Health Foundation evidence to the Public Administration & Constitutional Affairs Committee on unsafe hospital discharge

July 2016

1. Introduction

1.1. Thank you for the opportunity to submit evidence to the Public Administration and Constitutional Affairs Committee's (PACAC) evidence session into the issues raised by the Parliamentary and Health Service Ombudsman (PHSO) report, *A report of investigations into unsafe discharge from hospital*.[1] Our submission draws on our analysis of the financial pressures facing the NHS and social care, and our experience over the past decade of funding frontline improvement projects to make care safer and more person-centred.

1.2. The main points that we wish to draw your attention to are set out below.

- Unsafe discharge from hospital is a significant issue which has very serious consequences for the patients, carers and families concerned, as well as adding to the financial pressures affecting the NHS and social care.
- We have supported front line teams to improve the quality and expediency of discharge of patients from hospital, and to address issues that contribute to the pressures on hospital services which can affect the effectiveness of discharge processes. For instance, by reducing clinically unnecessary hospital admissions from vulnerable people in the community.
- Future progress will rely on: spreading such improvements and innovations to have the greatest impact on the greatest number of patients; fostering whole-system thinking and collaborations across entire health economies; and adopting a fundamentally new approach which conceives patient safety from the patient's perspective.

2. About the Health Foundation

2.1. The Health Foundation is an independent charity committed to bringing about better health and health care for people in the UK.

2.2. Our aim is a healthier population, supported by high quality health care that can be equitably accessed. From giving grants to those working at the front line to carrying out research and policy analysis, we shine a light on how to make successful change happen. We use what we know works on the ground to inform effective policymaking and vice versa.

2.3. We believe good health and health care are key to a flourishing society. Through sharing what we learn, collaborating with others and building people's skills and knowledge, we aim to make a difference and contribute to a healthier population.

3. Patient safety issues associated with discharge from hospital

3.1. The PHSO report describes the experiences of people who have been badly let down by the system, laying bare the human cost of problems associated with the unsafe discharge of patients from hospital. These personal stories are supported by empirical research in this area, summarised in a recent publication by Charles Vincent and Rene Amalberti,[2] supported by the Health Foundation. It states:

"The period following discharge from hospital is a particularly vulnerable time for patients. About half of adults experience a medical error after hospital discharge, and 19–23% suffer an adverse event, most commonly an adverse drug event (Greenwald et al. 2007; Kripalani et al. 2007)."

3.2. The authors go on to state that hospital discharge is poorly standardised and is characterised by discontinuity and fragmentation of care. For instance:

"At the time of first follow-up with their primary doctors after hospitalization, up to 75 % of patients find that discharge summaries have not yet arrived, which restricts their doctor's ability to provide adequate follow-up care (Schoen et al. 2012)."

4. Our evidence to the Public Accounts Committee's inquiry on *Discharging Older People from Acute Hospitals*

4.1. Our evidence submission to the Public Accounts Committee in May 2016 focused on three areas: the financial pressures facing the NHS and social care; an analysis of NHS performance on delayed transfers of care; and case studies of projects that the Health Foundation has funded to improve the discharge of older and vulnerable patients from hospital. The key points of relevance to the PACAC evidence session are summarised below, and the original submission is enclosed with this submission (see Annex).

Financial pressures affecting health and social care

4.2. In the wake of rising demand, people working in the NHS need the capacity, capability and headspace to make improvements to the safety, timeliness and effectiveness of transfers of care from hospital. However, this is being compromised by the financial pressures affecting health and social care. The NHS in England is already facing its worst ever financial challenge following an unprecedented squeeze in funding for health and social care. Funding for health care services is increasing by an average of 1% over the parliament, while funding pressures are set to rise by around 4% a year over the next decade. There is also a real risk that health funding might actually fall in the next few years; if the economic growth is lower than forecast there could be less available for public spending. To avoid a rise in the national deficit this would require a rise in taxation or further reductions to public spending, which could have implications for the budget for the NHS. Public spending on health in the United Kingdom is already projected to fall as a proportion of GDP by 2020-21, leaving us behind many other advanced nations on this measure of spending.

Delayed transfers of care

4.3. This degree of stress is reflected to some extent in the analysis of data on delayed transfers of care. A delayed transfer of care is defined by NHS England as when a patient is deemed ready to leave, but is still occupying a bed. In March 2016, patients were delayed for a total of 169,928 days. The total number of delayed days in 2015-16 was just over 1.8m, which is 436,491 more than in 2011-12. This equates to a 32% increase over 5 years.

