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# Hospital Discharge Arrangements

## A joint submission to the Health and Social Care Select Committee *Delivering Core NHS and Care Services during the Pandemic and Beyond* Inquiry

Thursday 7 May 2020

# Introduction

This is a joint submission by Patient Safety Learning and CECOPS to the Health and Social Care Select Committee's *Delivering Core NHS and Care Services during the Pandemic and Beyond* Inquiry. It focuses specifically on the issue of rapid hospital discharge.

- CECOPS is a user-led, independent, not-for-profit certification and standards body. It aims to raise the standard of all assistive technology related services across the UK, and beyond. It is a community interest company.

- Patient Safety Learning is an independent charity and voice for improving patient safety. It believes patient safety is not just another priority; it is part of the purpose of health and social care. Patient safety should not be negotiable.

During the initial impact of the Covid-19 pandemic, the Government recognised that a key enabler would be to increase capacity within the NHS, ensuring that enough acute beds were available to cope with the rising tide of patients. An important policy priority has been to ensure the safe discharge of patients back into their home or, where appropriate, into a placement with a community provider. While there were already pathways in place to accelerate this process, responding to the pandemic required a significant acceleration of hospital discharges.

Hospital discharges are complex. To enable a safe and timely transfer of care, they require good co-ordination between hospital and community staff to arrange clinical assessments and to equip the home or community setting with the appropriate equipment and care plans. In a challenging environment, further considerations are required, including:

- Modelling demand
- Ensuring access to foods and medicines
- Mobilising the equipment supply chain
- Addressing care staff shortages
- Ensuring sufficient appropriate Personal Protection Equipment (PPE)
- Maintaining the patient's mental wellbeing
- Provision of Primary Care at a distance
- Planning the community and care home capacity required, including the long-term rehabilitation of Covid-19 patients
- Communication with patients and families about the risk of Covid-19 contamination in care homes and the 'fear factor'
- Ensuring the financial stability of the social care system so there is sufficient capacity for good quality and safe care

As part the Inquiry into *Delivering Core NHS and Care Services during the Pandemic and Beyond*, the Health and Social Care Select Committee identified 'meeting the needs of rapidly discharged hospital patients with a higher level of complexity' as one of the issues it will cover.[1]

This submission will focus on this issue by looking at two components of this:

[1] UK Parliament, Call for evidence: Delivering Core NHS and Care Services during the Pandemic and Beyond, Last Accessed 29 April 2020. https://committees.parliament.uk/call-for-evidence/131/delivering-core-nhs-and-care-services-during-the-pandemic-and-beyond/

1) **Rapid hospital discharge** - looking at the specific challenges face in this respect, this section will consider:
   - Challenges to this caused by the pandemic
   - The importance of interoperability in overcoming these
   - Preventing care homes and nursing homes becoming vectors of transmission
   - Harnessing digital technologies, such as an app, to assist hospital discharges

2) **Community support** - as the rate of hospital discharges significantly increases, this section will look at the impact this has on community support, considering:
   - Availability of PPE supplies
   - Access to and guidance on supportive equipment and technologies
   - Other pressures that will need to be met by community support services

Throughout this we will consider the challenges, key patient safety issues and what steps are needed help address these, including evidence of innovative solutions. In the concluding section we will suggest an eight-point action plan for the Committee's consideration.

# Rapid hospital discharge

The scale of the challenge faced by the UK's health service in response to the pandemic has been well documented, including the need to free up NHS capacity and resources. To increase NHS capacity to respond, one key objective has been to accelerate the hospital discharge process, in turn, making more hospital beds available for incoming Covid-19 patients.

On 19 March, the Government announced that it would provide a £2.9 billion funding package to 'strengthen care for the vulnerable'.[2] As part of this package, £1.3 billion was allocated to enhancing the NHS discharge process and £1.6 billion for local authorities to respond to increased pressures on their services.[3] The funding for the hospital discharge process had the intention of making available up to 15,000 hospital beds across England and focus staff capacity on urgent care and the pandemic response.[4]

## Challenges caused by the pandemic

The discharge process can be complex and potentially result in a range of problems, varying from patients being discharged before they are clinically ready, to difficulties in coordinating the appropriate post-hospital care required.[5] These issues are further complicated during the pandemic, for example, with new challenges caused by restrictions on movement and social distancing measures.

