes

All of the above can result in boundary disputes in relation to professional roles and funding. Problems also arise from a lack of clarity about professional tasks and such ambiguity is particularly marked in the roles of nurses and social workers in discharge planning. Discharge planning is seen as a fundamental part of the role of nursing staff, and particularly that of the primary nurse. In recent years, nurse training has placed more emphasis on holistic care, counselling skills and family involvement. Both the Cumberlege Report (DHSS, 1986a) and Project 2000 (UKCC, 1986) emphasised the need for a nursing model to take account of social factors. In a discussion of the future for social work and nursing, Bywaters and Clay (1987) point out:

> *even the language is familiar: the reports speak of fieldworkers and clients, of teamworking and networking, of self help groups and the uptake of benefits, of counselling and helping relationships* (p. 11).

How far such aims are reflected on the ground, and the extent to which social work tasks are differently allocated where there is no on-site presence remains unclear. In one of the few attempts to identify what hospital social workers actually do, a recent inspection by the social services inspectorate (SSI/DoH, 1992) found that the degree to which individual social services staff or groups performed the wide range of accepted social work tasks varied widely:

> *The ethos of the hospital, the particular specialty, the attitudes of the consultants and ward staff, the social services department view and the social workers' interests and availability were all factors which made generalisation impossible* (para 8.3, Report No. 1).

While this has implications for the management of social services in hospitals and raises questions over the prioritisation of social work tasks, it also implies that where tasks are not routinely performed by social workers, a number of them may be absorbed by other professionals. Ambiguity surrounding the on-site social services role and the involvement of a wide range of professionals and of voluntary agencies in meeting social care needs can lead not only to professional boundary disputes but also to gaps in the planning of discharge.

Chapter 3 of this report highlighted the inadequacies of focusing simply on the clarification of the role of particular professionals in the discharge process, as reflected in the booklet which accompanied HC(89)5. In this respect, the NHS and Community Care Act 1990 takes a quite different approach. It deliberately does not start with the services available or with the distinct contribution of various professionals. Instead it emphasises assessment which can be carried out by a wide range of professionals and the coordination of packages of care by a key worker. Although such procedures are generic to the management of discharge, the emphasis throughout the reform process has been on complex packages of care for those at risk of entering residential or nursing home care. It appears as if arrangements for those requiring the bulk of discharge planning in hospitals remain the same, with discharge planning not seen as a separate activity, but incorporated within the roles of different professionals. Not surprisingly, given this fragmented approach, professionals who see discharge planning as an integral part of their role are confused as to the impact of the reforms on their work. For example, in relation to hospital-based social workers, the SSI points out that this group

> *were deeply involved in making assessments, putting together packages of care, and finding ways to access both health and social services provision often against tight deadlines. They were also key players in the admission to residential care from hospital* (DoH/SSI 1992, vol. 1 para. 9.27).

However they were uncertain about the implications of the community care changes for their role in assessment and discharge arrangements.

The SSI emphasised that in the light of new arrangements it was important to define which part of their provider service was integral to assessment and which was a specialist contribution to the care or treatment plan (DoH/SSI 1992, vol. 1, para. 2.9).

This raises wider questions of how roles and responsibilities of groups traditionally involved in discharge will be affected by changes in the procedures for assessment and care management. For example, final decisions as to whether residential or domiciliary care is more appropriate now rest with social services – a significant transfer of responsibility. The NHS and Community Care Act provided the opportunity for making complex assessments one part of integrated discharge arrangements, where processes would be clear and professional ambiguities minimised. The fact that attention was drawn to these issues relatively late in the process of policy implementation underlines the fact that in practice, the discharge process described as part of the community care reforms has not been fully integrated with existing arrangements for discharge planning. This is reflected in confusion over professional roles and duties.

Dependency and discharge destination

Planning care in the community requires an assessment of current and projected dependency levels along with a clear understanding of what patterns or degrees of dependency are likely to require which kinds of community-based services. The relationship between dependency and location of care, whether this care is provided in acute hospital beds, continuing care beds, nursing homes, private residential care or in the community is not straightforward. This section illustrates the complexity of these relationships.

