Northern Ireland
Legal Quarterly
Winter Vol. 74.4 (2023) 713–738
Articles DOI: 10.53386/nilq.v74i4.1075

Choosing home: discharge to assess and the Health and Care Act 2022

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ABSTRACT

In the early stages of the coronavirus pandemic National Health Service hospitals were instructed to rapidly discharge patients from wards with consequences which, in the case of some care homes, has been claimed to be catastrophic due to lack of effective testing and isolation. These tragic events also highlight a longer-term issue, namely hospital discharge policies and their relationship with obligations placed on local authorities to assess needs of individuals under the Care Act 2014. Concerns have been expressed for some time regarding the delays in getting patients discharged from hospitals – with them being labelled inappropriately as 'bed blockers'. The Health and Care Act 2022 includes new statutory measures concerning discharge to facilitate rapid discharge of patients from hospitals. This can be seen as a solution to a major resource problem, but could this ultimately undermine choice and respect for individual wellbeing?

The article explores the background to the recent controversies concerning hospital discharge decisions and their relationship with the Care Act 2014. It demonstrates that, while the current debates and controversies regarding hospital discharge decisions are nothing new and pre-date the pandemic by decades, hospital discharge processes accelerated during the pandemic and have left a problematic legacy. It interrogates the Health and Care Act 2022 discharge provisions and whether these will be an effective integration of health and social care provision going forward or whether there is a real risk of undermining individual autonomy, the Care Act 2014 obligations concerning promotion of well-being and a person's choice of their 'home'.

Keywords: hospital discharge; NHS; Care Act 2014; Health and Care Act 2022; patients; Covid.

INTRODUCTION

In the early stages of the coronavirus pandemic National Health Service (NHS) hospitals were instructed to rapidly discharge patients, including into care homes, to increase hospital capacity. The consequences of this approach were, in the case of some care

* The author wishes to gratefully acknowledge the support of ESRC Grant No ES/V015486/1 in relation to background work for parts of this paper.

homes, claimed to be catastrophic, resulting in seeding infection with consequent high death rates.[1] But these tragic events also highlighted what is a much broader and longer-term issue, namely the policies regarding discharge from hospital and their relationship with obligations placed on local authorities to assess the needs of individuals under the Care Act 2014, or as to whether patients are entitled to continuing funded NHS Continuing Healthcare (NHS CHC) outside the hospital.

Discharge from hospital can be seen as essentially an administrative task for the NHS trust and social services, in terms of bed management and a matter for the patient in terms of the next stage in their recovery and where this will be best facilitated. But the very process of discharge itself ought to be one which ideally should enable an individual to be able to make choices about 'home', where, ultimately, they want to recuperate and indeed live. Difficulties regarding patient discharge decisions long pre-date the pandemic. Over decades, the problems of patients being unable to be rapidly discharged from hospital even though clinically fit to be discharged – whether back to their own homes, or to respite care or to a permanent care home – have been highlighted, and successive governments have sought to address this issue. Frequently, the emotive language of 'bed blocker' has been used to describe such patients.[2] It has been suggested that this terminology, which today has been rightly criticised as being dehumanising and discriminatory, originated amongst clinicians in the 1950s.[3]

Major concerns remain regarding the shortage of hospital beds. Comparisons with the availability of hospital beds in other jurisdictions are notable. As the British Medical Association has commented: 'The average number of beds per 1,000 people in OECD EU nations is 5, but the UK has just 2.4. Germany, by contrast, has 7.8' and furthermore:

> Prior to the pandemic, the total English NHS hospital bed stock reduced by 8.3% between 2010/11 and 2019/20 as the average daily total of available beds fell from 153,725 to 140,978.[4]

Section 91 of the Health and Care Act 2022 has introduced new measures amending section 74 of the Care Act 2014 which are aimed at facilitating more rapid discharge of patients from hospital through what is known as a 'discharge to assess' model. Duties and powers which

1 See further *R (Gardner and Harris) v Secretary of State for Health and Social Care and Others* [2022] EWHC 967.

2 'Hundreds of "bed blockers" at University Hospitals Dorset every day' *Bournemouth Echo* (23 November 2022); 'Isle of Wight awarded £2m to help discharge bed-blockers' (*BBC News* 24 January 2023).