We have identified the following parts of the discharge process as potentially susceptible to error, and which could therefore result in patient harm:

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[2] Gov.uk, £2.9 billion funding to strengthen care for the vulnerable, 19 March 2020. https://www.gov.uk/government/news/2-9-billion-funding-to-strengthen-care-for-the-vulnerable
[3] Ibid.
[4] Ibid.
[5] Parliamentary and Health Service Ombudsman, A report of investigations into unsafe discharge from hospital, 2016. https://www.ombudsman.org.uk/sites/default/files/page/A%20report%20of%20investigations%20into%20unsafe%20discharge%20from%20hospital.pdf; Healthwatch, Why hospital discharge is everyone's problem (and how new plans can help), 21 February 2017. https://www.healthwatch.co.uk/news/2017-02-21/why-hospital-discharge-everyone%E2%80%99s-problem-and-how-new-plans-can-help

- Patients returning home with the correct medications and medical devices
- Communication with patients' families, carers, or friends to support their discharge from hospital while under constraints of social distancing measures
- Appropriate handover of information for patients moving from hospital directly into care settings
- Appropriate equipment/adaptations being in place for patients returning home
- In complex discharges, key decision-makers being known to patients and their carers, with lines of responsibility and governance clearly stated and an agreed review and monitoring system in place
- Patients and their responsible carers having access to timely clinical advice if there is clinical deterioration
- Patients and their families being decision-makers in their own care and having access to information and advice to enable this
- Modelling demand, activity, and capacity

It may only take one of these strands of the process failing to put a discharged patient's safety at risk and it is important that these issues are considered in a joined-up way.

Modelling demand and activity should be an urgent priority to inform detailed resource planning. This will support transparent decision-making by commissioners and with community and social care providers, patients, and families.

## The need for interoperability

To ensure this complex set of arrangements takes place as is necessary to ensure patient safety, it is vital that there is a clear chain of support that links them together. A key barrier to this in health and social care is interoperability, the ability of different systems to exchange and use information in a way that is meaningful and effective. This is not a new issue related to the pandemic, but an underlying one that has already been the focus of much recent attention in the NHS.[6]

Many of the challenges we have identified existed prior to the current crisis, with the health and social care system facing significant pressures. Within the planning for winter pressures, there was an emphasis on enhanced discharge but success varied significantly across England. Numerous factors prevented the effectiveness of enhanced discharge, including:

- Complex patients requiring senior opinion prior to discharge (and delays in accessing such opinion)
- Good practice not being consistently applied
- Pharmacy delays in dispensing medication to accompany the patient home
- Lack of coordination of services to provide a safe environment in the community
- Lack of capacity in the community, lack of staff and placements
- Lack of funding to support community placements (whether accommodation or equipment services)
- Poor communication between acute and community staff
- Lack of specialist equipment and adaptations at home

[6] NHS Digital, NHS Interoperability Framework, Last Accessed 30 April 2020. https://digital.nhs.uk/services/interoperability-toolkit/developer-resources/nhs-interoperability-framework; NHS England and NHS Improvement, Interoperability, Last Accessed 30 April 2020. https://www.england.nhs.uk/digitaltechnology/connecteddigitalsystems/interoperability/; Afeezat Oyeyemi and Philip Scott, Interoperability in health and social care: organisational issues are the biggest challenge, BMJ Vol. 25: Issue 3, 2018. https://informatics.bmj.com/content/25/3/196

Many of the above issues have been made harder to overcome because of the pandemic, particularly where they concern coordination and communication. The impact of social distancing measures, advice on self-isolation and shielding guidance for clinically vulnerable groups have created additional barriers to coordination and communication.

To address these issues, it is important that bodies such as NHS Digital, NHSX and INTEROPen work together to tackle these issues, and that they work in co-production with specialists in discharge planning, social and community care delivery, patient safety, and with patients and families.

## Preventing care settings become vectors of transmission

In addition to addressing challenges around the processes involved in rapid hospital discharge, it is also vital that we avoid healthcare settings, particularly social care settings, becoming vectors of transmission, as we have already seen evidence of in other European countries, such as Spain and Italy.[7]

While there is a need to discharge patients rapidly to free up beds, and those experiencing mild symptoms of Covid-19 may be medically fit in order for this to happen, it appears to be a high risk decision to then move those individuals into care settings. Professor Carl Heneghan, director of the Centre for Evidence-Based Medicine at the University of Oxford, has recently highlighted this as an issue and stated the need to revisit this strategy:

> *"It is incredibly important not to seed the infection in there, i.e. to put a patient from a hospital into a nursing home with active infection. I just cannot think of a clinical or medical reason why, anybody would do that. It's incredibly important to understand the vulnerability of people in nursing homes."* [8]

While it may be desirable not to transfer patients with Coivd-19 to community care homes during their recovery until we know they are no longer capable of spreading the disease, this is unlikely to be feasible as it will cause significant and ongoing pressure on the acute hospital service. To mitigate the risk, it will require segregation of the Covid-19 positive patients into either demarcated community homes (or floors of) or the setting up of temporary facilities in hotels or hosted rooms (such as that in the Care Rooms model) until the level of infectivity is negligible. We consider this to be a high priority action to prevent the transmission of Covid-19 into the community of vulnerable people.

