CareQuality Commission

Beyond barriers:

How older people move between health and social care in England

Annex: Discharge information flow tool – summary of findings

July 2018

Contents

Background 3
Executive summary and implications for policy 4
Detailed findings 6
Involvement in discharge process 6
Quality of assessments undertaken in hospital 8
Information received prior to discharge 9
Receipt and timeliness of discharge summaries 9
Format of discharge summaries 12
Content, Quality, Accuracy and Trust 13
Accessing missing information 16
Information returned to services 17
Other themes from free-text comments 18
Discharge issues 18
Relationships and understanding between services 19
High impact changes 20
Inconsistent experiences across systems and services 21
Communication and information sharing 22
Learning from positive experiences 23
Appendix 1: Methodology 24
Risks and limitations 24
Appendix 2: Discharge information flow tool questionnaire 27

Background

The discharge information flow tool is a short online questionnaire, designed specifically for CQC's local system reviews programme, which was emailed to the registered managers of adult social care services that were registered to provide care for people over 65 within the 20 local authority areas that CQC reviewed.

The questionnaire was designed to gather feedback from adult social care providers about their involvement in the discharge process from secondary care services and the quality of discharge information they receive. The tool and wording issued by CQC can be found in Appendix 2 to this document.

Responses received were analysed, summarised and presented to CQC's review teams ahead of them carrying out fieldwork in each area, in order to inform their lines of enquiry for the review.

Across all 20 areas we received 449 responses. These have been analysed and the key messages are reflected in the main report of the programme, *Beyond barriers: How older people move between health and social care in England*. This supplementary annexe has been produced to explore the responses to this questionnaire in more detail. Although the responses cannot be said to be representative nationally, and are skewed towards areas and service types with larger response volumes (see Appendix 1), there are common themes present that we believe to be important for wider consideration at a national and local level.

Executive summary and implications for policy

Although most adult social care providers have contact with secondary care services and the people they provide care for in advance of them being discharged from hospital, comments indicate they **are not routinely involved in a joined-up discharge process.**

The responses show **variability in how often social care providers receive discharge summaries**. The **content, accuracy and timeliness of the discharge information received are also inconsistent**, not just from one part of the system, but even within the same service, with some respondents commenting on the variability in the communication and handover of information from different wards within the same hospital.

Throughout, **responses from registered managers of domiciliary care agencies indicate that their services are the most overlooked** with regards to involvement in discharge and provision of adequate and accurate information.

Digital information sharing between health and social care systems appears to be largely absent.

These issues can have a substantial impact on the experience and outcomes of people using services. **When people are discharged to services with missing or incorrect information this puts people's health and wellbeing at risk.** Multiple respondents spoke of not being informed of when people would be discharged. Issues with medication and unsafe discharges resulted in people being readmitted to hospital.

The pressures surrounding discharge, lack of joined-up discharge planning and poor or inconsistent handover of information can have a **negative effect on relationships** between health and social care providers, leading to a breakdown in trust.

These issues impact on service delivery and effective system integration. Poor planning and information sharing can **undermine seven day working**, with some social care providers feeling ill-equipped to accept discharges at the weekend. A lack of joined-up planning for discharges can result in **duplication of work and unnecessary chasing for information**. Our findings also suggested that the lack of understanding and trust that can exist between services is a **barrier to the implementation of 'trusted assessment'**, a key part of the high impact change

model for managing transfers of care from hospital to home[1]. As social care aims to move towards greater provision in the community, outside of residential care, this data also highlights the importance of improving joined-up working and information handover processes with domiciliary care and other community social care providers. These services are key to ensuring that when people leave hospital they have a safe and sustainable return to their own home.

It is important to note that our questionnaire only gathered perspectives from providers of social care and so does not represent a complete picture across the range of perspectives of the different professionals involved in a person's discharge. This report does not intend to apportion blame on particular parts of the system, but rather shine a light on what is happening all too often in health and social care systems that are facing ever increasing pressures, and where integrated working is underdeveloped.

We did hear some examples of good practice. In their comments, respondents highlighted collaborative working arrangements and improvements in the discharge process in their local areas. Positive relationships, built on understanding, that facilitated open and honest interactions were key to this.

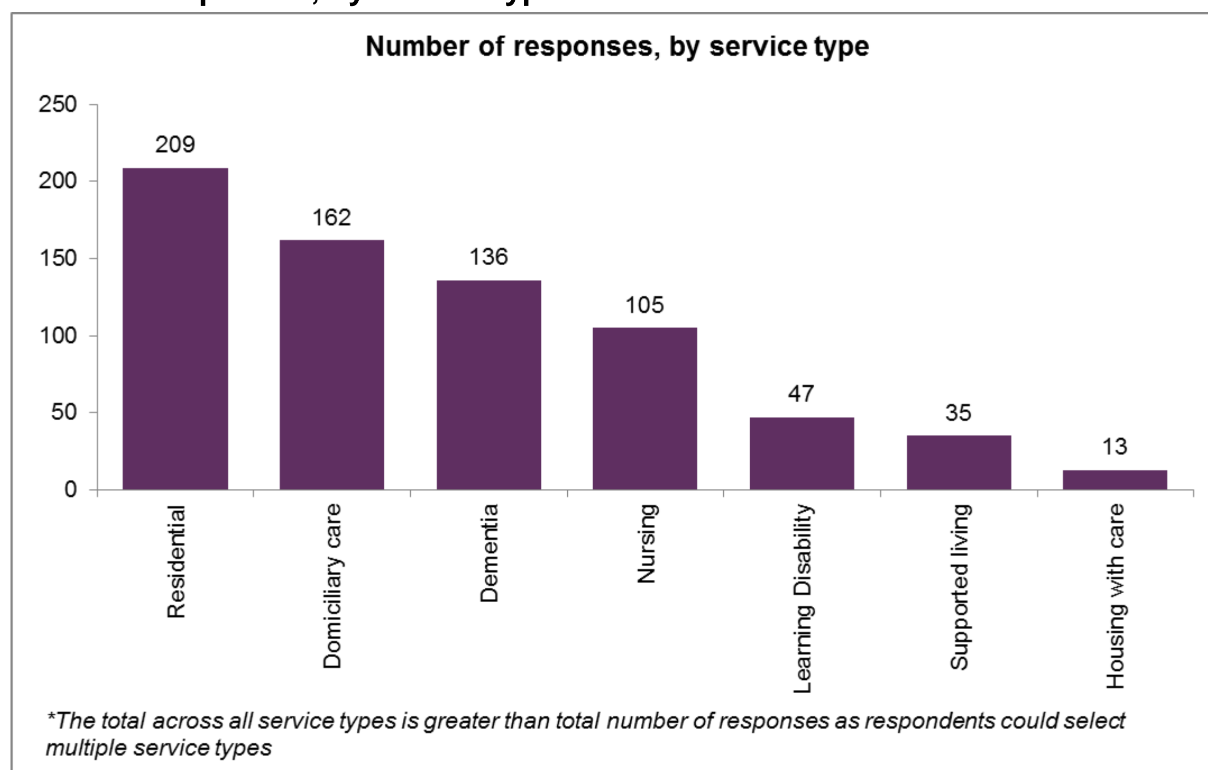
Professionals working across health and social care need to understand the journeys taken by the people they care for. This means developing knowledge and understanding of other services and building relationships with the people that work in them. This will mean that when people move between health and social care their discharge is smooth, effective and safe, leading to the high-quality experiences and care that people should expect.

