

# *Dis-charge to the Street* Is it Organisational Abuse?



**LNNM Conference - 9 June 2023**

**Michelle Cornes** (University of Salford)

**Jo Coombes & Jess Harris** (Kings College London)

[M.L.Cornes@Salford.ac.uk](mailto:M.L.Cornes@Salford.ac.uk)



University of  
**Salford**  
MANCHESTER

**KING'S**  
*College*  
**LONDON**

# Dis-charge to the Street – Is it organisational abuse?

## The perspective of lived experience

Survivor testimony does not enter so often into the ‘public’ domain. Experiences of unhousedness are too often unarticulated, un-remembered... It reminds us of the too numerous ways in which many of our fellow citizens are “*dissed*”

dis-respected, dis-possessed, dis-inherited, dis-enfranchised, dis-appointed, dis-membered....

We use the active verb ‘unhouse’ (to unseat or displace) instead of the more standard term homelessness to ensure that we don’t forget that someone has done the *unhousing* to someone else...

Chris Scanlon and John Adlam

Psycho-Social Explorations of Trauma, Exclusion and Violence (2022 p6-7)

# Organisational Abuse – through the lens of the Care Act, 2014

## What is organisational abuse?

According to the Care Act 2014 statutory guidance, **organisational abuse** includes neglect and poor care practice within an institution or specific care setting such as a hospital or care home... This may range from one off incidents to on-going ill-treatment. It can be through neglect or poor professional practice as a result of the structure, policies, processes and practices within an organisation.

## Neglect and acts of omission includes:

- ❑ Ignoring medical, emotional or physical care needs
- ❑ Failure to provide access to **appropriate** health, care and support or educational services
- ❑ The withholding of the necessities of life, such as medication, adequate nutrition and heating

## How common is organisational abuse (compared to other kinds of abuse and neglect)?

The most common type of risk in Section 42 Safeguarding enquiries that concluded in 2021/2022 was **Neglect and Acts of Omission**, which accounted for 31% of risks raised (NHS Digital, 2022).

# “Appropriate health, care and support ...” – through the lens of the whistle blower

Extract from a letter of complaint to a London hospital ....

Dear Chief Executive Officer,

**Re Unsafe Hospital Discharge: Failure to provide access to appropriate health, care and support.**

I am writing to complain about the treatment of Mr A while an in-patient at [name of Hospital]. The complaint concerns unsafe discharge leading to neglect and serious harm (accidental overdose and exacerbation of COPD requiring hospitalization).

During [a seven week] period, Mr A attended A&E on 6 separate occasions and was readmitted to hospital on 4 occasions. On each occasion Mr A was discharged with no provision for his housing, care and support. He spent time living in the hospital garden....

# “Appropriate health, care and support ...” – through the lens of the organisation

Dear Dr Cornes

... During the ward round Mr A was informed he would face discharge if he continued to consume alcohol of his own volition and he was assessed to have capacity and understanding of this... Due to his non-compliance with the detox treatment plan he was discharged from the ward...

The ward offered him a taxi to the day centre and we reassured you he had a lot of cash on him which would be more than enough to get hotel for the night. Staff also reminded him that he had been provided with information on local shelters...

I hope you can see we have taken your concerns seriously and have done all we can to investigate and answer them; as an organization we are committed to being open and transparent.

*Mr A died aged 44 the year after this complaint was made.*



# Different views on the same Health and Care system

**Comfort Seeking Leadership / Management**

**Problem Sensing – Inclusion Health Nursing**

Concerned with  
External  
Impression  
Management

Concerned  
with  
Advocacy

**Responsibility Cordons –  
potential for inter-organisational and  
interprofessional conflict**



# Discharge Hubs as Responsibility Cordons



“Bear Pits and Burnout”

# Problem Sensing - Impact on Inclusion Health Nurses Health and Wellbeing

“[In the hospital] You feel like you’re repeating yourself all the time when you are asking for help... You’re made to feel like you’re catastrophising.... You have no power... It just slowly, slowly burns you out.”

“I have had lots of horrendous jobs working in inclusion health. I worked with asylum seekers that was horrendous on a different level... That was probably where I should have been tested for PTSD.... “

(Views of Inclusion Health Nurses)

# The Recruitment and Retention Crisis in the NHS

“I see my line manager once a year for my appraisal... I cry to the cats when I get home. I get more out of my cat giving me a hug... I feel at work we're the invisible nurses”

“It feels like things are getting worse, and yet all these pots of money and London posts are being created and not going to be filled because they don't understand how to look after people properly and value them... You know [inclusion health nursing] is a network. We are all friends and my friends aren't going to come into this job, I am sorry but they know the reality of it... It will be someone fresh who will get burnt out”

(Views of Inclusion Health Nurses)



# Ending Abuse – Shifting to trauma informed (problem sensing) organisations

Scrutiny is intensifying from parts of the health care system that seeks to **deny health care** to those who are 'unfit' because their very real illnesses are seen as resulting from a lack of will power, greed or laziness rather than unhappiness, social exclusion, psychological dependency or some other psycho-social ailment ....