3 Johnny Marshall, 'They're not bed blockers, just older people who want to get home' *The Guardian* (30 August 2016).

4 British Medical Association, *NHS Hospital Bed Data Analysis* (December 2022).

may come into operation on discharge from hospital are placed on local authorities under the Care Act 2014 to provide care and support for patients. Care which is funded by local authorities is subject to means testing. In some instances, as we shall see below, there is provision for NHS health and care support on discharge under NHS CHC. In contrast to social care, NHS CHC is not subject to means-tested provision. However, in practice access to NHC CHC is exceedingly difficult to be awarded.[5] The aim of the 2022 Act provisions will be to speed up the hospital discharge process and move these decisions regarding assessment of the care and support needed for individuals to be made post discharge outside hospital. This can also be seen as part of the broader move of integration of health and social care under the 2022 Act. But what longer term will be the impact of the 2022 Act proposals and further enhanced measures for rapid discharge? Will this facilitate effective delivery of hospital care or is there a real risk of undermining patient choice and ultimately patient health? People are, of course, not simply parcels; being moved to an unexpected location whether within a hospital, a sudden move overnight to a different ward or to a new care facility outside hospital can be disorientating and indeed at times frightening for an ill and vulnerable person.

This article first explores the statutory requirements regarding the provision of care and support to patients post discharge, both in relation to the NHS and the assessment obligations set out in the Care Act 2014. Secondly, it examines the backdrop to the 2022 Act provisions. It demonstrates that, while the current debates and controversies regarding hospital discharge decisions are nothing new and pre-date the pandemic by decades, hospital discharge processes accelerated during the pandemic and left a problematic legacy. Thirdly, the article then interrogates the provisions in the Health and Care Act 2022 regarding hospital discharge. It considers the extent to which these provisions can be seen as part of an effective integration of health and social care provision going forward or whether there is a real risk of undermining patients' autonomy, and respect for their needs and their choice of 'home'. The focus of this article is upon the question of discharge decisions in relation to adults. While discharge decisions concerning children and those with mental illness give rise to many separately challenging issues, word constraints mean that they cannot be explored further in this particular article.

5 See further L Clements with K Ashton, S Garlick, C Goodhall, E Mitchell and A Pickup, *Community Care and the Law* 7th edn (Legal Action Group 2019) ch 13, 'NHS continuing healthcare responsibilities'.

PROVIDING CARE AND SUPPORT TO PATIENTS POST DISCHARGE – THE INTERFACE BETWEEN HEALTH AND SOCIAL CARE

While some patients are able to be discharged after hospital treatment without the need for further care and treatment, this is by no means the case for all patients, and some patients post discharge will need continuing healthcare and/or social care support. Although since its inception in 1948 health care provided by the NHS has been free at the point of delivery – albeit with some exceptions, for example prescriptions[6] – social care from the National Assistance Act 1948 onwards has been treated differently. Social care provision is subject to means testing.[7] The issue of the extent to which social care should be subject to charge and, if so, or at what level remains a matter of ongoing controversy, the precise details of which go beyond the scope of this article.[8] The assessment of whether care after leaving hospital falls under the category of NHS CHC or that of social care is thus a major financial issue for the patient and their relatives but also potentially for the NHS funders.[9] The Care Act 2014 imposes a range of duties and powers in relation to the provision of social care services. This is rooted in the 'wellbeing concept'. Section 1 of the 2014 Act places a general duty upon local authorities to promote an individual's wellbeing in relation to matters including personal dignity, their physical and mental health and emotional wellbeing, protecting them from being subject to abuse and neglect, care and support which is provided to them, their social and economic wellbeing and the suitability of their living accommodation. Furthermore, section 1(3) provides that when local authorities are exercising relevant functions under the legislation they need to work from the assumption that it is the person themselves who is best placed to ascertain what is their own wellbeing,[10] the person's views, wishes, feelings and any beliefs which they may have,[11] and their involvement 'as fully as possible' in decisions and provision of information enabling them to participate in

6 S 1(4) National Health Services Act 2006.

7 See further Cabinet Office, Department of Health and Social Care and Prime Minister's Office, Policy Paper Adult Social Care Charging Reform: Further Details (Updated 8 March 2022).