[1] Implementation of the High Impact Change Model is a national condition for funding through the 2017-19 Integration and Better Care Fund policy framework.

Detailed findings

Across the 20 local systems we reviewed, we received a total of 449 responses from registered managers for adult social care services that were registered to provide care for people over 65 (response rate ranged from 9% to 33% of the registered managers contacted in each area – see Appendix 1). Within the questionnaire, registered managers were asked to detail what type of adult social care service they provided. Most commonly responses were received from managers responsible for residential care; however views from domiciliary care, services providing care to people with dementia and services providing nursing care also featured prominently. For the purposes of this report, analysis based on service type was restricted to those service types with 100 or more responses[2].

Chart 1: Responses, by service type



Involvement in discharge process

The questionnaire asked registered managers how the service(s) they are responsible for are involved in the discharge process in terms of whether they:

i) undertake assessments of the client prior to discharge
ii) visit the client in the secondary healthcare facility prior to discharge

[2] As respondents could select more than one service type, the total count of responses by service is greater than the total count of responses.

iii) have phone contact with the secondary healthcare facility prior to discharge.

More than half of respondents said they were “always” or “almost always” involved in the discharge process for each of these options, although overall **phone contact was the most common method of involvement**, followed very closely by visiting clients and thirdly by undertaking assessments. Just under 40% of respondents said they “always” or “almost always” do all three.

Table 1: Involvement in the discharge process, all respondents[3]

	Involvement in the discharge process		
	Undertaking pre-discharge assessments	Visiting clients in secondary care settings	Phone contact with secondary care facility
Always	37%	40%	40%
Almost always	17%	18%	18%
Often	10%	11%	13%
Sometimes	11%	15%	16%
Rarely	14%	10%	10%
Never	11%	6%	3%
Total	**423**	**425**	**427**

However, a quarter of respondents said they “rarely” or “never” undertake pre-discharge assessments, while 16% of respondents said their service “rarely” or “never” visits clients and 13% stated they “rarely” or “never” had phone contact with the secondary healthcare service. Seven per cent of respondents said they are “rarely” or “never” involved in any of these activities.

When this data is broken down by service type, it is evident that responses relating to **domiciliary care agencies (DCA) indicated they are less commonly involved in the discharge process** than other types of service – they make up the vast majority of the 7% of respondents that are not involved in any of the discharge activities we listed. Responses relating to DCA services show that they were more commonly involved in discharges through phone contact with secondary healthcare services (37% stating they are “always” or “almost always” involved in this way) and more rarely involved in discharges by undertaking assessments (only 24% stating they are “always” or “almost always” involved in this way).

In contrast, for each of the three means of involvement listed, more than 70% of registered managers for nursing care services said they were “always” or “almost always” involved.

[3] Analysis excludes respondents that answered ‘N/A’

There is a contrast between the responses to the categorical questions and the supporting free-text comments about involvement in discharge that suggests respondents may have interpreted the questions less in the sense of involvement in a joined-up, planned discharge process; and more in the sense of undertaking the identified activities by themselves and in an ad hoc manner because of the absence of a joined-up process. A few registered managers across domiciliary and residential care reported that they were not often involved in discharge planning and were rarely invited to discharge planning meetings, and the themes in the free-text comments described throughout this report suggest that **involvement of social care providers in discharge planning was the exception rather than the norm.**

Registered managers from across residential, nursing and domiciliary care reported undertaking their own assessments prior to discharge. A few domiciliary care providers said that they always conducted their own face-to-face assessment before accepting the care package; some did this for new clients only and others for all clients. This was because **providers lacked confidence in the accuracy of assessments undertaken in hospital** which had previously led to unsafe discharges, for example, without correct support and equipment in place.

"As a company I feel that we have been forced to say that we will not accept a client from hospital until we have completed our own assessment"
Registered manager, domiciliary care

Similarly, residential and nursing home providers attended the hospital to complete pre-admission assessments; again some did this for new clients only and others for all clients. Like domiciliary care providers, they suggested that this was necessary to gain an accurate assessment of needs, and indicated a lack of trust in the assessments undertaken in hospital.

"We would never accept anyone on a summary from a third party as we have had too many occasions when information is incorrect."
Registered manager, nursing home

Quality of assessments undertaken in hospital

Managers of all service types reported experiences where they considered the referral to their service to be inappropriate. The needs identified in hospital assessments were not always accurate of the person's needs when they presented at the service.

