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Public Administration
and Constitutional Affairs
Committee

Follow-up to PHSO report on unsafe discharge from hospital

Fifth Report of Session 2016–17

*Report, together with formal minutes
relating to the report*

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Public Administration and Constitutional Affairs

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Summary

PACAC received a report of investigations into unsafe discharge from hospital by the Parliamentary and Health Service Ombudsman (PHSO). This highlighted nine harrowing experiences that illustrate the human costs of poor discharge, causing suffering and distress for patients, and anguish for their carers and relatives.

Our inquiry found that the discharge failures identified by the PHSO report are not isolated incidents but rather examples of problems that patients, relatives and carers are experiencing more widely. Despite increased attention to the issue, it remains a persistent problem. We identified a need for more data to be gathered on the scale and impact of these discharge failures.

We heard that, whilst excellent guidance on best discharge practice is available, the extent to which good practice is implemented varies across the country. Barriers to the implementation of best practice are prevalent both within hospitals and at the interface between health and social care. We heard that pressures on resources and capacity within hospitals are leading to worrying and unsafe discharge practices. We call upon health and social care leaders to ensure that staff are operating in a culture where person-centred care is the undisputed priority.

A lack of integration between health and social care is preventing seamless discharge processes, coordinated around the patient's needs. The NHS must support local areas to adopt the best models of integration.

At a structural level, the historic split between health and social care means that interdependent services are being managed and funded separately. We consider this to be political maladministration. The Government has accepted the recommendations of our predecessor Committee to merge the Local Government Ombudsman with PHSO as part of a new and comprehensive Ombudsman Service, and this will mean that it will be able to investigate the administration of health and social care together more effectively. The Government has developed promising plans to tackle this structural disconnect between health and social care, from the Discharge Programme Board to the Better Care Fund and long-term integration policy, but they are far from implemented. The Government must ensure that these plans are set out clearly and supported by sustainable funding arrangements, so that they may be effectively delivered.

Fundamentally, the problem of unsafe discharge requires high levels of trust and openness between leadership and staff, to ensure that staff are empowered to make the decisions that put patients, their relatives and carers first. We expect the Healthcare Safety Investigation Branch (HSIB) to play a major role in investigating serious incidents of unsafe discharge and to ensure that learning is disseminated and implemented throughout the NHS.

1 Introduction

1. The Parliamentary and Health Service Ombudsman (PHSO) makes final decisions on NHS complaints in England, and from time to time reports to Parliament on wider themes emerging from its casework. It is a function of the Public Administration and Constitutional Affairs Committee (PACAC) to examine these reports and to use their findings to hold Government to account. The post of Parliamentary and Health Service Ombudsman is currently held by Dame Julie Mellor DBE, who was appointed in 2012. She is supported in this role by casework and corporate staff at the PHSO.

2. This Report focuses on the issues arising from the PHSO's report of May 2016, *A report of investigations into unsafe discharge from hospital*, which highlights nine of the PHSO's most serious hospital discharge cases from 2014–15 to illustrate the gap between established good practice and people's experience of leaving hospital.¹

Simple and Complex patient discharge

3. About 80% of patients will experience a simple discharge process. These patients are usually discharged to their homes and require minimal ongoing care. The other 20%, however, (predominantly people over 65), will have more complex ongoing health and care needs, whilst some patients might have an existing package of care which needs to be reactivated before they are discharged from hospital. Once discharged they may need short or long-term support from their local authority or community health services, either to enable them to live at home or in a more formal care setting such as a residential care home. Funding arrangements vary depending on whether the NHS or Local Authority is responsible for providing care. Support from NHS Community Care is free, whereas Local Authorities have to apply a financial means test and an eligibility test based on the individual's level of need for other types of care.²

4. The guiding principles for carrying out patient discharge have not changed over many years. Best practice guidance has consistently emphasised the importance of identifying needs on or before admission, of effective co-ordination across hospital teams and non-acute services such as community care, GPs and pharmacies, and of the involvement of patients and carers in all stages of the planning process. Hospitals should work collaboratively with social care providers to ensure this is a smooth process.³

5. Failure to follow this established best practice is likely to result in poor or unsafe patient discharge. Poor patient discharge can take the form of both delayed transfers of care, where patients are kept in hospital longer than is necessary, and premature or early discharge, where patients are discharged before it is clinically safe to do so, or without appropriate support in place to allow them to cope at home or in another care setting.

1 [A report of investigations into unsafe discharge from hospital](#), Parliamentary Health Service Ombudsman, May 2016.

2 Department of Health (2010), *Ready to go? Planning the discharge and the transfer of patients from hospital and intermediate care*.

3 Department of Health (2003), *Discharge from Hospital: pathway, process and practice*; Department of Health (2004), *Achieving timely 'simple' Discharge from Hospital*; Department of Health (2010), *Ready to go: Planning the discharge and transfer of patients from hospital and intermediate care*.

6. The need to improve patient discharge has been highlighted extensively in recent years, most recently by Healthwatch England,⁴ the National Audit Office (NAO)⁵ and the Public Accounts Committee (PAC).⁶ Despite increased attention to the issue, it remains a persistent problem. Looking specifically at delays in discharging older people from hospital, the NAO's May 2016 report concluded that the current arrangements do not represent good value for money, estimating that the NHS spends around £820 million a year treating older patients who are staying in hospital unnecessarily.⁷

7. In July 2016, the PAC published a report building on the NAO's research. The PAC report illustrates that there is "unacceptable variation" across acute hospitals with regards to discharge delays, and stresses that the NHS should be doing more to ensure that local areas are implementing good practice. The PAC identified a need for improvements in information-sharing and greater integration across health and social care, as well as for clear lines of local accountability for tackling this shared problem. The PAC noted that the areas which are managing patient discharge most effectively are ones where "all the local system owns all of the problem".⁸

Overview of the PHSO Report

8. The PHSO report presents nine of the most serious hospital discharge cases that the PHSO investigated in 2014–2015. These harrowing cases are illustrative of the human cost of poorly planned discharge. Cases are grouped into four key themes:

- Patients being discharged before they are clinically ready to leave, resulting in emergency re-admission and/or potentially avoidable death.
- Patients being discharged when they are clinically ready but without necessary assessments and support from non-acute health and social care services, which can result in emergency re-admission and additional health problems, as well as distress and discomfort.
- Relatives and carers not being consulted in care planning and/or not being told that their relative has been discharged.
- Patients who are medically fit to leave having to stay in hospital due to delays in arranging packages of home care or nursing home placements, which can result in worsening health and psychological distress.⁹

9. The PHSO does not claim that these cases are representative of practice across England, but argues that "these serious cases, alongside the volume of cases coming to us, indicate that this is an area that needs attention".¹⁰

4 Healthwatch England (2015), [Safely home: What happens when people leave hospital and care settings?](#)

5 National Audit Office (2016), [Discharging older patients from hospital](#)

6 Public Accounts Committee (2016), [Discharging older people from acute hospitals](#)

7 National Audit Office (2016), [Discharging older patients from hospital](#)

8 Twelfth Report from the Public Accounts Committee, Session 2016–17, [Discharging older people from acute hospitals](#), HC 76.

9 [A report of investigations into unsafe discharge from hospital](#), Parliamentary Health Service Ombudsman, May 2016.

10 [A report of investigations into unsafe discharge from hospital](#), Parliamentary Health Service Ombudsman, May 2016, p.4.

10. The PHSO report emphasises long-standing “structural and systemic barriers” to effective discharge planning, in particular the way in which health and social care “have historically operated in silos”.¹¹ The PHSO asks the Department of Health and the NHS to establish the scale of the problems highlighted in the report, and to build an understanding of why such failings are occurring “so that others do not have to experience similarly avoidable suffering”.¹²

Our objectives

11. In this inquiry, we aimed to understand the scale of the problems highlighted in the PHSO’s report and the extent to which these nine cases point to wider issues in health and social care. We sought to assess the current measures for improving discharge practice and to clarify responsibilities and accountabilities across Government for ensuring that improvements are implemented and discharge processes are safe and effective.

12. We are grateful to all those who provided oral and written evidence in this inquiry. A full list is included at the back of this report.

11 [*A report of investigations into unsafe discharge from hospital*](#), Parliamentary Health Service Ombudsman, May 2016, p.2.

12 [*A report of investigations into unsafe discharge from hospital*](#), Parliamentary Health Service Ombudsman, May 2016, p.3.

2 Understanding the problem

13. Through our inquiry, we have sought to understand whether the issues raised in the PHSO’s report reflect problems being experienced by patients more widely and what the scale of these problems might be. The experiences of hospital discharge referenced in the evidence we have received echo many aspects of the nine case examples of poor discharge presented by the PHSO.¹³ The recurring issues include: patients being discharged without adequate care plans or care packages in place; staff discharging patients without consulting them or communicating with their families and carers, or involving them in discharge decisions; patients staying in hospital longer than necessary whilst waiting for suitable ongoing care; and, poor co-ordination across services. Witnesses from Independent Age,¹⁴ Carers Trust¹⁵ and Alzheimer’s Society¹⁶ all confirmed that the themes highlighted in the PHSO report are issues they encounter frequently in their work with patients and carers.

14. Professor Justin Waring and Dr Simon Bishop, who have conducted a research study funded by the National Institute of Health Research on the theme of ‘safe hospital discharge’, told us “that rather than being isolated or anomalous examples, these [PHSO] cases are indicative of a wider set of problems that surround hospital discharge in the NHS, and indeed in other care systems”.¹⁷ They conclude that, rather than being “one off” errors or failures in care planning, the evidence suggests that these incidents are produced by the coming together of a number of systemic and organisational problems that occur on a daily basis”.¹⁸

Discharging patients before they are ready

15. The PHSO report presents two cases of patients being discharged from hospital before they were clinically ready to leave. Reflecting on this, the Carers Trust stressed that they regularly hear from carers about “people coming home who are not well enough to come home”.¹⁹ Dr Mark Porter from the British Medical Association, however, told us that, whilst the cases of patients being discharged before being clinically ready represent serious clinical failures from which important lessons are learnt, they do not reflect a growing problem:

I do not think there is a specific increase in the number of patients being discharged who are not medically fit for discharge [...] Individual failings where somebody is discharged when they would still benefit from hospital care or should stay in are thankfully very small ...²⁰

13 Healthwatch Dorset [UEH 21]; Healthwatch England [UEH 08]; Parkinson’s UK [UEH 10]; Carers UK [UEH 14]; Mrs Teresa Rose Steele [UEH 01]; Mrs Margaret Whalley [UEH 09]; Mr John Patrick O’Brien [UEH 18].

14 [Q1](#) [Janet Morrison]

15 [Q3](#) [Ruth Hannan]

16 [Q10](#) [Andrew Boaden]

17 Professor Justin Waring and Dr Simon Bishop [UEH 05]

18 Professor Justin Waring and Dr Simon Bishop [UEH 05]

19 [Q5](#) [Ruth Hannan]

20 [Q29](#) [Dr Mark Porter]

16. The Royal College of Physicians of Edinburgh told us that its Fellows have expressed concern over use of the term “medically fit”, as it may lead to misunderstanding between the NHS, carers and relatives:

A frail 93 year old patient is unlikely to ever be “fit”. To use that term means that family will expect to have their loved one back to being as independent as they were pre-admission on the day of discharge. With the pressure to create flow through the system... patients are now discharged when [they are] “medically stable” and no longer require the services of an acute hospital. This discord between patient/public perception and NHS reality requires good communication to ensure that mistakes do not happen.²¹

17. This difference in perception may account for the divergent accounts given by witnesses on this issue. While the distinction between a clinically inappropriate discharge and other types of premature discharge is important, it is clear that discharging a “medically stable” person, when they are otherwise unable to cope, can be unsafe as well as distressing.