8 See further HM Government, *Build Back Better: Our Plan for Health and Social Care* (CP 506 September 2021).

9 See further Clements et al (n 5 above) ch 5 'Hospital discharge'. See also *R v North and East Devon Health Authority ex p Coughlan* [2000] 2 WLR 622; *R(Grogan) v Bexley NHS Care Trust and Others* [2006] EWHC 44; *R (Gossip) v NHS Surrey Downs CCG* [2019] EWHC (Admin).

10 Care Act 2014, s 1(3)(a).

11 Ibid s 1(3)(b).

those decisions.[12] There is emphasis placed upon the importance of preventing or delaying the development of needs for care and support, or needs for support, and of reducing needs of either kind that already exist.[13] Furthermore, restrictions on rights or freedom of action are to be 'kept to the minimum necessary' in the specific context.[14]

The Care Act 2014 places duties upon local authorities to assess whether an adult or carer has eligibility for support for care and support needs or, in the case of a carer, for support needs.[15] If they come under the threshold of eligibility there is then a duty to assess those care and support needs.[16] If individuals are assessed as eligible and have such needs then local authorities are placed under a duty to meet those needs for adults requiring care and support needs[17] and for carers with support needs.[18] In addition, a care and support plan must be provided.[19] There are also related obligations regarding the need to undertake financial assessments.[20] A financial assessment is practically very important as it provides advance information to the individual and their family as to what real choices are available to them with regard to what social care services they will be able to afford.

In addition to the Care Act 2014, statutory provisions enable provision of NHS care and support for free following hospital discharge through NHS CHC.[21] This scheme was introduced by the NHS and Community Care Act 1990. The development of such care could be seen alongside the movement away from 'indefinite' long-stay hospital patients and to a growth towards more 'personalised care'.[22] If an individual falls within the category for such care and treatment, this is classified as NHS care, and then, unlike for social care, the patient is not charged for this care. Inevitably, if it were the case that this scheme was very generous, then it would have a substantial impact on the budget of NHS Commissioners. In practice over time the criteria of

12 Ibid s 1(3)(e).
13 Ibid s 1(3)(g).
14 Ibid s 1(3)(h).
15 Ibid s 13.
16 Ibid s 9 and s 10.
17 Ibid s 18.
18 Ibid s 20 concerning carers needing care and support.
19 Ibid s 24.
20 Ibid s 17.
21 The National Health Service Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) Regulations 2012, SI 2012/2296 (as amended), pt 6. See further discussion in Clements et al (n 5 above) ch 13; and T Powell, *NHS Continuing Healthcare in England* (House of Commons Library 7 February 2023).
22 See further D Oliver 'NHS continuing care is a mess' (2016) 354 British Medical Journal Online (5 August).

this scheme have been notably tightened, and accessing NHS CHC has proved increasingly challenging,[23] and it has been claimed that access to funding is less likely now than before the pandemic.[24]

