Royal College of Physicians

Submission

Parliamentary and Health Service Ombudsman (PHSO) report on unsafe discharge from hospital

Royal College of Physicians' submission to Public Administration and Constitutional Affairs Committee follow up inquiry

Introduction

1. The Royal College of Physicians (RCP) welcomes the opportunity to submit written evidence to this important inquiry. The PHSO report on unsafe discharge from hospital rightly highlights current obstacles and systematic barriers faced by people waiting to be discharged from acute care settings. This submission focuses on the frontline experiences of the RCP's 32,000 members and fellows (predominately hospital doctors) of discharging patients. The submission further captures learning from the RCP's Future Hospital Programme's (FHP) three frontline, clinically led projects which are redesigning the delivery of medical care to achieve safe and timely discharge for patients.

Summary

- Research conducted by the RCP between 2014-2015 shows that 40% of advertised consultant vacancies remain unfilled, mostly due to a lack of unsuitable candidates[1]. Staff shortages and rota gaps are having a significant impact on doctors' ability to effectively discharge patients.
- Prevention of admission should be prioritised to ensure that patients have access to care most suited to their needs. Early access to multidisciplinary assessment has led to a 24% reduction in hospital admissions at the Mid Yorkshire NHS Hospitals Future Hospital project site.
- Better integration between hospital and community settings is fundamental in preventing patient readmission to hospital**.**
- Better use of new forms of communication technology such as telemedicine has lead to faster discharge of patient care and prevention of readmission.
- IT systems remain a major barrier to transferring patients between care settings. Poor interoperability and variations in coding structures create significant barriers when transferring patients from hospital to community settings.

[1] https://www.rcplondon.ac.uk/projects/outputs/2014-15-census-uk-consultants-and-higher-specialty-trainees

Evidence

Changing needs of patients

2. The UK is facing an ageing population at a time when the NHS is already struggling to cope[2]. Currently 65% of people admitted to hospital are over 65 years old and people over 65 occupy more than 51,000 acute care beds at any one time, accounting for 70% of bed days[3]. The service must adapt if we are to meet the challenge of providing person centred care, including for older people, with co-morbidities and complex needs. Fragmented services and stretched resources create significant challenges in delivering high quality care. Across the country, patients fit for discharge are waiting to leave hospital, often because social care support is unavailable. Increasing the level of social care funding will alleviate pressures on all sectors of the NHS.

Significant staffing shortages

3. Our members and fellows are working in an underdoctored, underfunded and overstretched health service. Patient demand matched with significant workforce gaps is making it difficult for them to care for patients. Research conducted by the RCP between 2014-2015 shows that 40% of advertised consultant vacancies remain unfilled and that the most common reason is due to a lack of suitable candidates. This is significantly impacting on the ability of doctors to deliver high quality care for patients. Up to 21% of consultant's reported 'significant gaps in the trainees rotas such that patient care is compromised'[4]. These figures are concerning and workforce pressures are likely to impact on the successful introduction of the new care models outlined in the NHS Five Year Forward View unless action is taken on training and retaining more doctors[5].

4. The staffing crisis is impacting on physicians' ability to swiftly assess patients presenting at hospital, to tailor their care plans and to work across disciplines to achieve safe and timely transfers of care. Studies suggest that as many as 40% of patients who die in hospital do not have the medical needs that require them to be there[6]. This is both distressing for the patient and for their family and friends involved in their care. The crisis in recruitment and retention of doctors is presenting looming challenges, and is adding to unnecessary delays in discharging medically fit people. Patient care, experience and outcomes will constantly be compromised until there are doctors in post.

Coordinating hospital services to prevent admission and offer better transfers of care to the community

5. The RCP is working with local clinical teams through the flagship Future Hospital Programme (FHP) to develop innovative models of care to help meet patient need using current resources[7]. Two of these programmes are working to reduce the unnecessary admission of patients to hospital by ensuring that they receive care in the community. The sites are based at Mid Yorkshire NHS Hospital Trust and East Lancashire Hospitals Trust.

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[2] https://www.rcplondon.ac.uk/guidelines-policy/hospitals-edge-time-action
[3] https://www.rcplondon.ac.uk/guidelines-policy/hospitals-edge-time-action
[4] https://www.rcplondon.ac.uk/projects/outputs/2014-15-census-uk-consultants-and-higher-specialty-trainees
[5] http://www.kingsfund.org.uk/press/press-releases/workforce-shortages-endanger-delivery-nhs-five-year-forward-view
[6] https://www.rcplondon.ac.uk/projects/outputs/national-care-dying-audit-hospitals
[7] https://www.rcplondon.ac.uk/projects/future-hospital-programme

6. Mid Yorkshire NHS Hospitals Trust has established a Rapid Elderly Assessment Care Team (REACT) within the acute admissions unit at Pinderfields Hospital in Wakefield. REACT are a multidisciplinary team made up of geriatric consultants, specialist nurses and therapists who work together to assess patients aged 80 and over, or those aged 65 and older who are care home residents, within 24 hours of their arrival at hospital. The team meet daily to coordinate the care and treatment of patients to help them leave hospital as soon as possible and prevent unnecessary hospital admission. The multidisciplinary nature of the team means that they are able to offer person centred care because they provide people both the health and therapeutic services they need.