For residential and domiciliary care managers it tended to be that **the person's needs were higher than had been identified**; mobility needs in particular were felt to be understated in assessments. This could mean that the right staffing levels and equipment had not been arranged. Respondents sometimes perceived that the

person’s level of mobility was purposely exaggerated in order to encourage them to accept the placement.

“I am unable to trust information given by the hospital and will always undertake my own assessment of needs. I do this as we may get told that someone transfers with two [care workers], in reality it may be that two people are physically holding the service user up.”

Registered manager, residential home

A couple of residential home managers had experienced people discharged with a wrong diagnosis, including for dementia. There were concerns across residential and nursing managers that **people were being referred to long term care too soon** and had been inappropriately deemed ‘medically fit for discharge’.

“We have to go and visit when we should really trust the “medically fit” scenario. It’s this mistrust that puts us off taking [clients] at weekends and Fridays so hence a delay.”

Registered manager, nursing home

Information received prior to discharge

Some domiciliary care managers described receiving very limited information from hospitals prior to discharge. This might include a phone call with basic information such as a date of discharge and package start date.

Domiciliary care providers could **accept placements with very limited information about the person**, for example the number of visits, length of visit and number of carers[4]. Where information was provided through the provision of assessments or phone calls, these could be lacking in detail and some providers were not given key information prior to discharge such as changes in condition or medication.

“There is rarely information about the clients’ medication and sometimes it does feel that we are not getting comprehensive information so that we will take the package on, only to find out that there are a whole host of issues we were not informed about and instead of a care call taking 30 minutes it takes an hour.”

Registered manager, domiciliary care

Receipt and timeliness of discharge summaries

While generally respondents to our questionnaire indicated it was more common to receive a discharge summary than not, responses were quite mixed and varied substantially between service types.

Sixty-one per cent of all respondents said they receive discharge summaries at least half of the time an older person is discharged from secondary care into their service. However, responses from domiciliary care services showed that 60% receive discharge summaries less than 25% of the time, and nearly three-quarters receive discharge summaries less than half the time.

Table 2: Frequency of receipt of discharge summaries, all and by service type[5] [6]

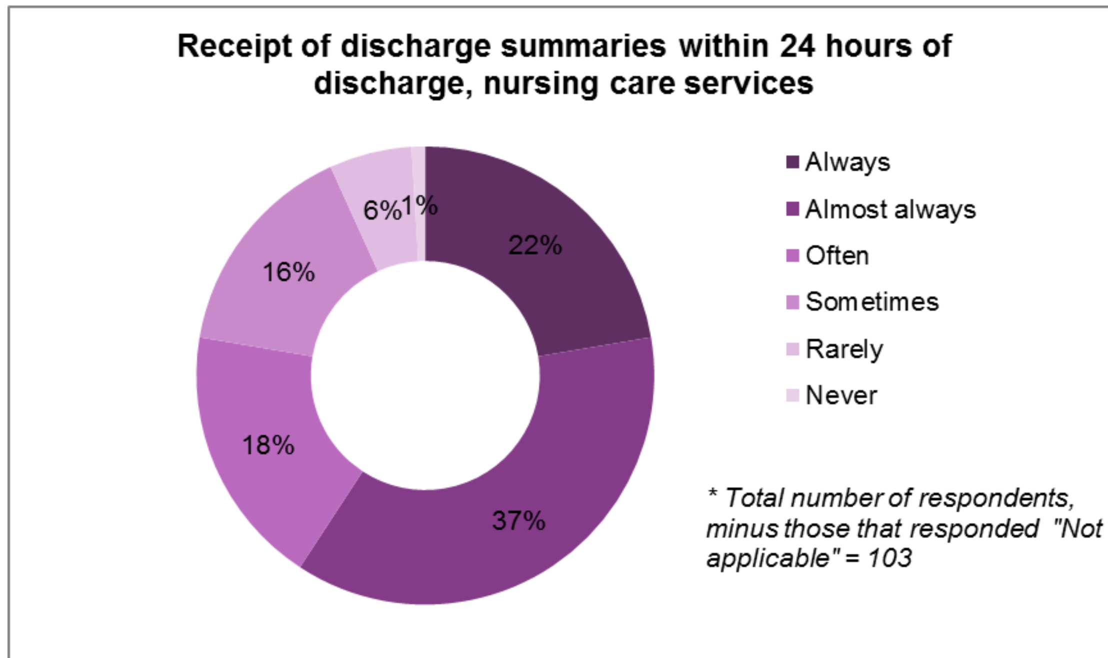
	Frequency of receiving discharge summaries				
	Total	**Residential**	**DCA**	**Dementia**	**Nursing**
Less than 25% of the time	29%	11%	60%	24%	12%
25%-50% of the time	10%	10%	13%	9%	4%
50%-75% of the time	20%	26%	10%	22%	32%
75%-100% of the time	41%	53%	17%	45%	52%
Total	**414**	**205**	**140**	**133**	**103**