18. Cases where patients were discharged when they may have been medically fit, but before they had been provided with adequate or appropriate support, were seen to represent a significant problem. Witnesses described patients and carers being put under pressure by hospital staff to leave hospital before they felt ready to²² and without adequate consultation about ongoing care needs.²³ Healthwatch England told us that some of the common problems they encountered through their 2015 inquiry into hospital discharge, ‘Safely Home’, included patients not having their full range of needs considered when being discharged.²⁴

19. The information provided to the Committee about the scale of this problem and the impact it has on patients was largely anecdotal. The Alzheimer’s Society emphasised that, while the PHSO’s report “very much resonates what we have heard over our phone lines and what we have collected through surveys” there is a paucity of data around the scale of the problem.²⁵ In their joint written evidence to us, the Department of Health, NHS England and NHS Improvement stated that where further metrics would improve patient experience and safety, this should be acted upon.²⁶ Healthwatch England told us that they have had “positive discussions with the Department [of Health] about the need to improve data on discharge”, with an emphasis on emergency readmission statistics.²⁷

20. There remains a need to improve the data to better understand both the extent to which patients are discharged before they are ready, and the relationship between early discharge and readmission. *The Secretary of State for Health and the NHS must set out, as part of the Government response to this report, how they will improve understanding of the scale of early discharge and its impact in terms of unplanned readmission.*

21 Royal College of Physicians of Edinburgh [[UEH 11](#)]

22 [Q9](#) [Ruth Hannan]

23 [Q1](#) [Janet Morrison]

24 Healthwatch England [[UEH 08](#)]

25 [Q10](#) [Andrew Boaden]

26 Department of Health, NHS England and NHS Improvement [[UEH 23](#)]

27 Healthwatch England [[UEH 08](#)]

21. The Alzheimer’s Society drew to our attention the need for hospitals to end the “incredibly dangerous” practice of patients being discharged between the hours of 11pm and 6am, where the potential for people to leave without the right information and support, and for this not to be in place when they get home, is significantly higher.²⁸

22. **We agree with the Alzheimer’s Society that night discharges are potentially dangerous for patients, and detrimental to their carers and relatives. Whilst we are aware than an outright ban on night discharges might have unintended consequences, the Secretary of State for Health must set out, in the Government’s response to this report, how he intends to ensure that only those who want to be are discharged between 11pm and 6am.**

Delayed transfers of care

23. The PHSO report highlighted the issue of patients being kept in hospital longer than necessary due to poor coordination across services. In oral and written evidence, we have heard about prolonged stays in hospital caused by delays in putting in place appropriate care packages, and disputes around whether the care required should be funded by continuing healthcare, social care or the individual themselves.²⁹ Independent Age described the severe delays experienced by people who have very complex needs and require a place in a care home.³⁰

24. The then Minister, Mr Ben Gummer MP, told us about a “growing number of people who are experiencing delayed transfers of care, most prevalently because of the unavailability of care packages”, whilst stating that the larger cause was the inability of hospitals and other agencies to co-ordinate care.³¹ Mr Gummer told us that the cases in the PHSO’s report were “representative of a significant but minority proportion of DTOCs [delayed transfers of care], which should not be happening”, and acknowledged that this has “been a feature of the system for many years”.³²

25. The PAC, in its July 2016 report, concludes that there is a poor understanding of “both the scale and cost of the problem of delays in discharging older patients from hospital”. The PAC recommends that NHS England develop measures for improving its understanding of these issues.³³ **We strongly agree with their recommendation.**

Poor communication with relatives and carers

26. The PHSO report presents two cases where relatives and carers were not informed of their loved one being discharged. Worryingly, this appears to be a recurring problem; Healthwatch England reported last year that of the 120 Trusts who responded to their inquiry, one in ten NHS Trusts do not routinely notify relatives and carers that someone has been discharged.³⁴ Professor Waring and Dr Bishop found through their research that, despite “concerted efforts” in some hospitals to involve families in patient care from

28 [Q18](#) [Andrew Boaden]

29 [Q6](#) [Janet Morrison]; [Q63](#) [Janet Davies]; Healthwatch England [[UEH 08](#)].

30 [Q6](#) [Janet Morrison]

31 [Qq78–79](#) [Ben Gummer]

32 [Q75](#) [Ben Gummer]

33 Twelfth Report from the Public Accounts Committee, Session 2016–17, [Discharging older people from acute hospitals](#), HC 76.

34 Healthwatch England (2015), [Safely home: What happens when people leave hospital and care settings?](#)

an early point in the hospital stay, this happened because of “ward-based initiatives”, rather than a general hospital policy. They also observed that some healthcare staff often saw families as a “barrier to achieving discharge rather than integral to it”.³⁵ Carers UK highlighted its findings from its 2016 ‘State of Caring’ report, that a quarter of carers of people who had experienced a hospital discharge that year reported that they were not consulted about the discharge process.³⁶

27. The Carers Trust emphasised to us the importance of hospitals recognising the value of carers and relatives by actively involving and consulting them before discharging patients.³⁷ Carers UK argue in their written evidence that carers are often experts in the care needs of the people they support and so including them in the discharge process is of benefit to both the patient and healthcare staff. It is also important for the carer that they are consulted, as they will often be directly affected by decisions made as part of the discharge process.³⁸ We heard about tragic instances of “crisis admissions” of carers to hospital who had neglected their own health because the person they were caring for was not being properly supported.³⁹

28. Witnesses also stressed that a patient’s diagnosis and needs can change significantly in the period between when they are admitted to hospital and when they leave, especially if they are acutely unwell.⁴⁰ In some cases, carers are not informed that circumstances have changed. The failure to perform a new care assessment or to follow through to check that it has actually been put in place can lead to patients being left unsupported, and unable to cope.⁴¹

29. Representatives from the British Medical Association and the Royal College of Nursing were at a loss to explain failures by hospital staff to effectively communicate with relatives and carers as part of the discharge process. These witnesses said they would need to understand the details of the individual cases where these issues arose, and highlighted that such failures were completely contrary to any of the guidance around patient discharge.⁴² Nevertheless, advocacy groups who gave evidence to the Committee presented this as a persistent problem.⁴³

30. We regard the failure of hospitals to involve carers and relatives in decisions to discharge patients, and even to inform them of these decisions, as maladministration and unacceptable. The Secretary of State for Health and NHS England must set out, in the Government’s response to this report, how this issue will be analysed and assessed and what steps will be taken to promote improved communication with relatives and carers by hospital staff.