Today NHS CHC[25] applies to individuals who have a 'primary health need'[26] which is ascertained by looking at the 'totality of all health needs'.[27] This is assessed by a multidisciplinary team using what is called the 'National Decision Support Tool'. The tool looks at a range of needs which are listed as breathing, nutrition – food and drink – continence, skin and tissue viability, mobility, communication, psychological and emotional needs, cognition, behaviour, drug therapies etc, altered states of consciousness, and other significant care needs. The needs are assessed with reference to levels from low to severe, or, in the case of some, such as breathing or behaviour, the highest level is that of 'priority'. If it is determined there is such a primary health need then the NHS itself will have the responsibility to undertake the commissioning of that patient's care package to address those 'assessed health and associated social care needs'.[28] This will, for example, include covering the cost of such things as washing and dressing the patient. However, those granted NHS CHC have a right to access and use their own personal health budget, and where they are receiving care in their own home there is an expectation they will use their own budget.[29] There is also a special 'fast track' for NHS CHC which operates where patients are suffering very serious deterioration in health, for instance, due to terminal illness. Ultimately, what constitutes nursing services which fall within a local authority's remit

23 See for example the discussion in National Audit Office Report by the Comptroller and Auditor General, *Investigation into NHS Continuing Healthcare Funding* (HC 239, Session 2017–2019 5 July 2017) and for criticism of the operation of the scheme in the pre-pandemic period focusing on complaints received by the Parliamentary and Health Service Ombudsman between April 2018 and July 2020: Parliamentary and Health Service, *Ombudsman Continuing Healthcare: Getting it Right First Time* (HC 872 3 November 2020). For further reflections on the scheme, see NHS Federation Report, *NHS Continuing Healthcare: Delivering Excellence* (1 June 2020).

24 P Gallagher, 'Adults with serious healthcare needs "less likely to receive NHS funding than before Covid pandemic"' (*I News* 11 February 2022).

25 See further NHS Regulations 2012 (n 21 above) and the Department of Health and Social Care Guidance, National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care (28 November 2012, updated 14 July 2023).

26 National Framework (n 25 above) para 4.

27 Ibid para 56.

28 Ibid para 5.

29 See further NHS England, Personal Health Budgets in NHS Continuing Healthcare (CHC).

and those of the NHS remains a matter to be determined on a case-by-case basis.[30]

The duties in relation to NHS CHC are imposed on NHS England, the body which leads the NHS in England, Integrated Care Boards, which are now the primary commissioners of healthcare at local level,[31] and also on local authorities. In addition, as the National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care states, it is the case that:

> If a person does not qualify for NHS Continuing Healthcare, the NHS may still have a responsibility to contribute to that individual's health needs – either by directly commissioning services or by part-funding the package of support. Where a package of support is commissioned or funded by both a local authority and an ICB, this is known as a 'joint package of care'.[32]

Today the new Integrated Care Boards have obligations to comply with and deliver the National Framework for NHS Continuing Healthcare, the governance arrangements for eligibility for promotion of and commissioning of packages, and decisions on eligibility.[33] They have the task of consulting:

> so far as is reasonably practicable, with the relevant social services authority before making a decision on a person's eligibility for NHS Continuing Healthcare (the Care and support statutory guidance should be used to identify the relevant social services authority).[34]

Other obligations relate to the implementation of good practice and quality standards.[35] Specific obligations are also placed on local authorities to refer persons who may be eligible for NHS CHC to Integrated Care Boards.[36]

Thus these obligations exist to assess in relation to individual needs concerning care and support under the Care Act 2014 and in relation to NHS CHC. The new Discharge to Assess provisions introduced under the Health and Care Act 2022, as its name suggests, mean that, rather than undertaking these assessments of needs while patients are in the hospital, assessment of long-term needs will be undertaken once they have been discharged. We explore the implications of this below.

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30 See *Coughlan* (n 9 above).
31 Established under the Health and Care Act 2022.
32 National Framework (n 25 above) para 20.
33 Ibid para 22(a)–(c) and (e).
34 Ibid para 22(d).
35 Ibid para 22 (i) and (j).
36 Ibid para 26.

