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ACUTE PERSPECTIVE

David Oliver: Zealotry risks making faster hospital discharge a cult

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We should be wary of single issue zealotry in health service delivery, which risks making adherence to even the soundest principles cultish. I worry that this obsession, driven by necessity with ever faster discharge of hospital patients, is nearing that status.

The NHS in England now has only 103 000 general and acute hospital beds for a population of 56 million. From 2000 to 2019, overall bed numbers fell from 240 000 to 165 000[1]; in the same period, acute hospital admissions nearly doubled.[2] The UK now has among the fewest hospital beds per head among developed countries, and England has fewer still.[3 4]

Since 2010, cuts in social care budgets and growing workforce gaps have left fewer people receiving social care services despite rising demographic demand,[5 6] and care home places have flatlined, with homes struggling to stay in business.[7] The NHS Benchmarking National Audit of Intermediate Care found that short term multidisciplinary post-acute rehabilitation and support, in community hospitals or patients' homes, was well received by patients and offered value for money. But we had only around half the required out-of-hospital capacity.[8]

Even by 2016, the National Audit Office had reported that delayed transfers of care from hospital, of patients otherwise medically safe to leave, had hit a record high, as official numbers underestimated the real scale.[9] Although formal reporting was suspended during the covid-19 pandemic, hospitals now report serious problems getting medically stable patients back home, as community services are saturated.[10] This "exit block" further pressurises hospitals, which are running at over 90% occupancy.[11]

Of course, we should focus on alternatives to hospital admission—from ambulatory emergency care to rapid community response teams, from medical support for care home residents to better support and planning for people living or dying with long term conditions outside hospital.[12] We should also ensure more consistent, proactive senior decision making in hospitals, with more prompt assessment, investigation, and treatment, helping more patients to avoid overnight admission through "same day emergency care."[13 14]

And yes, it's right to ensure that once people are on hospital wards we minimise any internal process delays, have regular decision making on next steps, and avoid inpatients remaining in beds when a continued stay adds little value to their care.[15] But, perhaps because of the huge pressure on beds, I think that the single focus on faster discharge at all costs now risks becoming a cult. Its advocates can tend to make biased, inflexible assumptions on behalf of patients or their families, filtering out inconvenient evidence.

Remember, we have a sound empirical evidence base in support of ward based comprehensive, multidisciplinary, geriatric assessment for older inpatients or specialist acute inpatient care for people with stroke.[16 17] Yes, research trials of "hospital at home," including for older, frailer people, have shown outcomes similar to hospital care—but not consistently, unequivocally better ones.[18-20] And empirical capacity in this and a range of other home based services, which could hypothetically support many patients who are now stranded in hospital or are admitted avoidably, remains very patchy. The notion that being on a ward is ipso facto more harmful, risky, or likely to lead to loss of function is one sided.

Not all older people want to leave hospital or to do so immediately. Plenty have major concerns and no longer feel ready, confident, or well enough. Many feel that their discharge is rushed or that the promised community supports are unavailable.[21-23] Their families, often integral to providing care and support, may also doubt their relative's fitness to leave and lack the confidence to support them, or they may be burnt out and stressed by their caring role. Even some patients who are dying, or their families, prefer the security of palliative care on a hospital ward rather than a move back home or to a care facility.[24]

I find the covid-era's "criteria to reside" listed in NHS England's discharge guidance restrictive, depersonalising, and prescriptive.[25 26] They de-legitimise all manner of reasons to keep someone in hospital an extra day or two, while marginalising patients' and families' concerns and choices. Furthermore, any set of performance indicators fit for purpose should move well beyond the percentage of same day discharges, or length of stay in medically stable patients, and consider rates of emergency readmission or death after discharge, as well as the patient's place of residence, physical function, level of involvement in their own discharge, and satisfaction with the process.

The huge pressure on our hospital beds can blind us to all other considerations. The practice of medicine for acutely sick and vulnerable individuals should never become machine management. Remember: there's a person in the bed and a social support network (or not) at home.

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