7. Since the REACT team was established in 2014, Pinderfields Hospital has seen significant improvements in the number of patients receiving care in the community rather than being admitted to hospital. Comparing data from 2014 to 2015, there has been a 24% increase in the number of people with frailty being transferred to community care rather than moving onto a ward in hospital. The total number of hospital ward admissions for patients aged 80 and over also decreased by 14% during the same period in 2014 to 2015. This quick assessment by a multidisciplinary team at the front door of the hospital ensures that patients are able to access the care most suitable to their individual needs and relieve some of the pressures faced by staff in the rest of the hospital.

8. Another FHP development site at East Lancashire Hospitals Trust aims to identify frail older patients who are available for discharge the same day they present at hospital. The medical assessment unit (MAU) nurse monitors the acute intake of frail older people in order to identify people suitable for rapid discharge, arranges their comprehensive geriatric assessment and liaises with secondary and social care professionals to plan for safe same-day discharge.

9. Preliminary data from the East Lancashire Hospitals Trust project suggests that 59% of admissions were avoided using this care model since the project started in 2014[8]. If admission can be avoided by streamlining the patient journey from the MAU through to social care, frail older people can be supported to leave hospital quickly and to live independently in the community.

Improving integration between hospital and community services

10. In addition to developing new systems to improve patient to multidisciplinary assessment the REACT team in Pinderfields Hospital has also been working closely with third sector providers to improve the transfer of care from the hospital to the community. The team work with Age UK who regularly visits the acute assessment unit at the hospital to provide safe transfers of care into the community[9]; they offer transport and a grocery shopping service so that vulnerable older people are not discharged without adequate support. Working collaboratively with health and social care professionals outside of the hospital building has enabled frail older people to receive personalised care, which has helped them to maintain their independence and prevent readmission.

[8] http://futurehospital.rcpjournal.org/content/3/1/13.full.pdf+html
[9] http://www.ageuk.org.uk/brandpartnerglobal/wakefielddistrictvpp/documents/frailty%20conference/frailty%20in%20secondary%20care.pdf

11. The partnership working between hospital and community services has reduced delayed discharge. Integrated secondary and social care for older people has secured lower rates of hospital bed use according to research conducted by The King's Fund and hospitals operating in an integrated way also tend to have a lower admission rate which in turn provides a better patient experience[10].

New ways of working to prevent readmission to hospital

12. The use of telemedicine for supporting effective and timely discharge of frail older people should be explored and implemented if there is infrastructure to support its introduction. The FHP development site at Betsi Cadwaladr University Health Board in rural Wales is using telemedicine to offer people who live far away from specialist care follow-up appointments with their consultants via video conferencing which is hosted at their local community hospital. The telemedicine initiative was introduced to support timely discharge so that patients who were medically fit could return home, and still have access to their follow-up specialist care. In May 2016, the Board was highly commended at the HSJ awards for the introduction of telehealth services[11].

13. For people with comorbidities, multiple trips to the hospital to see different physicians are intrusive, unsettling and can be detrimental to recovery. The telemedicine initiative at Betsi Cadwaladr has overcome the barrier that people face in accessing specialist care in rural areas. The project continues to show progress in travel time averted for patients who may have otherwise needed to return for care at the acute hospital, with on average, 450 travel minutes to appointments reduced to 275 minutes traveled for December 2015. Telemedicine is supporting timely discharge, as people are able to access specialist services easily outside of a hospital setting and prevents readmission as it supports people to manage long-term conditions independently.

The use of information technology (IT) across the health system

14. A key barrier our members face when trying to achieve a smooth transition for patients between hospital services and community settings is the complex IT infrastructures used for patient record keeping. There is little standardisation of clinical data in source systems, either in the headings under which data are recorded or in the definition of individual clinical terms. Huge variations in record structures and clinical language have led to major problems with the coding of clinical concepts and are fundamentally blocking transfers of care for patients.

15. It is vital that IT is standardised to improve communication between acute and community settings; without consistent and reliable data sharing, patients aren't able to be discharged or transferred. In particular, health service providers should use an agreed structure and content for electronic records. The RCP in collaboration with representatives of other medical specialities has produced a standardised structure for electronic records, which includes a uniformed format for discharge notes. The RCP recommends that NICE introduce the standardised templates for all discharges to ensure consistency.

[10] Imison C, Poteliakhoff E, Thompson J. *Older people and emergency bed use. Exploring variation*. London: The King's Fund, 2012.
[11] https://value.hsj.co.uk/winners-2016

Conclusion

16. The impact of an underfunded social care system is adding to the pressures being experienced in hospitals across the UK. There is an ever-pressing need to find a national solution to the recruitment and retention of doctors, as without physicians on the ground working in fully staffed multidisciplinary teams, patient care will always be compromised. As the FHP project teams show, effective multidisciplinary team working and the integration of healthcare services achieve better patient outcomes and experiences within the resources available to Trusts. Timely discharge of older people will only be achieved if new models of care, which operate within a robust integrated healthcare system, utilise new forms of communication such as telemedicine and operate using consistent patient records and data, is realised.

About the RCP

The RCP aims to improve patient care and reduce illness in the UK and across the globe. We are patient centred and clinically led, and our 32,000 members worldwide work in hospitals and the community across 30 different medical specialities, diagnosing and treating millions of people with a huge range of medical conditions.

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