Variation of best practice implementation

31. Witnesses highlighted the comprehensive guidance available on patient discharge, including from the Department of Health, NHS England, the National Institute for

35 Professor Justin Waring and Dr Simon Bishop [UEH 05]

36 Carers UK [UEH 14]

37 Qq3, 5 [Ruth Hannan]

38 Carers UK [UEH 14]

39 Q17 [Ruth Hannan]

40 Q16 [Andrew Boaden and Janet Morrison]; Q42 [Dr Mark Porter].

41 Q16 [Andrew Boaden and Janet Morrison]

42 Q39 [Dr Mark Porter and Janet Davies]; Q40 [Janet Davies].

43 Q20 [Ruth Hannan]; Carers UK [UEH 14].

Health and Care Excellence and the Royal College of Nursing. We learned of good practice examples around the country, including Northumbria Healthcare NHS Foundation Trust, where almost no patients end up waiting in hospital to return home or transfer to another setting.⁴⁴ Nottingham University Hospital uses patient-centred advisers within the A&E department and other departments to identify what went wrong when patients are readmitted within a specific time period. This includes examining whether any improvements could be made to the discharge process following the previous admission.⁴⁵ We heard that East Lancashire Hospitals NHS Trust utilises checklist tools to ensure that a checklist is used at each stage of the process.⁴⁶

32. However, it is clear from the evidence presented in this chapter that providers are not consistently using this guidance or following best practice. Healthwatch England cited its 2015 inquiry on discharge, which “found that too few hospitals made use of the information and guidance available”.⁴⁷ Healthwatch told us that almost all the NHS Trusts it surveyed had a discharge checklist, yet fewer than half of the Trusts checked whether patients had a safe home to go to or the basic support they needed after leaving hospital.⁴⁸ Witnesses reinforced the view that the implementation of good practice varies significantly between,⁴⁹ and even within⁵⁰ hospitals. We note that the PAC, has, in their July 2016 report on hospital discharge, identified that “[w]hile good practice on discharging patients from hospital is well understood, implementation is patchy across local areas”.⁵¹

33. The dissemination of best practice was seen as key to resolving the problem of poor discharge.⁵² Representatives of NHS England and NHS Improvement recognised the need to stop ‘reinventing the wheel’ with regards to discharge practice,⁵³ and focus energy on tackling the widespread variation in discharge processes, which is ultimately leading to variation in outcomes.⁵⁴

34. It is clear from the evidence presented to this Committee, and from the findings of the PAC’s inquiry into delayed transfers of care, that best practice guidance on patient discharge is not consistently implemented across healthcare providers. Tackling this variation in discharge processes is key to producing greater consistency in outcomes. We welcome and strongly support the recommendation of the PAC that NHS England and NHS Improvement report back to that committee by January 2017 on the steps they have taken to increase the pace of good practice adoption.

44 [Q100](#) [Dr Mike Durkin]

45 [Q41](#) [Phil McCarvill]

46 [Q101](#) [Dr Mike Durkin]

47 Healthwatch England [[UEH 08](#)]

48 Healthwatch England [[UEH 08](#)]

49 [Q22](#) [Ruth Hannan]; [Q23](#) [Andrew Boaden and Janet Morrison].

50 [Q85](#) [Dr Mike Durkin]

51 Twelfth Report from the Public Accounts Committee, Session 2016–17, [Discharging older people from acute hospitals](#), HC 76, p.6.

52 [Qq55–56](#) [Phil McCarvill]; [Q101](#) [Dr Mike Durkin].

53 [Q104](#) [Jane Cummings]

54 [Q86](#) [Dr Mike Durkin]

3 Barriers to best practice implementation

Barriers within hospitals

35. We asked witnesses to explain why some hospitals were failing to implement best discharge practice. They painted a worrying picture of hospital staff operating in a system under a great deal of strain, coping with significant pressures on resources. In particular, the written and oral evidence points to shortages of hospital beds as an impetus for staff to hurry patients through the discharge process.⁵⁵ Pressures on beds can result in some concerning practices, such as the use of ‘discharge teams’ who are responsible for identifying patients who may be discharged, in order to increase bed availability. Sometimes these teams may also play a role in the discharge process.⁵⁶ Janet Davies from the Royal College of Nursing was clear that this was “the incorrect way of assessing people who are ready for discharge.”⁵⁷ Ms Davies articulated the impact clearly: “When the focus is on beds rather than the person, that is when we sometimes find those difficulties [with poor discharge]”.⁵⁸

36. The Royal College of Physicians highlighted shortages of consultants in the NHS as impacting on the ability of physicians to “achieve safe and timely transfers of care.”⁵⁹ The Local Government Association (LGA) told us that staff shortages were putting staff under pressure. Sarah Mitchell, representing the LGA, linked limits on staff capacity with the problems around communication.

If you are going to communicate well with families and patients, you need time to do that. When staff in wards and in the community are feeling pressured for time because of the number of people that they have to see, the deadlines and the targets that they have to make, then they are going to cut corners. Where you cut corners is in talking to people, unfortunately.⁶⁰

37. The then Minister argued that a solution to these time pressures would be to arrange staff systems more efficiently, rather than to increase numbers of staff.⁶¹

38. A recurring theme throughout our inquiry was the importance of person-centred care. This is where staff are focused on meeting the needs of the individual, and services work seamlessly to meet them, rather than the individual having to navigate the various staff and organisations.⁶² We heard that the failure to assess patients or consult them properly before their discharge is symptomatic of a lack of person-centred care, and a failure to embed a culture of person-centred care into hospital working.⁶³ Sarah Mitchell stressed that it is the responsibility of health and social care leaders to ensure that staff are operating in the right kind of culture.