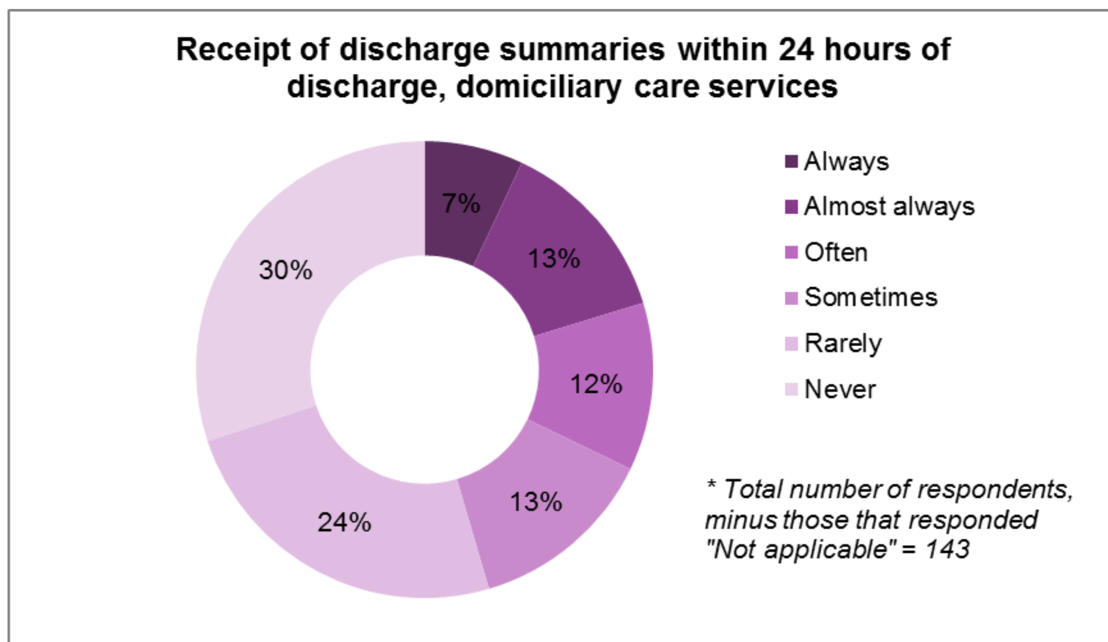
In terms of the timeliness of receiving discharge summaries, while just under half (46%) of all respondents said they "always" or "almost always" received discharge summaries within 24 hours of discharge, just over a quarter (26%) said this was "rarely" or "never" the case.

Again, there is a clear gulf in experiences between different service types. Registered managers for nursing and residential care services indicated more timely handover of information, with 59% of managers for nursing care services saying they "always" or "almost always" receive discharge summaries within 24 hours, while only 20% of managers for DCAs indicated this was the case.

[5] Analysis excludes respondents that answered 'N/A'
[6] Purple shading intensifies as percentage of respondents increases.

Charts 2 and 3: Receipt of discharge summaries within 24 hours of discharge, nursing care respondents and domiciliary care respondents[7]





In the free-text comments, a widespread concern across systems and service types (residential, nursing, domiciliary care and supported living) was that **discharge summaries were not received at the point of discharge**. Some managers across domiciliary, residential and nursing services described rarely or never having received this information with the person[8].

[7] Analysis excludes respondents that answered 'N/A'

Residential and nursing managers said that discharge summaries could arrive in the post days later, or by fax at the request of the service. Not receiving discharge summaries when a person is admitted and discharged from A&E was identified as a particular problem across three systems.

Format of discharge summaries

We asked registered managers to tell us what format discharge summaries were received in; paper, secure email or via a shared electronic system.

Responses show that discharge summaries are more commonly paper hard copies, while electronic sharing via email or shared electronic systems are rarely used. Seventy-one per cent of respondents “never” receive discharge summaries via shared electronic systems, while just under half (45%) “never” receive them via secure email.

Although paper discharge summaries were more common than the other formats listed, the frequency of receiving paper discharge summaries was still quite mixed. While we cannot be certain, this could suggest that at times there may be no formal documentation at all and discharge information is just relayed verbally.

Table 3: Format of discharge summaries, all respondents[9]

	Format of discharge summaries		
	Paper	Secure email	Shared electronic systems
Always	23%	10%	3%
Almost always	22%	7%	5%
Often	13%	10%	4%
Sometimes	16%	14%	7%
Rarely	13%	14%	10%
Never	13%	45%	71%
Total	**420**	**411**	**353**

In the qualitative comments, **information systems were cited as a barrier to effective communication.** A few managers expressed challenges or a desire to move away from traditional paper and fax systems.

Working on different information systems to their health and social service partners was a source of frustration. For example, one manager was told they were not allowed to receive NHS information by email because this was not secure, while

[9] Analysis excludes respondents that answered ‘N/A’

another was sent social worker assessments via encrypted emails that they couldn't open.

While the introduction of electronic information sharing solutions was improving information sharing in some parts of a few local systems, this could inadvertently create barriers to sharing information with social care providers. A few managers said that the **introduction of electronic systems in the hospital had made it more difficult for them to access information** to undertake their assessments, while another manager described how, since discharge information was now shared electronically, this went to the GP rather than to them.

Content, Quality, Accuracy and Trust

Responses were somewhat mixed with regards to whether or not the discharge information services receive is sufficient for them to make decisions about whether or not they can support placements, and whether it is accurate or can be trusted.

Again, registered managers for nursing and residential care services were more positive than those representing domiciliary care. More than a third (36%) of responses relating to DCAs said the discharge information received "rarely" or "never" provides sufficient information for the service to determine whether or not they can support the placement, compared to just 15% of responses relating to residential care and 12% of responses relating to nursing care.

Table 4: Whether discharge summaries are sufficient, accurate and can be trusted, all respondents[10]

	Whether discharge information is sufficient to decide whether the service can support the placement	Receipt of accurate discharge information	Receipt of discharge information that the service trusts
Always	13%	5%	6%
Almost always	24%	24%	23%
Often	15%	24%	16%
Sometimes	25%	31%	29%
Rarely	18%	14%	19%
Never	5%	2%	7%
Total	**419**	**420**	**419**

[10] Analysis excludes respondents that answered 'N/A'

Free-text comments often detailed that when received, the quality of discharge information could be poor. Similar complaints were made by managers across service types. Domiciliary care service managers said discharge information could be **incomplete or lacking in detail**. Their most common concern was that the information was **inaccurate or out of date**. This could include information around medication or the level of support needed.

"Some of the information given is inaccurate and once we have undertaken our own assessment we realise that care needs are different, i.e. they may need equipment, two carers or medication needs administering."