Dependency levels and institutional care

A first step towards understanding the relationships between dependency and location of care has been to describe dependency levels in the community and in different kinds of institutional care, including hospitals, and the various kinds of residential care. Institutions have been studied separately in attempts to identify the extent to which people are inappropriately placed, and studied together in order to look at the relationships between levels of dependency and care location, and to assess changes over time in the dependency levels found in different kinds of institutions. Increasingly, local authorities are also carrying out local surveys of dependency within both part III residential care and in the independent sector.

A number of hospital censuses have been carried out in order to assess dependency levels, usually with the aim of clarifying inappropriate placement in acute wards, and the extent of 'bed blocking' (See chapter 2, for further discussion). For example, a census of geriatric in-patients carried out in City and Hackney Health Authority (Jacobson and Brown, 1985) found that 29 per cent of those in acute geriatric beds, 43 per cent of those in acute/rehabilitation beds and 29 per cent of those in long-stay beds could in theory be at home with support. In Darlington (Acquilla *et al.*, 1987), a number of annual day censuses of the hospital population over 65 have been carried out since 1983. The censuses included information on the four 'giants of geriatrics': immobility, instability, incontinence and intellectual impairment (Issacs, 1981, quoted in Acquilla *et al.*, 1987). While there is no discussion of how this information might be used within health and social services, a census providing information on dependency levels can inform discharge planning and identify the level of demand for social care on discharge.

Other studies have carried out censuses of all those over 65 in institutional care (provided by the NHS, social services departments and voluntary/private agencies). For example, Clarke *et al.* (1979) found that while geriatric wards had the highest proportion of heavily dependent patients, nursing homes were providing care for practically the same number of heavily dependent elderly people as were found in the geriatric wards. A more detailed comparison between dependency levels in residential care and continuing care wards in Belfast (Hodkinson *et al.*, 1988) showed considerable overlap in the disability levels of the two kinds of care. Given the integration of health and social services in Northern Ireland in general and the close cooperation between hospital and community services in South Belfast, in particular, the authors comment that:

> *simple objective measures of disability and dependency do not completely assess the need for care, and other unmeasured characteristics such as personality, motivation, behaviour and the wishes of the old person and her family must also play a part* (p. 152).

In other words, dependency is not a perfect proxy for need. In addition, assessments may be influenced by an awareness of the alternatives available. In Gibbs and Bradshaw's (1988) study of old people in residential homes, assessors took into account the availability of resources that might have enabled the person to continue living at home. Based on this, 6.6 per cent were considered not to need residential care. If more community services had been available, particularly sheltered housing and day care, then the proportion increased to 17.2 per cent.

These and other studies show, as would be expected, that hospital populations are more dependent on every measure and that nursing homes care for residents who are more disabled than those in residential care. However, there are large numbers of heavily dependent people in each category and the levels of dependency in local authority residential care are increasing, except where there has been a rapid expansion in the use of private care. In some parts of the country, nursing homes are coping with the majority of totally dependent old people. Nevertheless, it has been estimated that there are two to three times as many bed-ridden or severely disabled people at home as in institutions (Walker, 1981, quoted in Wenger, 1985).

Although assessment is the key to effective placement and discharge, inappropriate placement is multi-faceted, and not simply a consequence of inadequate assessment procedures. For example, it is not always practical or humane to shift people from familiar residential surroundings due to fluctuations in their condition; people may lose their homes during a period of hospitalisation, or their homes may be unsuitable; relatives may be unwilling or unable to provide care for dependent relatives and there may simply be a lack of care alternatives, a fact which in itself has been shown to influence criteria adopted for entry into long-term care, with more stringent criteria being adopted where demand on places is highest.

Dependency levels in the community

Equally complex patterns of care and dependency are found in community-based studies. Population-based studies of disability in the community, regardless of the use of services, invariably identify unmet needs for support services. For example, Hunt's survey of people aged over 64 (1979) found that 4.5 per cent of over 65s were bed-fast or housebound rising to 21 per cent of the population aged over 85. Only 31 per cent of over 65s who were bed-fast or housebound received home helps and even less (12 per cent) received meals on wheels. The OPCS disability survey (Martin *et al.*, 1988) showed that 71.4 per cent of those over 80 were disabled in some way and showed, for example, that six times as many people in the highest severity categories wanted night sitting services than were currently receiving them. A longitudinal study of people over 65 in rural Wales (Wenger, 1985) showed that while levels of dependency have increased amongst the old elderly, levels of domiciliary support have not kept pace, with reductions in services for those aged 80-85, allied with positive discrimination in favour of the over 85s. A concentration and intensification of services for groups of greatest need may have dire effects on the spread of services for those whose 'absolute' needs are great but whose relative needs are less.