## Harnessing digital technology for safer hospital discharges

Effective communication and shared knowledge of good practice is key to the safe transfer of patients from the acute to community setting. Traditional methods of communication have been considerably enhanced by the broader use of digital technologies since the lockdown in March. As the effects of Covid-19 are likely to persist for many months, further innovation in handling patient sensitive data across pathways is required.

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[7] Reuters, Lockdown: Nursing homes in Spain a vector for deadly coronavirus, 22 March 2020. https://uk.reuters.com/article/uk-health-coronavirus-spain-lockdown-ins/lockdown-nursing-homes-in-spain-a-vector-for-deadly-coronavirus-idUKKBN2190N7.

[8] The Independent, Coronavirus: More than 5,000 deaths in care homes in England, 28 April 2020. https://www.independent.co.uk/news/health/coronavirus-care-home-death-toll-england-office-national-statistics-a9487481.html

Digital technology has been successfully developed at pace for primary care services, for diagnosis, referral and quick access to advice and guidance. We consider that, for safe hospital discharge, there should be similar investment in digital technology. We are proposing the development of a mobile app for staff (in hospitals, the community, and the care sector) and patients and their families. The app would offer best advice on discharge.

Knowledge of good practice can act as a link across community and acute teams with patients and their families. This could be developed from previously active systems, thereby reducing the lead-in times required for such complex digital platforms. The product would be an app and have a web-based version. We would hope that, at a later stage, this would link directly with electronic patient records.

The benefits of such an app includes:

- A faster discharge process
- Increased capacity in an already overstretched system (by reducing the number of people needed to organise a hospital discharge)
- Reduced duplication in administration and many dialogues, in turn, reducing the risk of miscommunication

Getting the right processes in place for hospital discharge will ensure people are safe without being neglected in their community environment. This app/website will enable staff to quickly identify the safe and appropriate route for discharge of patients. To ensure the app is effective, information gathered should include:

- All information relevant to the patient's care, including the agreed individual care package
- Planned discharge procedures, including safe handling (with PPE where appropriate) and the safe transfer of medication
- Good practice information required to complete discharge
- The patient's electronic health record (where agreed)

# Community support

When considering the issue of accelerating hospital discharges, it is also essential that we assess what community support needs to be in place to absorb increasing numbers of patients, as well as the length of time and complexity of support required.

## PPE availability

One known element of this has been staff PPE requirements in health and social care. This issue has been significantly covered by the press in recent weeks, and while clearly a major issue, we will not seek to go into further detail here. Suffice to say, we echo the call to address supply issues as a matter of urgency.

## Equipment supply: lack of availability and confusing guidance

Another element of this is the supply of necessary supportive equipment and technologies that are essential to maintain and improve the health of patients transferring to the community. So far, supplies have often been difficult to access in a timely manner. Reasons for this have included a lack of supply, an uneven distribution of equipment, and equipment

currently being in a different place and in need of collection and redistribution.[9] This has been reflected in a recent appeal to the public by the British Healthcare Trades Association (BHTA), a working group of leading community services providers, to return unneeded equipment in order to support the system during the pandemic.[10]

Equipment also needs to be delivered and maintained, so that people are supported in the community and to lower the risk of readmission to hospital. We have already seen reports of patients putting off seeking medical care for non Covid-19 issues, potentially exacerbating existing health problems.[11] The same could be happening around the upkeep of equipment. A reluctance to receive visitors, due to fear of the pandemic, could result in people struggling on without equipment they require, or with damaged equipment that may subsequently lead to injury/harm.

Following on from Sir Simon Stevens' and Amanda Pritchard's letter of 17 March 2020, a letter was sent to all NHS providers and commissioners from Matthew Winn Director of Community Health, NHS England and NHS Improvement, and Dr Adrian Hayter National Clinical Director for Older People and Integrated Person-Centred Care NHS England and NHS Improvement. The letter set out how providers of community services can release capacity to support Covid-19 preparedness and response.[12] It stated that medium to low risk provision of wheelchair, orthotic, prosthetic and equipment services was to be stopped and that people were to be signposted to mobility outlets. There was no criteria or guidance as to what constitutes high, medium, or low risk. This has created confusion and has led to uncertainty in how to apply the guidance, resulting in inconsistency in access to these services.