Registered manager, domiciliary care

Similarly, residential and nursing home managers commonly said that discharge information could be of a poor quality with insufficient detail to enable them to care for the person, such as the person's care needs and medications.

As with domiciliary care providers, inaccurate, out of date, or omitted information was a common concern and resulted in **people presenting at services with needs different to those detailed in the discharge summary**. Again this related to needs such as mobility or behaviour and medicines, including disparities between the medications sent home with the person and those prescribed in their documentation. In one system this had led managers to raise **safeguarding concerns**. Another manager told of receiving a discharge summary that omitted details of harm incurred in the hospital:

"One discharge summary for example read a resident was mobile, and he could eat and drink independently, but this wasn't the case. This resident had a fall while in hospital but this was not documented in the discharge summary."

Registered manager, residential home

While not as commonly mentioned, these issues around the quality and accuracy of information applied to social care support plans too.

Similarly, the discharge information received by social care providers varies in how comprehensive the content is. We asked respondents to tell us how frequently discharge information provides comprehensive information on:

i) The person's diagnosis and treatment
ii) Changes in the person's care needs
iii) Mobility issues
iv) Medications and prescriptions
v) Future plans, including escalation and Do Not Resuscitate orders (DNACPR)

Across all respondents it appears that discharge information more commonly contains details of medications and prescriptions and the person's diagnosis and

treatment; and less frequently details mobility issues, future plans or changes in the person's care needs.

Table 5: Comprehensiveness of discharge information[11]

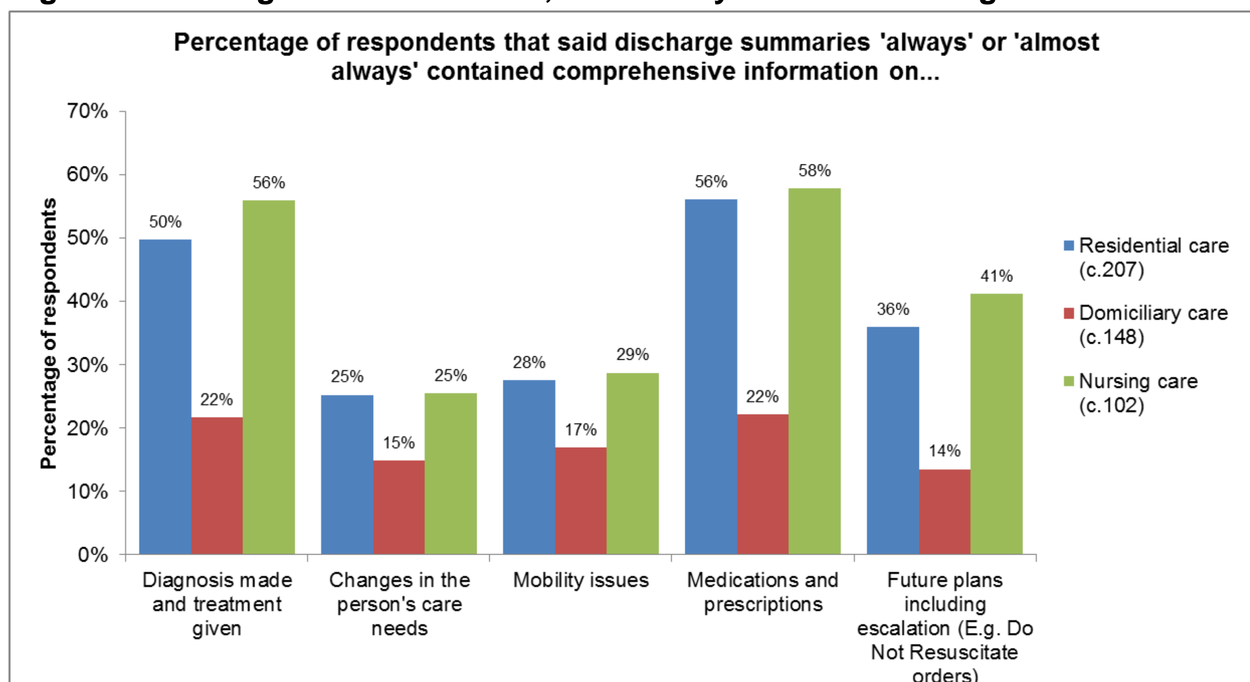
	Frequency of receipt of discharge information that provides comprehensive information on...				
	Diagnosis made and treatment given	Changes in the person's care needs	Mobility issues	Medications and prescriptions	Future plans including escalation (E.g. Do Not Resuscitate orders)
Always / almost always	40%	21%	24%	44%	29%
Often / sometimes	44%	49%	48%	37%	37%
Rarely / never	16%	30%	29%	18%	34%
Total	**426**	**424**	**424**	**427**	**425**

Again, registered managers for DCAs say the discharge information they receive less commonly contains comprehensive details on these matters compared to other types of service. In particular, more than half (53%) of responses relating to DCAs said discharge summaries “rarely” or “never” detail information on future plans or escalation.

Among the five questions about content of discharge summaries, responses from registered managers of residential services and nursing care services revealed that discharge information least often included details about changes in the person's care needs. However, a quarter of respondents for both types of service still said this was “always” or “almost always” comprehensively detailed.

[11] Analysis excludes respondents that answered ‘N/A’

Chart 4: Comprehensiveness of discharge information, responses from registered managers for residential, domiciliary care and nursing care[12] [13]



Accessing missing information

In the free-text comments, managers across different service types reported having to follow up with the ward for information and clarifications to enable them to care for the person discharged to their service.

From the way these experiences were described it was clear that **the onus was on the service managers to "chase" hospital staff and social workers** for the information required. Examples of the types of follow up information requested included discharge summaries, medications records, Do Not Resuscitate (DNR) forms, treatment escalation plans, risk assessments and support plans.

"The only reason we get the information is because we chase it or we do not admit, if it were left to the authority it would not happen. The information is very often lacking and we have to undertake numerous calls to get the information required to care for an individual."