There have been numerous local surveys by social services departments, although measures of dependency differ from study to study. Even before the community care reforms, some authorities had been developing different levels of service to meet the needs of people with different levels of dependency.

Community studies demonstrate that simplistic associations between dependency levels and kinds of care provided, required, or wanted, cannot be made. They also demonstrate a body of unmet need – for support services, for continuing assessment in institutional care, and for more flexible services. Most worryingly, studies carried out over time demonstrate the mismatch between the goals of community care and the levels of domiciliary-based services. Increased targeting of services may engender its own problems of unmet needs amongst the many.

Leaving hospital ... entering residential care

As part of the concern to unpack the relationship between dependency levels and destination on discharge, patterns of discharge from hospital have been analysed. Most people over 65 are discharged home. However, there are variable patterns of discharge for heavily dependent people. In a study of over 65s discharged from the care of geriatricians, Turner *et al.* (1990/1) found that eleven per cent of the surveyed population were heavily dependent; most of this group were transferred to institutional care but 44 per cent were discharged home, usually with a spouse or other carer. The authors conclude that 'the dependency of a patient is one of several factors which determine their destination on discharge from hospital: social; psychological and environmental factors must also be considered' (p. 160). While factors related to the individual and living arrangements are clearly important, organisational and institutional factors are also relevant – the availability of institutional care, the accessibility of domiciliary support and, since April 1993, the variable, and locally determined, links between assessment and eligibility for entry to publicly supported residential care.

Taking a rather different starting point, there have been attempts to identify the triggers for people seeking to enter long-term residential care. In a study of people over 60 in Hackney on waiting lists for residential care, Bowling and Salvage (1986) found that 79 per cent had experienced a personal trauma in the year prior to the interview with 33 per cent experiencing between two and three incidents. Almost a third felt that these experiences had contributed to their decision to apply for care. This supports research which shows that a critical difference between elderly people in residential homes and in the community is the lack of support during crises. Over half the applicants in Bowling's study also needed help with heavier domestic tasks. Of the total sample, almost a fifth received no statutory services and over one half felt they could stay at home given specific kinds of community support. The result of this study, along with the documentation of many post-discharge schemes, demonstrate that wider notions of support in the community may need to be developed if less people are to seek to enter residential care.

All these studies demonstrate that the relationship between dependency levels and destination on discharge is neither straightforward nor predictable; it is influenced by individual factors, social support, the quality of the home, the standard and availability of local services, and, of course, the quality of assessment procedures, although the links between assessment conclusions and placement decisions are equally influenced by what is available and acceptable.

Assessment and care management

The lack of assessment for entry to independent private residential care raised concern that public resources were being used for institutional care which was not really needed. This was a major stimulus for the community care reforms, although there was little supporting evidence that admissions were inappropriate or unnecessary. There was, however, considerable evidence that more cost-effective alternatives were available. Assessment and care management, the processes through which care packages tailored to individual needs are to be provided, form the cornerstone of the new community care provisions. Numerous studies have documented the poor match between the need for support in the community and the care provided, with assessment being mainly for services rather than of needs, and care planning taking place within rather than between agencies (Charnley, 1989; Bebbington and Charnley, 1990). The responsibilities of home help and home care providers have been based on 'informal rules and established routines rather than clear policy guidance about eligibility and the need to match resources to client need and preference' (Beardshaw and Towell, 1990 p. 11) and intensity of service has commonly been sacrificed to wider coverage. There is little formal reassessment despite the rapidity with which needs may change in frail elderly people. In the same way, there have been criticisms of the assessment procedures hitherto adopted by social services for entry to residential care. Where the decisions have been framed by a shortage of places, social services have rarely been involved in making judgements at the 'margins of need'. However, with the community care reforms, social workers will be denying the use of public funds for nursing home care, sometimes against the wishes of clients and their carers.

