Improving hospital discharge in England: the case for continued focus and support

31 March 2022

Suzanne Wood
Tim Horton

Most people admitted to hospital want to get better and get home, as soon as possible. But delayed discharges – where people remain in hospital when they no longer need hospital care – are an ongoing problem for the NHS. For example, NHS figures suggested that on 13 March 2022, 12.9% of all available acute hospital beds were occupied by patients who no longer needed to be there. And while overall bed occupancy fell drastically early in the pandemic, as part of a national effort to prepare for a wave of COVID-19 admissions, it is now at very high levels.

Thankfully, there are approaches, including the 'discharge to assess' model, that can help the NHS tackle these delays. But while they have the potential to free up capacity and unlock better use of resources for the health and care system, they must be implemented safely and effectively – and that in turn requires some resourcing up front. With central ringfenced funding to support hospital discharge coming to an end this week, there's a risk that without further action, discharge pressures could grow and disrupt the NHS's wider recovery objectives – such as clearing the waiting list backlog.

The challenges of discharging people from hospital

How and when people are discharged from hospital matters. Discharging people too early or without the necessary support can be unsafe and increase the risk of readmission. Delayed discharge, on the other hand, increases the risk of hospital-acquired infection, and is associated with low mood and reduced motivation, which can also increase the risk of readmission. For older people in particular, long stays in hospital can lead to loss of muscle strength – by up to 5–10%

within the first 7 days – which can hinder their return to living independently, or increase the level of support they need.

Good and timely discharge matters for the wider health and care system too. Recent Health Foundation analysis shows how delayed discharges can disrupt other services, including elective care. If hospitals can't discharge patients promptly and safely, then this affects their ability to move people through services. This in turn means surges in demand will put pressure on bed occupancy, leading to bottlenecks in emergency care and potentially also to planned treatments being cancelled. There is also a financial cost: Age UK highlights that each day someone remains in hospital beyond the end of treatment costs the system £346.

The 'discharge to assess' model

A decade ago, the Health Foundation supported a team at Sheffield Teaching Hospitals on a project to improve the flow of patients through the hospital. Analysis of their care pathways identified a cohort of frail older patients who were medically fit but not able to go home because they were waiting for an assessment of their social support needs.

This led to the team creating the concept of 'discharge to assess' (D2A), flipping the traditional discharge model on its head. The D2A approach seeks to get people home as soon as they no longer require hospital care, then assesses their support needs at home. It also allows them to be assessed in the environment they will be living in, which has advantages. In its first year, the D2A model contributed to a reduction in average length of stay for the cohort group from 5.5 to 1.2 days, with no observed change in readmissions.

Other communities then followed in developing their own versions of D2A, such as the Home First model in Medway. D2A has been promoted as good practice by NHS England since 2016, though there has been variation in whether and how it has been adopted.

Hospital discharge during the COVID-19 pandemic

To help avoid hospitals being overwhelmed during the pandemic, there has been a specific

push to speed up discharge. In 2020, NHS guidance set the expectation that D2A should become the default process, with extra funding to help cover the costs of post-discharge services. The Health and Care Bill seeks to remove any legal barriers to D2A, amending legislation to clarify that assessments of care and support needs may happen after patients are discharged from hospital.

While this increased national focus on discharge has been welcome, it is critical that new approaches are implemented safely and in ways that maximise the benefits to patients and services originally envisaged by the D2A approach. A 2020 study revealed worrying problems with how new discharge arrangements were working during the first wave of the pandemic, with many people who reported having unmet needs in the community saying they didn't receive a home assessment after leaving hospital. More generally, the discharge process exposes the interdependence of hospital performance on community care, social care and the voluntary sector – underscoring the need to invest in those services, and their critical importance for NHS recovery.

Making 'discharge to assess' work well

In recent years, the Health Foundation has carried out research with teams implementing D2A in Sheffield, South Warwickshire, Tower Hamlets and Medway. These teams identified some common ingredients for success – specifically, factors underpinning effective cooperation across the NHS, social care and the voluntary sector:

- strong relationships and trust between colleagues across different sectors
- a shared understanding of the problems of delayed discharge and the benefits that successful discharge can yield
- collaborative working to design, test and iterate new approaches.