Registered manager, nursing home

[12] Analysis excludes respondents that answered 'N/A'
[13] Numbers of respondents to each question (minus 'N/A' responses) vary very slightly, the approximate number of respondents per service type is indicated in the chart legend.

Chasing for information was a frustration for registered managers, but could also be detrimental to the person's safety; not having accurate information about medications was most commonly stated.

"*The main difficulty we have is receiving discharge summaries from hospital. If the client arrives without a summary we are having to chase with numerous phone calls. This can lead to delays in administering medications as we are unable to give [them] without a discharge summary. This can also potentially become an unsafe discharge."*

Registered manager, residential home

While some managers tended to receive information promptly following their request, for others the processes could be met with delays. There were challenges accessing the right information from the right people when the staff on duty had changed since the time of discharge. Information was not always given to managers over the telephone. One residential home manager described having to call a person's GP to get clarity around their medications because they had not received a discharge summary.

Information returned to services

An issue raised across several systems, most prominently by residential home managers, was that **the information they send in with the person when they are admitted to hospital is not returned**. DNR documentation was mentioned specifically; a few managers said these were often not returned and this could cause problems for a home in getting the GP to create a new one, and present risks to people using services. Other documentation that could be "lost" through the system included 'person passports', care plans and Medication Administration Records. It was an added frustration that when services provided this information they were called by the hospital with questions about the person's needs. Even the existence of a 'red bag initiative[14]' had not addressed the issue for one manager.

[14] A system to facilitate a smooth handover of information between care home, ambulance and hospital staff.

Other themes from free-text comments

Discharge issues

Notice of discharge
Service managers said they **did not always receive notice of a person's discharge** to their service. Domiciliary care service managers across six systems had experienced their clients being sent home without them being informed. Residential and nursing home managers across several systems had also experienced people arriving at their service without notice.

"We have experienced several unsafe hospital discharges where we have not been informed what time the service user will arrive home and if there have been any changes in their care package. Not only has this caused disruption to our own services but also causes undue stress to the service user and their families".

Registered manager, domiciliary care

Time of discharge
A few residential and nursing home managers said that **people had been discharged at inappropriate times** such as late at night or in the early hours of the morning. While not widely noted as an issue, the impacts for the person could be significant and had resulted in two homes calling emergency services when they were unable to meet the person's medical needs.

Medication issues
Medication issues were the most commonly described problem with discharges and were a clear risk to safety. A few domiciliary care service managers described how medication information was not communicated to them, such as their clients being sent home with new medication without them being informed.

Residential and nursing home managers across more than half of systems we reviewed described medication issues at discharge, such as residents being discharged without medication and this arriving later by taxi, or in one case an urgent prescription had to be sought from the GP. Other issues included: discharges with incorrect medication or insufficient medication; discrepancies between the medication with the person and what was detailed in the paperwork; and unclear instructions and documentation.

"Often medication doesn't come with the person. [It's] delayed or arrives late in a taxi. Recently a person arrived without medication and was EOL [at the end of their life]. Medication including pain relief arrived over 24 hours later"

Registered manager, nursing home

Other discharge issues
Discharge issues described less commonly included:

- Discharging before the right equipment is in place
- People being discharged without their personal effects
- People being discharged without the appropriate referrals having been made to community support services.

Relationships and understanding between services

Understanding between services
A key overarching theme throughout the free-text comments was the impact that relationships and understanding between staff across health and social care has on the quality of the discharge process.

Registered managers felt that **hospital staff could lack understanding about their services and what they could offer** which contributed to inappropriate referrals and discharges. This issue was identified in relation to independent living and extra care services, which might be expected as these services are less common and sometimes newer types of provision:

"We find the hospital try to discharge without the required equipment assuming that we should have shared equipment. As we are independent living each resident has to have their own equipment. We have allocated calls not like in a residential care home where you can just ring if you need something"
Registered manager, domiciliary care

Interestingly, however, there were also care home and domiciliary care managers who felt their service was poorly understood:

"We also always have to explain that we are not a residential or nursing home and that the resident needs to be medically fit to come home to domiciliary care with support. We have many difficult conversations with discharge nurses who insist that someone can come home even if there is no mobility aids etc. in place"
Registered manager, domiciliary care and supported living

Relationships between staff
In a few instances registered managers suggested there were **adversarial interactions** between hospital staff and themselves. They reported being pressured to proceed with discharges at a pace that were uncomfortable to them (for example before they had undertaken an assessment), and a lack of parity between health and social care:

"I want to be part of the health community with NHS mail and secure access to records. We need to be viewed as a health partner not an older person's warehouse."

Registered manager, nursing home

"Health has a completely different view of social care and are too busy to care as long as the patient is off their hands... Discharges only go well in my area if I threaten them with a failed discharge prior. It is so very frustrating from our point of view".

Registered manager, domiciliary care

High impact changes

Trusted assessor

Registered managers across service types told us that they did not have trust in hospital assessments. The impact was that some providers felt compelled to undertake their own assessment of need before accepting a referral, as described previously.

The lack of trust between staff has implications for the implementation of the trusted assessor model. Indeed, **two managers explicitly stated that that they would not buy into the trusted assessor model** for this reason. Another said that their trusted assessor was not always available.

"We do not use the hospital's trusted assessors as they don't know our home, current dependencies and how we work, so they are in no place to make that decision for us."

Registered manager, nursing home

There was, however, another manager who had seen a marked improvement in the quality of the discharge information they received and put this down to the work of their trusted assessor.

Seven day services

A lack of seven day services was mentioned across several systems as impacting on the quality of discharge. **Service managers suggested that there was not the same response to issues at the weekend as in the week**, with bank holidays mentioned in particular as challenging times. For example, concerns were raised when a person was discharged with insufficient medication, or without the correct information on a Friday:

"Sometimes the information needs further discussion, and if the admission is late in an evening, particularly on a Friday, it can be difficult to get that information… We

rely on [the out of hours GP service] who have raised their comments that we should have received all the necessary information at the time."