This matter poses a range of problems which could impact on hospital discharges. Firstly, the group of disabled and older people requiring these services could be anywhere between 2-4 million people. Not getting equipment in a timely way will result in more people being admitted to hospital and it will significantly slow down the discharge process, as these services are an important part of discharge, e.g. bed, hoist, mattress and wheelchair. Also, many of the clinical teams working within these services have been moved to the front-line to deal with the pandemic, meaning it will be more difficult to arrange hospital discharges. Furthermore, according to BHTA approximately 75% of mobility outlets are closed, so if people wanted to buy their equipment, they may not be able to.

The consequence of this is that more patients will be awaiting discharge in hospital. Whilst this causes concern for patients and their families, it will also slow down hospitals' response to delivering the backlog of non Covid-19 acute care that has emerged during the pandemic.

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[9] THIIS, NHS Trust urges public to return community equipment including beds, mattresses & mobility aids, 9 April 2020. https://thiis.co.uk/nhs-trust-urges-public-to-return-community-equipment-including-beds-mattresses-mobility-aids/; THIIS, Devon County Council warns of community equipment supply shortages as returns appeal issued, 16 April 2020. https://thiis.co.uk/devon-county-council-warns-of-community-equipment-supply-shortages-as-returns-appeal-issued/

[10] BHTA, Don't forget to return your community equipment – help the NHS and social services, 17 April 2020. http://bhta.com/dont-forget-to-return-your-community-equipment-help-the-nhs-and-social-services/

[11] BBC News, Coronavirus: Please for public to get medical care when they need it, 25 April 2020. https://www.bbc.co.uk/news/health-52417599

[12] NHS England and NHS Improvement, Next steps on NHS response to COVID-19: Letter from Sir Simon Stevens and Amanda Pritchard, 17 March 2020. https://www.england.nhs.uk/coronavirus/publication/next-steps-on-nhs-response-to-covid-19-letter-from-simon-stevens-and-amanda-pritchard/; NHS England and NHS Improvement, COVID-19 Prioritisation within Community Health Services, 19 March 2020. https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2020/03/C0145-COVID-19-prioritisation-within-community-health-services-1-April-2020.pdf

How many hospital discharges might be compromised by the lack of equipment and suitable safe accommodation? What impact will this have on hospital capacity and non Covid-19 acute care?

### Staffing capacity and redeployment

Many community-based staff, such as community occupational therapists and physiotherapists, have been redeployed to support hospital pandemic responses. At some point, they will be needed to redeploy once again, back into the community. How do we deploy staff to ensure the community provision is equipped to deal with a rising workload?

### Addressing the backlog of demand

We will need strategies in place to address the backlog of demand required to service the needs of Covid-19 rehabilitation patients.

### Learning and models of innovation and good practice

It is important that we are capturing the learning from successful models of commissioning during the crisis – often ideas from expert private providers – and adopting them nationally. This way we can maintain the momentum of new ways of working, particularly in the use of digital technologies.

### Financial support to ensure there is capacity in the community

There is a need for support and partnership with private providers (care homes, specialist equipment providers etc) who are facing financial pressures.

### Patient and family communication

There needs to be clarification around what should happen to in terms of communication and engagement with patients and families. What is the support that they should be getting? Who do they escalate concerns to?

# Concluding comments

Hospital discharge planning, associated support for patients and families in the community and social care has been under significant pressure in recent years. The pandemic has added to these pressures and we have yet to assess the full impact on community and social care. We must tackle hospital discharge and community care provision now. It is expected that the needs of Covid-19 affected patients with rehabilitation needs and the non Covid-19 care more generally will rise during the next stage of the pandemic, with much of this will be focused in the community.

We consider that there should be an eight-point action plan. We want to see:

1) **A model of demand to inform hospital discharge and planning of community and care services**

2) **New agile ways of working using digital technologies. An improved cross health and social care information system is imperative to ensure safe transfers of care**

3) **Strengthened cross-sector leadership and communication with clinical teams and patients and families**

4) **The provision of equipment services addressed urgently - to support hospital discharge and prevent admissions i.e. wheelchair, prosthetic, orthotic and equipment services**

5) **Integration of planning and service delivery across sectors with the right leadership, the ability and capacity at a local level to streamline services and procurement to the needs of patients, families, and care providers**

6) **Innovation in the development of safe transfers of care. We must adapt the traditional bureaucratic processes and regulatory framework to ensure that the needs of patients are met speedily**

7) **Financial support to ensure that there is capacity to provide community-based care**

8) **The safety of patients at the core of all plans and service delivery. All plans should include how the safety of patients is being prioritised**