As well as these crucial components, teams also highlighted some important lessons both for those implementing D2A and for policymakers:

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1. Don’t forget to focus on quality

Successful improvements in discharge tend to be driven by front-line staff wanting to improve patient care, rather than simply reduce length of stay in hospital. Our teams told us that their efficiency gains tended to follow from these wider improvements in quality. So rather than valuing D2A simply for the capacity it frees up, it’s important to embed a focus on the wider quality benefits, including patient experience.

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2. Allow space and flexibility for D2A to be adapted and improved

While a national drive to embed D2A can provide a helpful focus, it is important to remember there is not one single blueprint. For example, which teams lead D2A models or how they integrate with other community services might need to be different in different places. So local teams require space and flexibility to create, test and develop a D2A model that meets local needs. The original model in Sheffield was developed from detailed diagnostic work, and required multiple tests before getting to the most effective design.

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3. Make sure D2A is adequately resourced across the system

D2A needs sufficient resourcing, in particular to ensure that the relevant post-discharge support is available. This is especially important for sustaining the model: one of the teams in our research described how reliance on non-recurrent funding created uncertainty, making it more challenging to embed the approach and creating barriers to collaboration as friction re-emerges about who is responsible for funding care at the point of discharge.

Next steps for managing hospital discharge

Despite progress during the pandemic, NHS leaders know hospital discharge remains a challenge. In December, with the Omicron variant spreading, NHS England told providers to halve their numbers of delayed discharges and established a national discharge taskforce to develop best practice.

The question of funding remains contentious, however. During the pandemic, extra funding was made available to support discharge – health and care leaders cited this as critical in enabling the expansion of D2A. However, the most recent NHS planning guidance confirms this funding will end on 31 March, despite previous calls by the NHS Confederation and NHS Providers to make it permanent.

There are real concerns that, in this context, pressures in social care and community services will risk people being discharged from hospital without the necessary support in place (a letter this week from NHS England to local leaders acknowledged that 'in some areas capacity for post-discharge services may decrease'). There are also fears – echoed at March's NHS board meeting – about the knock-on effect on the wider system if the withdrawal of discharge funding results in even greater pressures on bed capacity.

One potential area for optimism is the development of virtual wards. These expanded rapidly during the pandemic and are now being used to support patients with a wider range of conditions. As well as being an alternative to hospital admission, virtual wards and 'hospital at home' models of care appear to offer significant potential to enable supported discharge. So this could be one part of the solution, with further clinical guidance on virtual wards forthcoming.

NHS England clearly sees virtual wards as a key part of the plan for NHS recovery, with up to £200m being made available in 2022/23 to support their expansion. But while this funding might go some way towards compensating for the withdrawal of dedicated D2A support, it seems unlikely to plug the gap entirely (by comparison, the national discharge fund amounted to around £490m from October 2021 to March 2022).

Priorities for policymakers and the NHS

Our research suggests some key considerations for front-line teams, integrated care systems (ICSs) and policymakers.

First, D2A should be implemented in ways that are true to the original aims of the D2A approach and not used as a shorthand for any attempt to speed up hospital discharge. Teams seeking to embed D2A need the flexibility to implement it in ways that fit local circumstances and should be encouraged to focus on the wider quality benefits, including patient experience.

Second, with the end of ringfenced central funding, it will be essential that ICSs develop plans to further support D2A. This will require working with providers to embed and improve new discharge approaches, including through the development of virtual wards and hospital at home.

Finally, while D2A offers quality and efficiency gains – for both patients and the NHS as a whole – it requires sufficient resourcing and staffing across a range of services to realise and sustain these benefits. Ultimately, it is incumbent upon the government and system leaders to ensure services have the funding they need to secure the future of D2A. Failure to do so will risk undermining the resilience of the acute sector – and with it, disrupt wider objectives such as elective recovery.

Tim Horton (@timjhorton) is Assistant Director of Insight and Analysis in the Improvement team at the Health Foundation.

Suzanne Wood (@suzannewTHF) is now Head of Population Health at the BMA, but her contribution to this research was made while she was an Improvement Fellow at the Health Foundation (until February 2022).

https://www.health.org.uk/news-and-comment/blogs/improving-hospital-discharge-in-england-the-case-for-continued-focus