MEMORANDUM OF EVIDENCE FROM THE BRITISH MEDICAL ASSOCIATION TO PUBLIC ADMINISTRATION AND CONSTITUTIONAL AFFAIRS SELECT COMMITTEE INQUIRY.

Follow-up to the PHSO (Parliamentary and Health Service Ombudsman) report on unsafe discharge from hospital

The British Medical Association (BMA) is an apolitical professional association and independent trade union, representing doctors and medical students from all branches of medicine across the UK and supporting them to deliver the highest standards of patient care. We have a membership of over 170,000, which continues to grow each year.

The BMA welcomes this opportunity to submit written evidence to the Public Administration and Constitutional Affairs Committee’s inquiry on the Ombudsman report on unsafe discharge from hospital.

Introduction

1. The BMA supports the conclusions of the Ombudsman report and welcomes the Committee’s follow-up inquiry. It is of paramount importance for patients, and their families and carers, that they are discharged from hospital in a safe, appropriate and timely manner that is coordinated and centred on their needs. There are a number of key principles that should underpin all discharge processes to ensure they meet these criteria. There are also specific considerations around patients with multiple and complex needs, communication, the pressure of bed shortages, and assessing mental capacity, all of which are factors in safe and timely discharge. Finally, there are some systemic barriers which must be overcome, most notably the lack of integration within and between services.

Executive Summary

- The BMA believes it is crucially important that hospital discharge should be a timely, co-ordinated process with patients, their families and carers fully involved in discharge discussions and decisions.

- There should be continual communication between different health and care professionals involved in a patient’s care, in order to ensure co-ordination throughout the discharge process.

- Discharging patients with multiple and complex needs requires additional considerations and must take into account patients specific needs, including ensuring that effective home-care plans are in place.

- The BMA believes that trends in reducing hospital beds have gone too far and the impact of bed shortages needs to be urgently evaluated. Staff can feel pressured into discharging patients who may be medically fit, but for other social or practical reasons are not yet ready.

- There is a need for greater integration, coordination and collaboration within and between services in order to ensure safe and timely discharge. The BMA supports integrated care pilots and new models of care which promote collaborative, joined-up working based around the needs of patients.
Safe and appropriate discharge from hospital

2. Safe and appropriate discharge from hospital is of crucial importance. The BMA’s Patient Liaison Group (PLG) published a report into hospital discharge in 2014, which explores both premature and delayed discharge.1 The report provides patient, carer and doctor perspectives, and includes a discharge checklist for patients and their carers so they know what they should expect. It also identifies a number of key principles that apply to every patient who is admitted and discharged from hospital. These are of vital importance for patients with multiple or complex needs, but they should apply equally to patients who require only straightforward medical investigations and treatments.

2.1. Discharge should be timely, with patients transferred home, or to an appropriate level of care, as soon as they are clinically stable and fit for discharge. However, timely discharge should not equate to premature discharge. In addition to clinical safety, being ‘fit for discharge’ must take into account patients’ social, emotional and practical needs.

2.2. Discharge must be a planned and co-ordinated process. Effective planning requires multidisciplinary and multiagency teams working together to manage all aspects of the process.

2.3. Communication throughout the discharge process is of fundamental importance. Patients, and their families and carers where appropriate, must be fully involved in discharge discussions and decisions.

2.4. Discharge coordinators can provide a single point of contact during a patient’s journey through hospital, with responsibility for coordinating all aspects of a patient’s discharge. This may be particularly beneficial for patients with ongoing needs.

2.5. Discharge summaries facilitate the transfer of care of patients from the hospital to general practice. They should be received by the GP on the day of discharge; patients and their carers should also receive a copy.

3. The new national programme on improving discharge, as cited in the Ombudsman report, should also seek to work closely with NICE. NICE’s guideline NG27 published in December 2015 covers the transition between inpatient hospital settings and community or care home settings for adults with social care needs – and successfully incorporates these principles2:

3.1. Section 1.1 describes overarching principles that should underpin care during the discharge process, based on person-centred care, communication and information sharing. It also refers to decisions on mental capacity.

3.2. Section 1.5 focuses exclusively on discharge, covering the following areas: discharge coordinators; communication and information sharing; discharge planning, including for end-of-life-care needs; early supported discharge; involving, supporting and training carers; and the period after transfer from hospital.

4. As NICE have highlighted, this guideline directly addresses the issues raised by the Ombudsman report, and other similar reports.3 Work is underway to improve uptake of the guidance and
NICE will be publishing the associated quality standard in September 2016. Time must be given for the guideline to become embedded; however, this process should be actively supported, with stakeholders across health and social care working together to achieve widespread promotion and uptake of the guideline.