Registered manager, nursing home

A few managers suggested that they were particularly concerned with Friday and weekend discharges because they lacked confidence in the appropriateness of discharges overall and didn't want to risk readmission at the weekend:

"When we are asked to reinstate a package after discharge from hospital there have been many occasions when the service user has been admitted back to hospital as they were not suitable for discharge. This is not ideal when a service user is discharged from hospital on a Friday."

Registered manager, domiciliary care

Another reported issues with wards discharging people at weekends with very little planning, suggesting that hospital capacity and procedures might not be as robust over this time. Because of these issues a couple of managers indicated they were **not accepting discharges into their services between Friday and Monday**.

Inconsistent experiences across systems and services

Inconsistency was a key theme throughout registered managers' comments with regards to their experiences of discharge; sometimes they had poor experiences of assessments, communication and discharge, and sometimes they did not. Managers also explicitly highlighted the **variation of experience across different parts of the system, and even within the same service**.

Across a system, we heard how the quality of discharge could differ depending on the discharging hospital, and service. For example, in one system information sharing was facilitated by a nursing home service, but this was only operational in one patch of the system.

Within a service, while one manager said that the quality of discharge could depend on the ward, several others went further to say it depended on the particular person managing the discharge.

Interestingly, one manager had identified a difference depending on whether the person was a new client to their service or a returning client, observing that discharge information was of a poorer quality for people returning as they assumed an existing level of knowledge.

Variation by professional involvement

Some specific teams and roles were associated with an improved discharge process. A few managers said that when social workers or a care manager were

involved this was seen to make a difference; however others pointed out that information received from social services and their level of knowledge could also be poor.

Other professionals identified as supporting a better discharge process were the palliative care team, a trusted assessor, and the care home liaison team (who requested feedback on discharges).

Communication and information sharing

Communication was seen as key to a safe and effective discharge. Due to the variable quality and accuracy of assessment and discharge information described above, direct verbal communication between the hospital and the provider was seen to be important for the provider to plan effectively for the discharge and to fill information gaps.

However, communications between the discharging unit and the receiving service could be poor. Across service types, **a lack of communication on the part of the hospital was commonly observed**, with the onus being on the registered managers to instigate and chase for information, which could be time consuming and pose a risk to people using services.

Managers from across several systems said that hospitals would not always provide them with information over the phone for reasons of confidentiality. However this practice was applied inconsistently by different staff within the system which was a source of frustration for service providers.

"The major drawback is that during a hospital stay should we wish to follow progress, ward staff are reluctant to speak with us because we are not 'family'. At the point of discharge the staff…are usually only too willing to speak via telephone."

Registered manager, residential home

A lack of communication with regard to discharge could mean that when the person arrives at a service the staff don't know when the person has last eaten or when their medication was last taken. Communications from the hospital could be contradictory between what was given verbally and the information recorded in documentation.

"Despite phoning on a daily basis for updates hospital teams tell my team they are too busy to talk and therefore we cannot effectively plan their discharge. On occasion we have been phoned to say a client is on their way home without confirming we are able to accept them."

Registered manager, domiciliary care

Challenges with communication extended to after the person had been discharged, in circumstances where a change in needs was identified by the provider and they tried to arrange an increase in care package.

"In the last month we have had two clients experience a bad death, as poor communication has led to equipment not arriving or additional nights/care calls not be funded in time before they passed away."

Registered manager, domiciliary care

Learning from positive experiences

Registered managers' comments were largely negative around information flow during the discharge process. There were, however, also good experiences and an improving picture in some places. The factors associated with good discharge information were:

- Having positive relationships between the provider and discharge team, responsive two way communication and open and honest interactions
- Staff being available and willing to speak to the provider on phone and in person
- A responsive social worker
- The use of a planning checklist on discharge.

Effective collaborative working was described in one system, underpinned by positive relationships, honest interactions, a shared endeavour, and an understanding of the pressures and challenges in each other's service:

"We have found recently that the discharge team are keen for us to place individuals appropriately, and subsequently we want to help ease the demands on the hospital and are keen to free up beds on the wards… In recent months we have been pleased that any information we have been given is accurate and honest…This builds for better relationships between the hospital and care home."

Registered manager, nursing home

Appendix 1: Methodology

The discharge information flow tool consists of seven categorical questions and one free-text comment box. The questionnaire was built specifically to support evidence gathering for CQC's programme of local systems reviews. The questions were developed using findings from a consultation with care homes undertaken by the Professional Record Standards Body, which indicated that there were issues with the quality of care records produced at discharge[15].

The questions were built into an online survey tool and a web link created for each local system review area. Contents of the tool and the wording issued by CQC can be found in Appendix 2.

All active registered adult social care locations that provide care to older people and were situated within the relevant local authority areas were identified as potential respondents. Registered managers of these locations were emailed the web link to the questionnaire in week one or two of the review process for each local system and given at least two weeks to complete their feedback[16].

After the deadline the responses were extracted, analysed and summarised in a briefing document that was presented to the CQC review team ahead of them carrying out their fieldwork. Quantitative data were summarised categorically with numbers and percentages and free-text comments were reviewed for common themes.

For the purpose of producing this report, we undertook more detailed analysis of all free-text comments across the 20 areas in the local systems review programme by coding and theming them using MaxQDA analysis software.

Risks and limitations

There are several caveats regarding the methodology used to set up the questionnaire as well as in regards to interpretation of the results.

As this questionnaire was only issued to registered managers of adult social locations in the 20 areas where we carried out a local system review, responses cannot be said to be representative nationally.