Recognition of the problems of fragmented assessments, duplicate assessments and the tailoring of individuals to existing services rather than the reverse have provided widespread support for this plank of the community care reforms. There have been models of how care management systems, combined with devolved budgets can work (see Beardshaw and Towell, 1990, for a review of different approaches); guides to implementing the assessment and care management aspects of the community care act for managers and practitioners (Welch, 1991a,b) along with various warning statements about the difficulties of extrapolating results from a few successful initiatives country-wide and the problems in spanning the health and social care divide in seeking to formulate jointly agreed assessment and care management procedures. As already mentioned, all authorities had to furnish evidence to the Department of Health by December 31st, 1992, of their joint agreements on discharge. As part of this, health and local authorities had to agree who was going to pay for what. Clearly, the procedures involved in assessing need and formulating packages of care form part of the spectrum of discharge planning, and could be expected to inform the basis of discharge planning more generally. However, a more complex relationship between the assessment initiatives and existing patterns of discharge planning is emerging.

First of all, the emphasis is firmly placed on having procedures in place to assess and make provision for those requiring complex assessment. In a letter from Herbert Laming (C1(92)34) of 14th December 1992, it is noted that the Social Services Inspectorate had set out options for the development of comprehensive care management over the next decade. However, it was recognised that the immediate priority was to have in place by April, 1993, assessment arrangements for all users, but particularly for the '110,000 or so people who would previously have accessed residential care via the social security system' (para. 1). Furthermore, the guidance on discharge and assessment from the community care Support Force makes clear that the estimated number of complex community care assessments is to be based on an agreed estimate of the current number of placements made into residential and nursing homes.

Quite apart from the difficulties in estimating numbers entering nursing homes, given that social services were not routinely involved prior to the act, there are larger questions related to discharge more generally. While the guidance correctly identifies a highly vulnerable group, and not everyone will qualify for a full community care assessment leading to care management, complex discharge arrangements are not confined to this group. Already, people with highly complex needs for health and social care are being discharged, and hopefully these will also benefit from a needs led and care management approach. However, developments in this area are not included in the grant to be received, and while there is much emphasis on the integration of assessment and discharge planning for potential entrants of homes, this is not explicitly extended to the integration of these procedures with discharge planning more generally. Some local authorities have attempted to categorise the different kinds of assessment in operation – initial assessments, assessments for specific services, assessment by specialists and multi-disciplinary complex assessment (see, for example, Calderdale Metropolitan Borough Council, 1992). Definitions of what constitutes a complex assessment are variable and the relationships between making an assessment and being legally obliged to provide a service are unclear. The Laming letter (CI/92/34) was sent to all authorities at the end of 1992, warning them of the dangers of assessing a need for a service which could not be provided.

> *An authority may take into account the resources available when deciding how to respond to an individual's assessment. However, once the authority has indicated that a service should be provided to meet an individual's needs and the authority is under a legal obligation to provide it or to arrange for its provision then the service must be provided. It will not be possible for an authority to use budgeting difficulties as a basis for refusing to provide the service* (para. 13).

Section 7 of the Chronically Sick and Disabled Persons Act 1970, states that a local authority has a duty to procure or provide that which it assesses a user to need. This has raised questions over whether published criteria for the eligibility for services are legally binding, and SSDs are receiving legal challenges on this issue. There is a clear tension here between 'absolute' need and prioritisation of needs. While a distinction between assessing need and assessing service requirements may circumvent legal problems, it provides little consolation for those whose assessed needs are not matched by appropriate services. The inevitable result is that authorities will tighten their eligibility criteria for different levels of assessment and that this will be reflected both in the people offered complex assessments and in the relationship in practice between dependency and 'need' for services. This is reflected in the guidance from the community care Support Force that 'it is accepted that in the event of projections indicating the numbers of complex assessments will be exceeded, the eligibility criteria will be subject to joint review and revision'. The implied move away from 'absolute' assessment of need to a system of assessment framed by available resources raises a number of questions over the kinds of care that are going to be considered acceptable for vulnerable groups, the extent to which this will vary from authority to authority, and, of particular importance to the discharge process, the ways in which this will square with the ways of carrying out assessment current amongst nurses and other health professionals, working outside the social services hierarchy. If eligibility is framed by resources, then criteria will inevitably shift, leading to inequities in the provision of care for similar levels of need over time. The Health Committee (1993) was unequivocal in its view that:

> *clear guidance be issued urgently to local authorities on this matter and, if necessary, legislation be introduced to make sure that there are no inhibitions on the ability of social services departments and health authorities to make a full assessment of unmet needs... We further recommend that information about the assessment of needs and whether they are being met or not should be required from local authorities as part of their community care plans by the Department to assist it in making its own future assessments* (para. 64).