A psychosocial model of trauma foregrounds the objective violence of practices such as...  
***“Dis-charge to the street”***

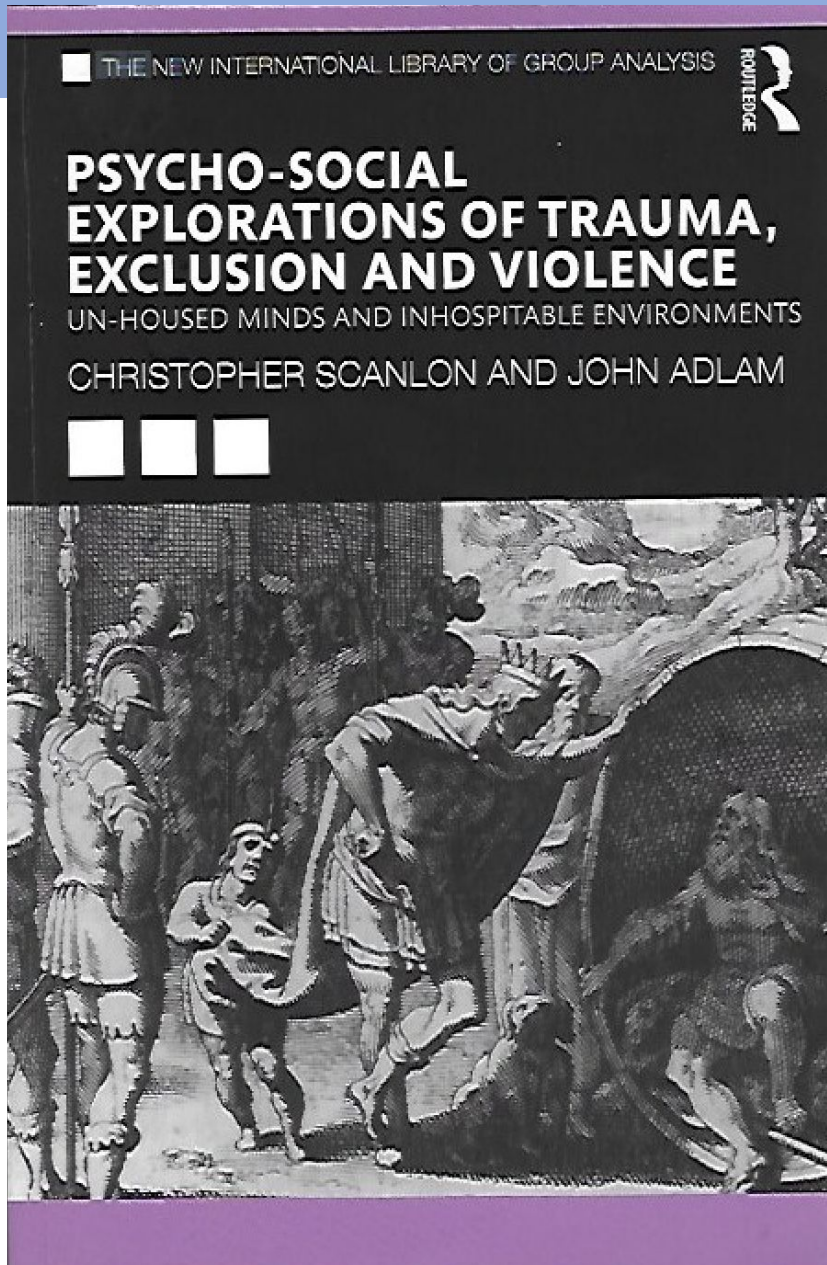
... Our task is to create containing structures in which to have conversations in communities of learning about the psychosocial processes of (re) traumatization that are at the dark heart of our current states of mutual misunderstanding and cycles of violence...

(Scanlon and Adlam, 2022\_p14/17)

## Recommendations for Senior NHS Leaders:

- Adopt 'problem sensing' not 'comfort seeking' practices
- Comit to an ethic of learning and honesty
- Nurture the core values of compassion, patient dignity and patient safety
- Make sure staff feel safe, supported, respected and valued at work – compassion circles not bear pits and burnout.