55 [Qq1–3](#) [Janet Morrison]; [Q9](#) [Ruth Hannan]; British Medical Association [[UEH 22](#)].

56 [Qq29–30](#) [Janet Davies]

57 [Q29](#) [Janet Davies]

58 [Q29](#) [Janet Davies]

59 Royal College of Physicians [[UEH 06](#)]

60 [Q88](#) [Sarah Mitchell]

61 [Q89](#) [Ben Gummer]

62 [Q35](#) [Dr Mark Porter and Janet Davies]

63 [Q3](#) [Janet Morrison]; [Q30](#) [Janet Davies].

When you look at the examples of what happened in the report, there is no nurse, doctor or social worker working in the system at the moment who would think it was right to send someone home in the circumstances of some of those cases, late at night or without care. There is something about the pressure and the frustration that they are feeling in the system at the moment. That is about how we support them and that is about the culture and the leadership because it is the responsibility of us as leaders to make sure that they do not feel that.⁶⁴

39. We agree with the Local Government Association that strong leadership and engagement with staff is needed to support staff who are operating under significant organisational constraints. We are deeply concerned that hospital staff may be put in positions where they feel pressured to discharge patients before it is safe or appropriate to do so. We believe that it is the responsibility of hospital leadership to communicate to staff that organisational pressures should never take priority over person-centred care. Leaders should also ensure there are clear mechanisms for staff to raise concerns about unsafe discharge with hospital leadership. This can only be achieved with high levels of trust and openness between leadership and staff and this must be understood not just by the leadership of hospitals and social services, but by NHS Improvement too.

Barriers across care systems

40. According to the National Audit Office, one of the main drivers behind the increase in delayed discharges is the number of days people spend waiting for a package of home care (which more than doubled between 2013 and 2015, from 89,000 to 182,000) and waiting for a nursing home placement or availability (which increased by 63% in the same period).⁶⁵ The Local Government Association highlighted a direct correlation between a high number of delayed discharges and the unavailability of care packages.⁶⁶ The then Minister recognised that while the unavailability of care packages is a minority cause of delayed transfers of care, this is a growing problem.⁶⁷

41. There was a broad consensus across the witness panels that one of the most significant barriers to improving patient discharge is the lack of integration between health and social care.⁶⁸ We heard about the problems caused by different communication systems, including the lack of compatibility of IT and record systems between hospitals, GPs and social care.⁶⁹ In its July 2016 report on hospital discharge, the PAC identified the need to make practices of information-sharing more effective and we fully endorse its recommendation on this point.⁷⁰ We also heard about different funding systems and related disputes about which system is applicable to an individual's care.⁷¹ Independent Age emphasised that delays often occur where there is conflict over whether the individual's care after their discharge will be self-funded, council-funded or funded by the NHS under continuing healthcare.⁷²

64 [Q88](#) [Sarah Mitchell]

65 National Audit Office (2016), [Discharging older patients from hospital](#), p.17

66 [Q83](#) [Sarah Mitchell]

67 [Q75](#) [Ben Gummer]

68 E.g. [Q21](#) [Janet Morrison, Andrew Boaden]; [Q30](#) [Phil McCarvill]; [Q31](#) [Janet Davies]; [Q76](#) [Ben Gummer]; Royal College of Physicians [[UEH 06](#)]; British Medical Association [[UEH 22](#)].

69 [Q15](#) [Ruth Hannan]; Professor Justin Waring and Dr Simon Bishop [[UEH 05](#)]; Royal College of Physicians [[UEH 06](#)].

70 Twelfth Report from the Public Accounts Committee, Session 2016–17, [Discharging older people from acute hospitals](#), HC 76, p.7.

71 [Q6](#) [Janet Morrison]; [Q63](#) [Janet Davies].

72 [Q6](#) [Janet Morrison]

A further obstacle to integrated working on patient discharge is the ‘culture clash’ between a medical model and social care model of care, leading to poor coordination across services.⁷³ The medical model seeks to discharge patients once the specific cause of a hospital admission has been addressed and the social care model requires appropriate care plans to be in place to deal with other underlying physical or mental health needs.⁷⁴

42. The PAC has shown that the areas which are the best at managing patient discharge are those where health and social care is fully integrated.⁷⁵ They recommend that “NHS England, working with local government partners, should clearly set out good practice models for integrated and closer working that they expect to be adopted by local health and social care systems” and that they should report back to PAC on “what steps they have taken to increase the pace of adoption of such models”.⁷⁶

43. A lack of integrated working between health and social care presents a long-standing, persistent barrier to coordinated, safe and timely patient discharge. We fully endorse the recommendation of the PAC, aimed at establishing good practice models for improving integrated working across local health and social care systems. We look forward to NHS England’s response to the PAC on what steps have been taken to increase the pace of adoption of such care models.

73 [Q3](#) [Janet Morrison]; [Q18](#) [Ruth Hannan].

74 [Q3](#) [Janet Morrison]

75 Twelfth Report from the Public Accounts Committee, Session 2016–17, [Discharging older people from acute hospitals](#), HC 76, p.7.

76 Twelfth Report from the Public Accounts Committee, Session 2016–17, [Discharging older people from acute hospitals](#), HC 76, p.7.

4 National responsibilities for improving discharge practice

44. On a structural level, we heard about how the long-standing separation of health and social care, where interdependent health and social care services are independently funded and organised, hampers the ability of both systems to meet people’s care needs.⁷⁷ The British Medical Association labelled the separate structures as a “fundamental design problem”⁷⁸ and we put it to the witnesses that this constituted an act of political maladministration.⁷⁹ While we strongly support initiatives at a local level to improve integration across services, this structural disconnect between health and social care also requires national level solutions. In this chapter, we will assess the Government’s current approach to tackling this issue.