Second, there are inconsistencies in the discharge planning envisaged as part of the community care legislation and existing guidance on discharge planning in hospitals. This concerns the question of patients' rights concerning care in nursing homes. In a letter to Dr Brian Mawhinney, Minister of State for Health, Sally Greengross, Director of Age Concern, England (1992), asks:

> *whether local authorities will have the power to place a person in a nursing home against his or her wishes, where he or she will have to pay the fees, and whether the local authority could then place a charge on the property of that person.*

She points out that this would imply a compulsory means test on a person with health needs.

Since April 1993, local authorities have been able to arrange a placement in nursing and residential care and means test the individual for ability to pay. In the booklet accompanying HC(89)5, however, arrangements for care in nursing homes cannot be made without the patient's consent, and user choice was also presented as one important plank of the community care reforms. It remains unclear how the rights to free nursing care and right to refuse residential care, or choose a home, will be affected by the new arrangements. In the same ways, the rights of carers to assessment and involvement in the discharge process will be hard to reconcile with the need to ration services.

Third, one of the aims of the legislation is to reduce inappropriate entry into long-term institutional care. As pointed out above, there are large numbers of highly dependent people in the community already, and there is evidence that social factors often trigger a demand for residential care. With the targeting of services towards highly dependent people, intensity of coverage will take priority over low levels of coverage for larger numbers of people. There is already evidence that some of the 'friendship' services are being reduced. For example, in its community care plan (Berkshire County Council, 1991), Berkshire classified its services as 'core', 'high priority' and 'highly desirable' and commented that for elderly people 'some of the day and respite activities which have a friendship rather than a care focus are classed as highly desirable, and therefore may not be provided by social services in future' (p. 15). Post-discharge services often have a reassuring element and it is possible that in the absence of an overall strategy for the community care of elderly people and of truly integrated assessment and discharge procedures across the board, the changes on the ground as a result of the policies for community care may trigger increased demands for residential care. In particular, the effects of substituting broader coverage for intensity of care, are likely to affect the risks of entering residential care of a different group. In addition, the requirement that 63 per cent of the overall funding allocation to local authorities is to be spent in the independent sector is surprising given the absence of any significant independent domiciliary care market. Unless there is a major shift in provision, most of the money for community care will be spent on residential care (Henwood, 1993).

Fourth, the community care reforms are premised on a greater role for social services, a position advocated by the Griffiths report of 1988 and widely accepted. However, this means that community care is also built upon local organisations where access to particular services has been described as 'a game of geographical chance' (Harding, 1992). Just before the implementation of the Act about 87 per cent of local authorities were planning budget cuts (Anon., 1993). Local authorities define needs and at what level to respond to them and Harding points out that there is a 'real tension between an approach which claims entitlement to services and one which sees the role of social services as distributing available resources in the most effective manner' (p. 3). One effect of the community care reforms will be to make such decisions both explicit and publicly available, through publication of the criteria for eligibility for assessment. The existence of this variation in access to social services will create problems particularly for hospitals seeking to discharge patients drawn from a wide catchment area, and therefore from different local authorities.

Variations between local authorities in the provision of immediate and flexible post-discharge support will also influence the extent to which highly dependent people may be discharged home to await an agreed package of care, as well as the quality of discharge more generally. In those areas where flexible post-discharge support is provided, schemes are often transitory, project-based and with uncertain funding. They may derive from health authorities, from local authorities, voluntary agencies or from some combination of the statutory and voluntary sectors (see Box 2). This mix is less the result of a planned pluralism in health care than of fundamental differences over the priority attached to this form of care as well as confusion over the most appropriate authority to provide this support. With earlier discharge and an increasing proportion of frail elderly people it becomes of increasing importance that this area of policy is resolved, and that 'absolute' post-discharge needs for care and support of this vulnerable group are not prioritised out of existence.

This section has highlighted unavoidable complexities in the discharge element of the implementation of the NHS and Community Care Act 1990. In neither of the three areas studied is management fiat an option. Sensitive joint negotiations are required. The question remains, however: how far will the discharge planning arrangements envisaged by HC(89)5 be weakened by the new and pressing requirements of the NHS and Community Care Act? And how far does either of them fully take on board the notion of discharge as a process?