[15] Professional Record Standards Body. (2017). 'Care home information flow: Consultation report'. Available at: https://theprsb.org/wp-content/uploads/2018/02/Care-home-information-flow-consultation-report-v1.4-3.pdf

[16] This wasn't the case for a couple of areas, namely Halton and Sheffield, that had just over a week to submit responses.

The size of the local authority areas selected for the local system reviews vary a great deal, from small single unitary authorities like Hartlepool, to large counties like Hampshire. Accordingly, the number of respondents from each area varies, so the analysis presented in this report will be skewed towards the areas that provided more responses. Across areas the response rate varied, ranging from just 9% to 33%. Because of the generally low and varying response rates, we have not compared responses from different areas to one another, but simply presented the overall themes from across the 20 areas.

Table 6: Response rate, by area[17]

Local A=authority	Count of unique registered managers emailed	Count of completed responses	Count of free-text responses	Response rate (%)
Halton	15	3	2	20%
Stoke-on-Trent	105	14	7	13%
Bracknell Forest	24	8	2	33%
Hartlepool	26	6	2	23%
Manchester	125	16	8	13%
Trafford	64	15	10	23%
York	52	9	5	17%
East Sussex	280	46	21	16%
Oxfordshire	190	17	7	9%
Plymouth	95	21	7	22%
Coventry	128	17	6	13%
Birmingham	356	36	20	10%
Bradford	150	18	5	12%
Cumbria	171	25	7	15%
Liverpool	117	15	5	13%
Sheffield	152	19	9	13%
Wiltshire	177	31	14	18%
Hampshire	460	76	30	17%
Stockport	78	8	3	10%
Northamptonshire	254	49	31	19%

We received 201 comments to the open ended free-text question. Over half of the comments (116) received were from the five areas with the largest volume of responses overall and most free-text comments were received from services providing residential and domiciliary care – these points should be taken into account when considering the findings.

[17] Table sorted by review date for each area, starting with the earliest review.

It should be noted that for most areas there were some ‘bounce back’ emails and automated ‘out-of-office’ responses, so the true number of people that received the invite to respond to the feedback tool in each area will be lower than the number quoted in the table above. Furthermore, a small percentage of responses related to services that were out of scope for this questionnaire as they could not be easily excluded from the overall analysis.

Finally it should be noted that the same person can be a registered manager for multiple locations and a single location may have multiple registered managers. This is because registered managers are registered against Regulated Activities, of which a single location may undertake several. For these reasons we can’t conclude that responses relate to individual locations.

Appendix 2: Discharge information flow tool questionnaire

Discharge Information tool

Dear colleague,

You may be aware that under Section 48 of the Health and Social Care Act 2008, your local authority area has been selected for a local system review from the Care Quality Commission (see https://www.cqc.org.uk/news/stories/cqc-conduct-12-local-system-reviews-health-social-care).

The review will focus on the way different parts of the health and care system work together in your area, with a particular focus on how health and social care services work together to provide care and support for older people. One aspect of this review is to look at how information is shared across the system and how this works when care is transferred from NHS care to adult social care services.

We will be conducting a range of evidence gathering activities during the review. One important aspect of this is understanding how information is shared between secondary care providers and adult social care (including care homes and domiciliary care agencies).

We would like to invite you to provide us with your views on how you feel the information flow works in your local system.

Below you will find some questions and statements relating to the information you receive when a person is discharged to your service. Please consider the statements below and answer based on your recent experience of working in the local system of health and care for older people (over 65).

This will take up to ten minutes to complete and your feedback will be anonymous. The information you provide will only be used for the purpose of the local system review. It will not inform regulatory activity around individual providers unless there are concerns raised around the quality and safety of care. Please submit only one response per organisation.

Many thanks for your help.

Care Quality Commission

1.

*What type of adult social care do you provide for people over 65
(tick all that apply)

- ☐ Domiciliary care
- ☐ Residential
- ☐ Nursing
- ☐ Dementia
- ☐ Learning Disability
- ☐ Housing with care
- ☐ Supported living
- ☐ Other: ______

2.

*How many people do you provide services for?

- 0-25
- 26-50
- 51-75
- 76-100
- 100+

3.

*Approximately how often do you receive a discharge summary when one of the people you provide services for is discharged from acute care, intermediate care or re-ablement?

- Less than 25% of the time
- 25%-50% of the time
- 50%-75% of the time
- 75%-100% of the time
- N/A

4.

*How often are you involved in the discharge process through:

	Always	Almost always	Often	Sometimes	Rarely	Never	N/A
Undertaking pre-discharge assessments	●	●	●	●	●	●	●
Visiting a resident in hospital or a	●	●	●	●	●	●	●

community setting							
Phone contact with the hospital/ intermediate care/ re-ablement service	●	●	●	●	●	●	●

5.

*How often do you receive discharge information in the following formats:

	Always	Almost always	Often	Sometimes	Rarely	Never	N/A
Paper	●	●	●	●	●	●	●
Secure email	●	●	●	●	●	●	●
Shared electronic systems	●	●	●	●	●	●	●

6.

*How often are the following statements true of the discharge information you receive:

	Always	Almost always	Often	Sometimes	Rarely	Never	N/A
I receive discharge summaries within 24 hours of discharge	●	●	●	●	●	●	●
I am provided with enough information on discharge to make a decision on	●	●	●	●	●	●	●

whether my service can support the placement							
The discharge information I receive is accurate	●	●	●	●	●	●	●
I trust the discharge information I receive	●	●	●	●	●	●	●

7.

*How often does the discharge information you receive provide you with comprehensive information on:

	Always	Almost always	Often	Sometimes	Rarely	Never	N/A
The diagnosis made and treatment given	●	●	●	●	●	●	●
Changes in the person's care needs	●	●	●	●	●	●	●
Mobility issues	●	●	●	●	●	●	●
Details of medications and prescriptions	●	●	●	●	●	●	●
Future plans including escalation (E.g. Do Not Resuscitate orders)	●	●	●	●	●	●	●

8.

Please use this space to provide any further comments.