The Discharge Programme Board

45. Until recently there has been no attempt to co-ordinate nationally the respective health and social care bodies that are responsible for patient discharge. We share the PAC’s frustration at the lack of effective accountability nationally and locally for a “shared problem” for health and social care systems of discharging patients.⁸⁰ We heard about the establishment of the Discharge Programme Board in December 2015, which brings together national health and social care organisations, to improve patient discharge. We were told that the Secretary of State for Health is accountable for the work of the Board.⁸¹ The establishment of this Discharge Programme Board is certainly a positive step. However, since the Department of Health has not published the Board’s benchmarks for success, we remain unclear about the Board’s specific objectives, and how success will be measured.

46. **We welcome the establishment of the Discharge Programme Board, which will bring together national health and social care organisations to improve patient discharge. *The Secretary of State for Health must establish by March 2017 a clear set of objectives for the Discharge Programme Board, together with success measures and timelines against which the progress of the Board in improving patient discharge can be measured.***

Initiatives to promote integrated working

47. Witnesses discussed initiatives, such as new care models, Sustainability and Transformation Plans (STPs) and the pooling of health and social care budgets, which are aimed at improving health and social care integration. Witnesses noted that these were helpful in driving forward integration between health and social care, in turn having a positive impact on patient discharge.⁸² We also heard about the Better Care Fund (BCF),

77 [Q38](#) [Dr Mark Porter]

78 [Q38](#) [Dr Mark Porter]

79 [Q28](#) [Chair], [Q93](#) [Chair]

80 Twelfth Report from the Public Accounts Committee, Session 2016–17, [Discharging older people from acute hospitals](#), HC 76, p.7.

81 [Q122](#) [Ben Gummer]

82 [Q23](#) [Andrew Boaden]; [Q60](#) [Phil McCarvill]; [Q104](#) [Jane Cummings].

which aims “to join up health and care budgets and services”.⁸³ We were informed that the BCF now requires health and social care providers to produce a locally agreed action plan for addressing delayed transfers of care.⁸⁴ Witnesses identified the BCF as a useful tool and part of a “bigger package” in driving the integration of services,⁸⁵ and we welcome the positive impact this should have on patient discharge. However, we were concerned to learn that a significant proportion of money from the BCF is dependent on savings from the New Homes Bonus, a Government grant scheme designed to incentivise local councils to allow planning permission for new homes their area.⁸⁶

48. We were also told by the Local Government Association that the BCF’s money has been “backloaded” in 2016–17, meaning that no additional money will be available in 2016–17 and only a smaller sum in 2017–18; this prompted the LGA to call on the Government to bring forward £700 million to help deal with immediate pressures.⁸⁷

49. We are concerned to learn that a significant proportion of the Better Care Fund’s current funding is reliant on savings from the New Homes Bonus. This seems to PACAC to be an extraordinary way to fund essential public services. The Government must explain what is happening in parts of the country where these funds do not materialise.

Long-term sustainability of social care funding

50. Local authority spending on adult social care has declined by 10% in real terms between 2009–10 and 2014–15 from £16.3 billion to £14.6 billion.⁸⁸ The NHS Confederation told us that “the funding issue is really important to NHS organisations and that is why we have stood shoulder to shoulder with ADASS [Association of Directors of Adult Social Services] and colleagues in social care to say that we agree with Simon Stevens [Chief Executive of NHS England] that this is unfinished business. We have not yet sorted the issue of sustainable settlement for social care funding”.⁸⁹

51. The then Minister highlighted an adult social care precept that allows councils to charge extra council tax to pay for adult social care, and which would “release significant new funds into the social care system”.⁹⁰ However, we heard from the Local Government Association that this has not enabled employers to pay the living wage, and they told us there is a remaining “£1 million gap in a number of local authorities who have invested all of it in social care”.⁹¹

52. We are clear that pressures on funding and overall resources in health and social care do not excuse the egregious examples of poor discharge that we have heard about. However, it is clear from the evidence we received that pressures on social care funding have made it increasingly difficult for hospitals to discharge patients in a timely and appropriate manner.

83 HM Treasury [UEH 25]

84 HM Treasury [UEH 25]

85 Q23 [Andrew Boaden]; Q60 [Phil McCarvill].

86 Local Government Association [UEH 15]

87 Local Government Association [UEH 15]

88 National Audit Office (2016), *Discharging older patients from hospital*, p.31.

89 Q30 [Phil McCarvill]

90 Q99 [Ben Gummer]

91 Q83 [Sarah Mitchell]

53. We are concerned that the current funding plans for adult social care will not adequately tackle the long-standing social care funding gap. *We ask the Government to bring forward a comprehensive solution to health and social care funding that reflects a long-term, sufficient, sustainable, integrated approach to adult social care funding. Recognising that change will take time, but that the status quo is not adequate, the Government should set out a route map for how the new funding arrangements will be implemented, by March 2017.*

Future integration policy

54. In written evidence to the Committee, HM Treasury described the Government's vision for health and social care to be integrated across the country by 2020, as set out in the 2015 Spending Review. As part of this policy "every part of the country will develop a plan for integrating health and social care in 2017, to be implemented by 2020". Local areas will be able to choose from a shortlist of integration models, graduating from the Better Care Fund programme "once they can prove they have moved beyond its requirements".⁹²

55. We welcome the Government's clear policy statement and vision for comprehensively integrated health and social care spending. We note however, that HM Treasury has yet to fully articulate how this vision will be achieved. *We recommend that the Government sets out a clear plan for implementing this policy without delay, taking into consideration ongoing funding pressures in social care, which are yet to be adequately addressed.*

92 HM Treasury [[UEH 25](#)]

Concluding remarks

56. **The incidence of unsafe discharge from NHS hospitals is much too high and this is unacceptable. Spending constraints and demand pressures can only make matters worse, but these in themselves are not an excuse for poor practice or failure to communicate, leading to unacceptable risk to patients. This is a challenge that can only be met by empowering staff and ensuring that their attitudes and procedures can guarantee that clinical judgement and humane common sense are not marginalised by the pressure to provide bed space to other patients. These pressures add to the challenge, and PACAC pays tribute to all those on the front line of care who face this challenge.**