6 Conclusions

The goal of seamless care will remain elusive in the absence of coherent discharge policies translated, in turn, into effective discharge practice. One of the strengths of the NHS has been the relative ease with which patients can be transferred from one care framework to another. However, one of the less fortunate consequences of this has been a lack of attention to discharge policy, a gap which has allowed failures in routine discharge planning to persist over at least a twenty year period. The separation of purchasers from providers, combined with the new arrangements for community care, demand a greater specificity in discharge policy and clearer arrangements for discharge planning. Demarcation lines between the authorities providing aftercare need to be clearly drawn, transfer of responsibility agreed and levels of aftercare established prior to discharge. Contracts between purchasing authorities and the hospital can go some way towards resolving these issues and experience from the US shows that the contract culture can lead to a more coherent approach to discharge planning and its development as a discrete discipline.

Within the UK context, developments in this area have also been hindered by a traditional focus on the difficulties in discharging particular groups of patients – particularly frail elderly people – and on the roles of professionals in the process of discharge. This has taken priority over management tasks and the delineation of boundaries of responsibility between providers of health and social care after discharge. This focus is now changing in the sense that managers within hospitals are giving more attention to developing criteria for appropriate admissions, protocols for the management of specific conditions, which include discharge arrangements, and the better management of acute beds, in which discharge policy plays a crucial part. Thus discharge arrangements take their place within the broader context of efficient patient management from the time of admission for emergencies and well before this for planned admissions. Innovative discharge schemes, which reflect or encourage shifting boundaries in acute care, and which are shown to be successful, should be reflected more widely in protocol development. There is as yet no clear channel for the dissemination of good practice in discharge planning, however.

In addition to these developments in the acute sector, the community care act has refocused attention on discharge although there are clear difficulties in building the more complex discharge arrangements incorporated in the community care reforms on top of the less than stable structure of existing discharge arrangements. It is also important that financial imperatives to cater for the discharge needs of a small but highly dependent group – those who might be eligible for residential care – do not obscure the importance of implementing discharge as a process, relevant to the whole spectrum of dependency and aftercare needs. For example, the immediate post-discharge needs of dependent people are often not met, demanding as they do a flexible and integrated blend of health, social and personal care which is not easily met by an organisational structure which fragments them. In addition, the whole area of immediate and short-term post-discharge care is one where voluntary organisations have often filled the breach through their hospital discharge schemes, and where local authority provision is particularly patchy. With the decline in convalescent and longer-term nursing care provided in hospitals and the increased interest in providing a hospital level of care in the home, it is important to clarify how the associated social care will be provided and the additional costs faced by local authorities as the nature of in-patient care shifts. The plethora of the variously entitled community care workers reflect in their work the blend of personal, domestic and health care functions which reflect the reality of more heavily dependent people in the community. Currently, however, it is in the financial interests of hospitals to discharge patients early and in the financial interests of local authorities to leave patients in hospital until their needs for social and domestic care are reduced. Longer-term funding for initiatives which shift the boundaries of acute care is inevitably problematic.

If greater priority is afforded to discharge as a process, then many of the problems which have dogged the discharge process in hospitals will be resolved. However, discharge policy is an umbrella term for a range of activities, and its success is contingent on a host of factors, many of which lie outside the control of the hospital. However efficient the discharge policy of a particular provider, it can do little in the absence of adequate resources and appropriate facilities for aftercare in the community. Geographical variation in absolute levels of provision of social care in the community, and in the match between assessment for services and the provision of those services create problems for hospital staff both in deciding whether people are fit to be discharged and in coping with the administrative complexity of a patchwork quilt of social services arrangements. To the extent that patients do not attend their local hospitals, such arrangements take on a greater complexity. The relationships between dependency levels and discharge destination are complex and this complexity is inevitably reflected in the assessment process.

Beyond the remit of either the hospital or the social services department is the responsibility of national government to clarify rights of patients on discharge. Local flexibility can also mean that rights to expect a certain level of care for a certain level of dependency are transformed into a game of geographical chance. The right to free long-term nursing care, enshrined in discharge guidance but less evident in the implementation of the community care reforms is a case in point. In the words of Age Concern (1992) 'some people find themselves squarely in the middle of a conflict about who has ultimate responsibility for a particular patient's continuing nursing care'. In this way, ambiguities which require debate and resolution at national level are translated into discharge difficulties which impinge on patients and families when they are at their most vulnerable. It is, however, through auditing the response of such vulnerable groups to discharge arrangements that discharge policy can be judged and progress towards seamless care gauged.

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