Health Foundation-funded improvement projects

4.4. A number of Health Foundation projects have supported frontline teams to improve the arrangements for the discharge of older patients from hospital. These are summarised briefly below:

- East Kent Hospitals University NHS Foundation Trust introduced a range of interventions to tackle 'revolving door' admissions from community providers into hospital.[3] The interventions included the establishment of a community geriatric team to prevent readmissions from care homes; an evening 'on call' service and a 24-hour telephone line to provide additional support for care homes; and a forum to improve relationships between hospital and care home staff, and to deliver bespoke training to care home staff.

- Sheffield Teaching Hospitals NHS Foundation Trust implemented an innovative discharge process – known as 'discharge-to-assess' – where patients leave hospital as soon as they are medically fit to do so, and then have their support needs assessed in their own home.[4] Over the last year, 10,000 patients have been transferred out of hospital into an 'active recovery' service, which is a health and social care collaborative aimed at ensuring that their needs are met and addressed in real time.

- Royal Free London NHS Foundation Trust introduced a specialist dementia service to offer the services and support needed by patients and family members to return home safely.[5] The intervention included a specialist dementia occupational therapist providing a single point of contact, the development of a community-based infrastructure to ensure adequate ongoing care, and one-to-one training, guidance and support to external carers and family members on the individuals' care needs.

5. Broader challenges and opportunities

5.1. The above examples illustrate how practical improvements in discharge arrangements can be delivered to improve safety, and place patients, carers and families at the centre of their care. Another example includes *MyDay* at University Hospitals Birmingham NHS Foundation Trust, supported by the Health Foundation, which uses a patient diary to coordinate activities and interventions around the patient's day, rather than at times which only suit the care teams. *MyDay* not only makes more efficient use of staff time – who were often having to rearrange appointments and treatments – but crucially helps to reduce feelings of anxiety amongst patients. Such an approach, if applied to discharge arrangements, could improve the psychological safety of patients – which is an aspect of patient safety which has largely been ignored in most safety improvement initiatives.

5.2. The improvement projects listed in section 4.4 also demonstrate the importance of health and social care providers working together to develop solutions to problems that transcend organisational boundaries. We know that the most intractable problems facing health and social care cannot be solved by teams and organisations working in silos.[6] We are therefore delighted to be supporting the *Making Safety Visible* programme, which is bringing together senior leaders from provider and commissioning organisations, as well as the local authority, right across Greater Manchester to build skills in monitoring patient safety across entire pathways of care.[7] We believe that programmes such as this offer a future vision for how patient safety issues across multiple settings can be tackled.

5.3. This vision is most clearly set out in the publication by Charles Vincent and Rene Amalberti (see 3.1, 3.2). The authors argue that we need to take a view of patient safety that moves away from developing strategies based on traditional organisational boundaries, and instead as seen through the patient's eyes; where safety is seen as the management of risk over time, spanning multiple care settings. This approach would better reflect the typical journey that the most vulnerable patients take, and is particularly relevant when it comes to tackling the issues associated with the unsafe discharge of people from hospital. A free download of the publication is available here: http://link.springer.com/book/10.1007%2F978-3-319-25559-0

References

[1] Parliamentary and Health Service Ombudsman. *A report of investigations into unsafe discharge from hospital.* http://www.ombudsman.org.uk/reports-and-consultations/reports/health/a-report-of-investigations-into-unsafe-discharge-from-hospital [accessed 4 July 2016]
[2] Vincent C, Amalberti R. *Safer Healthcare: Strategies for the Real World*. http://link.springer.com/book/10.1007%2F978-3-319-25559-0 [accessed 4 July 2016]
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[5] Health Foundation. *My discharge: getting discharge right for someone with dementia.* http://www.health.org.uk/programmes/shine-2012/projects/my-discharge-getting-discharge-right-someone-dementia [accessed 4 July 2016]
[6] Health Foundation. *Safer Clinical Systems: evaluation findings.* *http://www.health.org.uk/publication/safer-clinical-systems-evaluation-findings* [accessed 4 July 2016]
[7] Health Foundation. *Building skills for safety at board level.* 30 November 2015. http://www.health.org.uk/newsletter/building-skills-safety-board-level [accessed 4 July 2016]

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