(Dixon-Woods et al., 2014)



OPEN ACCESS



Open Access  
Scan to access more  
free content

## Culture and behaviour in the English National Health Service: overview of lessons from a large multimethod study

Mary Dixon-Woods,<sup>1</sup> Richard Baker,<sup>1</sup> Kathryn Charles,<sup>2</sup> Jeremy Dawson,<sup>3</sup> Gabi Jerzembek,<sup>4</sup> Graham Martin,<sup>1</sup> Imelda McCarthy,<sup>4</sup> Lorna McKee,<sup>5</sup> Joel Minion,<sup>1</sup> Piotr Ozieranski,<sup>6</sup> Janet Willars,<sup>1</sup> Patricia Wilkie,<sup>7</sup> Michael West<sup>8</sup>

<sup>1</sup>Department of Health Sciences, University of Leicester, Leicester, UK

<sup>2</sup>Imperial College Centre for Patient Safety and Service Quality (CPSSQ), London, UK

<sup>3</sup>Institute of Work Psychology and School of Health and Related Research, University of Sheffield, Sheffield, UK

<sup>4</sup>Aston Business School, Aston University, Birmingham, UK

<sup>5</sup>Health Services Research Unit, University of Aberdeen, Aberdeen, UK

<sup>6</sup>Department of Social and Policy Sciences, University of Bath, Bath, UK

<sup>7</sup>National Association for Patient Participation, Surrey, UK

<sup>8</sup>Lancaster University Management School, Lancaster, UK

**Correspondence to** Professor Mary Dixon-Woods, Department of Health Sciences, University of Leicester, 22–28 Princes Road West, Leicester LE1 6TP, UK; md11@le.ac.uk

Received 3 March 2013

Revised 16 July 2013

Accepted 17 July 2013

Published Online First

9 September 2013



► <http://dx.doi.org/10.1136/bmjqs-2013-002471>

**To cite:** Dixon-Woods M, Baker R, Charles K, et al. *BMJ Qual Saf* 2014;**23**:106–115.

### ABSTRACT

**Background** Problems of quality and safety persist in health systems worldwide. We conducted a large research programme to examine culture and behaviour in the English National Health Service (NHS).

**Methods** Mixed-methods study involving collection and triangulation of data from multiple sources, including interviews, surveys, ethnographic case studies, board minutes and publicly available datasets. We narratively synthesised data across the studies to produce a holistic picture and in this paper present a high-level summary.

**Results** We found an almost universal desire to provide the best quality of care. We identified many ‘bright spots’ of excellent caring and practice and high-quality innovation across the NHS, but also considerable inconsistency.

Consistent achievement of high-quality care was challenged by unclear goals, overlapping priorities that distracted attention, and compliance-oriented bureaucratised management. The institutional and regulatory environment was populated by multiple external bodies serving different but overlapping functions. Some organisations found it difficult to obtain valid insights into the quality of the care they provided. Poor organisational and information systems sometimes left staff struggling to deliver care effectively and disempowered them from initiating improvement. Good staff support and management were also highly variable, though they were fundamental to culture and were directly related to patient experience, safety and quality of care.

**Conclusions** Our results highlight the importance of clear, challenging goals for

high-quality care. Organisations need to put the patient at the centre of all they do, get smart intelligence, focus on improving organisational systems, and nurture caring cultures by ensuring that staff feel valued, respected, engaged and supported.

### INTRODUCTION

A commitment to delivering high-quality, safe healthcare has been a policy goal of governments worldwide for more than a decade, but progress in delivering on these aspirations has been modest.<sup>1</sup> Patients everywhere continue to suffer avoidable harm and substandard care.<sup>2–3</sup> England’s National Health Service (NHS) has not been immune to these problems. Despite some encouraging evidence of improvement in quality and safety,<sup>4–5</sup> large and inexplicable variations in quality of care are evident across multiple domains and sectors of healthcare, from primary through to community and secondary care.<sup>6–7</sup> England has also seen a number of high-profile scandals involving egregious failings in the quality and safety of individual providers. These include the case of Mid Staffordshire NHS Foundation Trust,<sup>8</sup> the subject of a recently published public inquiry by Sir Robert Francis into how catastrophic failings in the quality and safety of care went undetected and uncorrected.<sup>9</sup>

Francis identified the causes of organisational degradation at Mid Staffordshire as systemic; he saw the underlying faults as institutional and cultural in character. He found significant weaknesses in NHS systems for oversight, accountability and

# Interested in our research?

## Opening the 'too difficult box': Strengthening Adult Safeguarding responses to homelessness and self-neglect (2019 – 2023)

- Communities of Practice Report 2022
- Economic analysis and modelling presentation 2022
- Lived experience perspectives of MEH and Safeguarding presentation 2023

## Evaluation of the Out-of-Hospital Care Models programme for people experiencing homelessness (2021 – 2023)

- Home First Discharge to Assess and homelessness: Updated support tool 2023

## NEW: Housing Model Evaluation (HOME): Improvements in health associated with housing-led systems for people experiencing homelessness (2023 – 2026)

## HSCWRU Homelessness Events Series (free, online, open to all)

Join the mailing list: [jess.harris@kcl.ac.uk](mailto:jess.harris@kcl.ac.uk)

Thank you