57. **Our predecessor committee's sixth report of the 2014–15 session, 'Investigating clinical incidents in the NHS', has resulted in the government establishing the Healthcare Safety Investigation Branch (HSIB). We expect this emerging body to play a major role in investigating serious incidents of unsafe discharge, to learn lessons from each case, and to ensure that learning is disseminated and implemented throughout the NHS.**

Conclusions and recommendations

Understanding the problem

1. There remains a need to improve the data to better understand both the extent to which patients are discharged before they are ready, and the relationship between early discharge and readmission. *The Secretary of State for Health and the NHS must set out, as part of the Government response to this report, how they will improve understanding of the scale of early discharge and its impact in terms of unplanned readmission.* (Paragraph 20)
2. We agree with the Alzheimer's Society that night discharges are potentially dangerous for patients, and detrimental to their carers and relatives. *Whilst we are aware that an outright ban on night discharges might have unintended consequences, the Secretary of State for Health must set out, in the Government's response to this report, how he intends to ensure that only those who want to be are discharged between 11pm and 6am.* (Paragraph 22)
3. The PAC, in its July 2016 report, concludes that there is a poor understanding of "both the scale and cost of the problem of delays in discharging older patients from hospital". The PAC recommends that NHS England develop measures for improving its understanding of these issues. We strongly agree with their recommendation. (Paragraph 25)
4. We regard the failure of hospitals to involve carers and relatives in decisions to discharge patients, and even to inform them of these decisions, as maladministration and unacceptable. *The Secretary of State for Health and NHS England must set out, in the Government's response to this report, how this issue will be analysed and assessed and what steps will be taken to promote improved communication with relatives and carers by hospital staff.* (Paragraph 30)
5. It is clear from the evidence presented to this Committee, and from the findings of the PAC's inquiry into delayed transfers of care, that best practice guidance on patient discharge is not consistently implemented across healthcare providers. Tackling this variation in discharge processes is key to producing greater consistency in outcomes. *We welcome and strongly support the recommendation of the PAC that NHS England and NHS Improvement report back to that committee by January 2017 on the steps they have taken to increase the pace of good practice adoption.* (Paragraph 34)

Barriers to best practice implementation

6. We agree with the Local Government Association that strong leadership and engagement with staff is needed to support staff who are operating under significant organisational constraints. We are deeply concerned that hospital staff may be put in positions where they feel pressured to discharge patients before it is safe or appropriate to do so. *We believe that it is the responsibility of hospital leadership to communicate to staff that organisational pressures should never take priority over person-centred care. Leaders should also ensure there are clear mechanisms*

for staff to raise concerns about unsafe discharge with hospital leadership. This can only be achieved with high levels of trust and openness between leadership and staff and this must be understood not just by the leadership of hospitals and social services, but by NHS Improvement too. (Paragraph 39)

7. A lack of integrated working between health and social care presents a long-standing, persistent barrier to coordinated, safe and timely patient discharge. *We fully endorse the recommendation of the PAC, aimed at establishing good practice models for improving integrated working across local health and social care systems. We look forward to NHS England's response to the PAC on what steps have been taken to increase the pace of adoption of such care models. (Paragraph 43)*

National responsibilities for improving discharge practice

8. We welcome the establishment of the Discharge Programme Board, which will bring together national health and social care organisations to improve patient discharge. *The Secretary of State for Health must establish by March 2017 a clear set of objectives for the Discharge Programme Board, together with success measures and timelines against which the progress of the Board in improving patient discharge can be measured. (Paragraph 46)*
9. We are concerned to learn that a significant proportion of the Better Care Fund's current funding is reliant on savings from the New Homes Bonus. This seems to PACAC to be an extraordinary way to fund essential public services. *The Government must explain what is happening in parts of the country where these funds do not materialise. (Paragraph 49)*
10. We are clear that pressures on funding and overall resources in health and social care do not excuse the egregious examples of poor discharge that we have heard about. However, it is clear from the evidence we received that pressures on social care funding have made it increasingly difficult for hospitals to discharge patients in a timely and appropriate manner. (Paragraph 52)
11. We are concerned that the current funding plans for adult social care will not adequately tackle the long-standing social care funding gap. *We ask the Government to bring forward a comprehensive solution to health and social care funding that reflects a long-term, sufficient, sustainable, integrated approach to adult social care funding. Recognising that change will take time, but that the status quo is not adequate, the Government should set out a route map for how the new funding arrangements will be implemented, by March 2017. (Paragraph 53)*
12. We welcome the Government's clear policy statement and vision for comprehensively integrated health and social care spending. We note however, that HM Treasury has yet to fully articulate how this vision will be achieved. *We recommend that the Government sets out a clear plan for implementing this policy without delay, taking into consideration ongoing funding pressures in social care, which are yet to be adequately addressed. (Paragraph 55)*

Concluding remarks

13. The incidence of unsafe discharge from NHS hospitals is much too high and this is unacceptable. Spending constraints and demand pressures can only make matters worse, but these in themselves are not an excuse for poor practice or failure to communicate, leading to unacceptable risk to patients. This is a challenge that can only be met by empowering staff and ensuring that their attitudes and procedures can guarantee that clinical judgement and humane common sense are not marginalised by the pressure to provide bed space to other patients. These pressures add to the challenge, and PACAC pays tribute to all those on the front line of care who face this challenge. (Paragraph 56)
14. Our predecessor committee's sixth report of the 2014–15 session, 'Investigating clinical incidents in the NHS', has resulted in the government establishing the Healthcare Safety Investigation Branch (HSIB). We expect this emerging body to play a major role in investigating serious incidents of unsafe discharge, to learn lessons from each case, and to ensure that learning is disseminated and implemented throughout the NHS. (Paragraph 57)

Formal Minutes

Wednesday 14 September 2016

Members present:

Mr Bernard Jenkin, in the Chair

Ronnie Cowan

Mrs Cheryl Gillan

Oliver Dowden

Mr Andrew Turner

Draft Report (*Follow-up to PHSO report on unsafe discharge from hospital*), proposed by the Chair, brought up and read.