**Patients with multiple and complex needs**

5. Discharging patients with multiple and complex needs in a timely, but safe manner requires additional considerations. These patients are often elderly, with multiple long term conditions and social care needs, and are therefore often the most affected when integration between and within services is lacking. Indeed the majority of examples given in the Ombudsman report were of older people. In addition to premature discharge, the more complex nature of their needs often leads to a delayed transfer of care while waiting for social care arrangements to be made. This is an increasing problem, as highlighted in a recent report by the National Audit Office,\(^4\) making good communication and joined-up thinking between hospital and social care agencies particularly important.

6. Discharge planning and processes must take into account the specific needs of this population, including ensuring effective home-care plans are in place and community nursing where necessary. As part of a wider project on healthy aging, the BMA will be highlighting the needs of older people living with long term conditions. Care pathways are often focused on single conditions, but managing multiple conditions does not necessarily fit into neat pathways. It requires clinicians to make decisions in collaboration with patients, and depending on their needs, their family and carers. As explained in more detail below, clear communication with patients, families and carers is an essential part of safe and effective discharge.

7. NICE have recognised that while multimorbidity “is associated with increased frequency of health service use (...) and poor care co-ordination”, existing guidelines focus only on the management of individual diseases and conditions. Consequently they are developing a guideline to “inform patient and clinical decision-making and models of care for people with multimorbidity who would benefit from a tailored approach”\(^5\).

8. The NICE guideline, *Multimorbidity: the assessment, prioritisation and management of care for people with commonly occurring multimorbidity*, is due to be published in September 2016. This should help inform development and implementation of safe and timely discharge processes. In addition to this the 5YFV’s (Five Year Forward View) new care models should support greater cooperation between different parts of the health service going forward, which may lead to reduced emergency admissions for those with multi-morbidities (see below)\(^6\).

**Communication**

9. Clear and effective communication helps ensure that care and discharge planning is centred on the patient and their needs. Patients must be able to discuss discharge arrangements with staff and be fully involved in decision making. There should also be continual communication between the different health and care professionals involved in a patient’s care, in order to ensure coordination throughout the discharge process. This should also include transport services as part of the process. We are aware that often problems can arise when services have been contracted out and hospital staff have little or no authority to override schedules set by the transport company, which can lead to patients waiting for very long periods to be transported home.
10. As highlighted above, extending communication to families and carers can be particularly important for older people or those with more complex needs. Whilst of course, ensuring that the patient has given consent before any confidential information is shared (patients’ capacity to consent must of course be appropriately assessed). As the Ombudsman report suggests, involving families and carers as partners throughout discharge planning helps ensure a smooth process that aids patients’ recovery and can prevent avoidable readmission.

11. The BMA has actively promoted the importance of communication and genuine cooperation with patients, and their families and carers, through its Patient Liaison Group. Since its launch in 2004 the Patient Liaison Group has produced a number of patient-focused resources on topics ranging from self-care to toolkits for doctors on patient involvement. It also provides support for doctors, offering communication skills courses and an online toolkit.

Pressure of bed shortages

12. It is widely acknowledged that the shortage of beds in hospitals can cause staff to feel pressurised into discharging patients who may be medically fit, but for other social or practical reasons are not yet ready. Indeed, the example of Mr Y in the Ombudsman report showcases this – despite inadequate care arrangements at home, Mr Y’s wife was told that the hospital ‘needed the bed’.

13. The BMA has raised concerns about the crisis in available beds and the impact this may have on the safety and quality of care, as there has been a steady decline in the number of beds over the last decade. This is partly explained by the increase in day admissions and treatment in primary or community care settings.

14. However, the pressure of reduced numbers is clearly being felt in hospitals and is counterproductive to the provision of optimal care. This is best illustrated by the increase in the occupancy rate of hospital beds, which severely limit the flexibility and resilience of hospitals. The most recent data from January - March 2016 showed the average occupancy rate in acute and general hospitals was 91.2%, with 20% of trusts averaging 95% or above. The BMA believes that trends in reducing hospital beds have gone too far and that the impact of these trends needs to be urgently evaluated. It is vital to support staff so that pressure to make beds available does not result in badly planned or uncoordinated discharge.

Mental capacity and vulnerable patients

15. Doctors need to take a holistic view of patients when considering discharge that goes beyond direct medical need. With some patients there may be concerns as to whether they have the requisite capacity to manage some aspects of their affairs on leaving hospital. In other circumstances there is a risk that patients may be discharged back into circumstances that may be abusive or undermining of their wellbeing.

16. Where there may be doubt, doctors should consider whether an assessment of the individual’s capacity to make relevant decisions would be necessary. Where a patient does have relevant capacity, but may be vulnerable, doctors should explore with patients how they can best be supported, including, where appropriate the offer of appropriate community-based services (eg building on primary care lessons in social prescribing).
17. The BMA has developed a comprehensive toolkit to inform and support doctors in assessing whether a patient has the capacity to make decisions.\textsuperscript{14} The toolkit is aligned to the Mental Capacity Act for England and Wales, including the amendment which introduced the Deprivation of Liberty Safeguards, and at appropriate stages it refers doctors to the Mental Capacity Act Code of Practice.\textsuperscript{15}

**Integration**

18. All of the factors discussed above are crucial in ensuring safe and timely discharge. However, the Ombudsman report correctly identifies that there are “structural and systemic barriers to effective discharge planning”, the most significant of which is the need for improved integration. Whether between health and social care or primary and secondary care, or even within a multidisciplinary team, divisions result in a lack of coordinated care for patients, and can result in poor discharge processes.

19. The BMA has been calling for greater integration, coordination and collaboration within and between services for a number of years.\textsuperscript{16} We are supportive of initiatives, such as integrated care pilots and the new models of care described in the 5YFV, which promote collaborative, joined-up working based around the needs of patients. Integration should always take priority over competition and the internal market.\textsuperscript{17}

20. The BMA believes there are five key principles that the new care models must follow if they are to be genuinely successful in integrating services and care around patients.

- There should be full consultation with the relevant stakeholders.
- The models should ensure collaboration between the different sectors, not domination of one sector over another.
- The models should focus on delivering services in an area, rather than competing with other providers outside their locality.
- Plans must be clinically led.
- Inter-organisational partnerships should be forged, rather than focusing on mergers and structural reorganisation. Existing evidence suggests that structural integration in itself is insufficient to achieve better coordination or integration.\textsuperscript{18} It is also a distraction in the NHS’ current financial climate.

21. These principles are equally applicable to integration initiatives beyond the new models of care programme. Yet while integration should be widely promoted, cost should not be the primary driver for change, as existing evidence suggests integration is unlikely to lead to major savings in the short or medium term.\textsuperscript{19} Indeed, successful integration of services requires up-front investment, as the BMA has recently highlighted\textsuperscript{20}.

22. It is also important that future moves to integrate health and social care do not undermine the principle of a publicly funded and provided NHS. Patients must not be disadvantaged by any devolution or delegation of health spending.

23. Alongside ensuring medical professionals have the time and resource for transformation, other potential barriers to integration must also be overcome. These include IT system interoperability, workforce shortages and PbR (Payments by Results). The BMA does not support PbR and believes faster progress should be made towards payment mechanisms that support integrated, personalised care.\textsuperscript{21}
24. As the Ombudsman report recommends, learning from the new models of care vanguards and other integration initiatives must be shared and applied to patients’ experience of care, including their discharge from hospital. The BMA has supported members to actively engage with these initiatives, sharing best practice, whether locally or through national briefings and webinars. The BMA has also just commenced a UK-wide project on integration, which will identify barriers and solutions to integration, alongside profiling developments across the country.

References

1 BMA, Hospital discharge: the patient, carer and doctor perspective, January 2014
2 NICE, transition between inpatient hospital settings and community or care home settings for adults with social care needs (NG27), December 2015
4 National Audit Office, Discharging older patients from hospital, May 2016
5 NICE, Scope: Multimorbidity - the assessment, prioritisation and management of care for people with commonly occurring multimorbidity, November 2014
6 Kings Fund, Avoiding hospital admissions. Lessons from evidence and experience, 2010
7 BMA Patient Liaison Group
8 BMJ Learning – Communication skills
9 NICE, transition between inpatient hospital settings and community or care home settings for adults with social care needs (NG27), December 2015
11 NHS England, Bed Availability and Occupancy Data
12 NHS England, Bed Availability and Occupancy Data
13 BMA, Annual Representative Meeting, 2016
14 BMA Mental Capacity Toolkit
15 Department for Constitutional Affairs, Mental Capacity Act Code of Practice, 2007
17 BMA, Annual Representative Meeting, 2015.
18 The King’s Fund, Clinical and service integration: the route to improved outcomes, 2010
19 The King’s Fund, The reconfiguration of clinical services: what is the evidence? 2014
20 BMA, Responsive, safe and sustainable: our urgent prescription for general practice, 2016
21 BMA, Models for paying providers – DRGs (the national tariff), 2015