Ordered, That the draft Report be read a second time, paragraph by paragraph.

Paragraphs 1 to 57 read and agreed to.

Summary agreed to.

Resolved, That the Report be the Fifth Report of the Committee to the House.

Ordered, That the Chair make the Report to the House.

Ordered, That embargoed copies of the Report be made available, in accordance with the provisions of Standing Order No. 134.

[Adjourned till Tuesday 11 October at 9.15am.]

Witnesses

The following witnesses gave evidence. Transcripts can be viewed on the [inquiry publications page](#) of the Committee's website.

Tuesday 12 July 2016

Question number

Ruth Hannan, Policy and Development Manager, Carers Trust, **Andrew Boaden**, Senior Policy Officer, Alzheimer's Society, and **Janet Morrison**, Chief Executive, Independent Age [Q1–28](#)

Dr Mark Porter, Council Chair, British Medical Association, and **Phil McCarvill**, Deputy Director of Policy, NHS Confederation, and **Janet Davies**, Chief Executive and General Secretary, Royal College of Nursing [Q29–72](#)

Ben Gummer MP, Parliamentary Under-Secretary of State for Care Quality, Department of Health, **William Vineall**, Director, Acute Care and Quality Policy, Department of Health, **Jane Cummings**, Chief Nursing Officer, NHS England, **Dr Mike Durkin**, National Director of Patient Safety, NHS Improvement, and **Sarah Mitchell**, Director, Social Care Improvement, Local Government Association [Q73–124](#)

Published written evidence

The following written evidence was received and can be viewed on the [inquiry publications page](#) of the Committee's website.

UEH numbers are generated by the evidence processing system and so may not be complete.

- 1 Alzheimer's Society ([UEH0013](#))
- 2 British Medical Association ([UEH0022](#))
- 3 Carers Trust ([UEH0024](#))
- 4 Carers UK ([UEH0014](#))
- 5 Department of Health, NHS England and NHS Improvement ([UEH0023](#))
- 6 Healthwatch Dorset ([UEH0021](#))
- 7 Healthwatch England ([UEH0008](#))
- 8 HM Treasury ([UEH0025](#))
- 9 Local Government Association ([UEH0015](#))
- 10 Mr John O'Brien ([UEH0018](#))
- 11 Mrs Margaret Whalley ([UEH0009](#))
- 12 Mrs Teresa Rose Steele ([UEH0001](#))
- 13 National Development Team for Inclusion ([UEH0020](#))
- 14 Parkinson's UK ([UEH0010](#))
- 15 phsothefacts ([UEH0007](#))
- 16 Professor Justin Waring and Dr Simon Bishop ([UEH0005](#))
- 17 Royal College of Nursing ([UEH0012](#))
- 18 Royal College of Physicians ([UEH0006](#))
- 19 Royal College of Physicians of Edinburgh ([UEH0011](#))
- 20 The Health Foundation ([UEH0016](#))
- 21 The Royal College of Radiologists ([UEH0002](#))

List of Reports from the Committee during the current Parliament

All publications from the Committee are available on the [publications page](#) of the Committee's website.

The reference number of the Government's response to each Report is printed in brackets after the HC printing number.

Session 2015–16

First Report	Follow-up to PHSO Report: Dying without dignity	HC 432 (HC 770)
Second Report	Appointment of the UK's delegation to the Parliamentary Assembly of the Council of Europe	HC 658 (HC 962)
Third Report	The 2015 charity fundraising controversy: lessons for trustees, the Charity Commission, and regulators	HC 431 (HC 980)
Fourth Report	The collapse of Kids Company: lessons for charity trustees, professional firms, the Charity Commission, and Whitehall	HC 433 (HC 963)
Fifth Report	The Future of the Union, part one: English Votes for English laws	HC 523 (HC 961)
Sixth Report	Follow up to PHSO Report of an investigation into a complaint about HS2 Ltd	HC 793 (HC 258)
Seventh Report	Appointment of the Commissioner for Public Appointments	HC 869
Eight Report	The Strathclyde Review: Statutory Instruments and the power of the House of Lords	HC 752
Ninth Report	Democracy Denied: Appointment of the UK's delegation to the Parliamentary Assembly of the Council of Europe: Government Response to the Committee's Second Report of Session 2015–16	HC 962
First Special Report	Developing Civil Service Skills: a unified approach: Government Response to the Public Administration Select Committee's Fourth Report of Session 2014–15	HC 526
Second Special Report	Lessons for Civil Service impartiality for the Scottish independence referendum: Government Response to the Public Administration Select Committee's Fifth Report of Session 2014–15	HC 725
Third Special Report	Follow-up to PHSO Report: Dying without dignity: Government response to the Committee's First Report of Session 2015–16	HC 770

Fourth Special Report	The Future of the Union, part one: English Votes for English laws: Government response to the Committee's Fifth Report of Session 2015–16	HC 961
Fifth Special Report	The collapse of Kids Company: lessons for charity trustees, professional firms, the Charity Commission, and Whitehall: Government Response to the Committee's Fourth Report of Session 2015–16	HC 963
Sixth Special Report	The 2015 charity fundraising controversy: lessons for trustees, the Charity Commission, and regulators: Government response to the Committee's Third Report of Session 2015–16	HC 980

Session 2016–17

First Report	PHSO review: Quality of NHS complaints investigations	HC 94
Second Report	Appointment of the Chief Investigator of the Healthcare Safety Investigation Branch	HC 96
Third Report	Better Public Appointments?: The Grimstone Review on Public Appointments	HC 495
Fourth Report	Pre-appointment hearing: First Civil Service Commissioner	HC 655
First Special Report	Follow up to PHSO Report of an investigation into a complaint about HS2 Ltd: Government and HS2 Ltd responses to the Committee's Sixth Report of Session 2015–16	HC 258