HOSPITAL DISCHARGE DECISIONS – THE BACKDROP TO THE HEALTH AND CARE ACT 2022

Delays regarding hospital discharge decisions have long been the subject of controversy both for the very fact that these delays existed but also for what reasons patients were occupying hospital beds for a long period of time. Concerns about the impact of an ageing population and lack of suitable provision outside hospital for older patients resulting in beds being 'blocked' were raised in the mid-1970s.[37] There was criticism of use of this as a term. In 2000 Scott argued that 'bed blocker': 'must cease to be used as it creates a negative attitude towards elderly people in hospital and propagates ageism which is already widespread in the NHS'.[38]

There was also the question as to whether delays in discharge should be seen as an administrative matter or whether these could, at least in part, be attributed to problems in the approach to hospital clinical care. In relation to elderly surgical patients, Gwyn Seymour and Pringle writing in 1982 suggested that, concerning this group of patients and also younger patients, their length of stay in hospital was a matter relating to clinical concerns and stay could be shortened by an improvement in treatment approaches, for example, a reduction in postoperative complications such as sepsis.[39] Patients may have faster rehabilitation outside a hospital setting.

There was high-level discussion as to the impact of delayed hospital discharge on the NHS and NHS funding in the 1990s. McCoy et al stated that:

> The National Audit Office (NAO) reported that 2.2 million bed days could be attributed to delays in discharge in England in 1998/99 costing the NHS £1 million a day. The House of Commons Health Committee concluded that delayed discharges affected 6% of all acute beds and cost the NHS £720 million in 2001/02.[40]

It appears that until 2001 there was no standard definition as to what constituted a 'delayed discharge'.[41] In that year the Department of Health stated that:

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37 See discussion in S G Rubin and G H Davies, 'Bed blocking by elderly patients in general hospital wards' (1975) 4 Age and Ageing 142.

38 H Scott, 'Elderly patients: people not "bed-blockers"' (2000) 9(9) British Journal of Nursing 528.

39 D Gwyn Seymour and D Pringle, 'Elderly patients in a general surgical unit: do they block beds?' (1982) 284 British Medical Journal 1921.

40 D McCoy, S Godden, A M Pollock and C Bianchessi, 'Carrot and sticks? The Community Care Act (2003) and the effect of financial incentives on delays in discharge from hospitals in England' (2007) 29(3) Public Health 281.

41 See discussion in the House of Commons Health Committee Report, *Delayed Discharges* (Third Report of Session 2001–2002 HC 617-1) para 1.

> A delayed transfer occurs when a patient is ready for transfer from a general and acute hospital bed but is still occupying such a bed. A patient is ready for transfer when:
>
> — a clinical decision has been made that the patient is ready for transfer
>
> — a multi-disciplinary team decision has been made that the patient is ready for transfer
>
> — the patient is safe to discharge/transfer.[42]

The Health Select Committee Report, *Delayed Discharges*, in 2001 noted that despite the definition being produced in practice there was considerable lack of clarity in relation to what precisely constituted a delayed discharge.[43] It also noted concerns in relation to lengthy discharge of older patients which could have consequent adverse impacts on their health. Reasons for delay were cited in the Select Committee Report as including individuals waiting assessment of care needs, finding an appropriate place for care (including care home placements) and awaiting domiciliary care packages such as home adaptations. Further reasons given were the need to resolve social services funding for care, patients needing further NHS care or patient and family choosing further care settings.[44]

The Blair Labour Government attempted to address the problem of the delayed discharge during its second term in the period 2001–2005. Alan Milburn, the Secretary of State for Health, speaking in the House of Commons on 18 April 2002, stated that:

> Reductions in waiting times to get into hospital must, of course, be accompanied by cuts in waiting times to get out. Older people are the generation that built the health service, and they have supported it all their lives. This generation owes that generation a guarantee of dignity and security in old age. Bed blocking denies both.[45]

Various interrelated policy measures were taken forward at the time. These included the creation of the role of liaison nurse or discharge coordinator and of 'discharge lounges' in hospitals, with funded initiatives (with the aim of diversion of patients from accident and emergency) enabling 72-hour 'emergency care packages' for community support.'[46]

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42 Cited in ibid, para 1.

43 House of Commons Health Committee Report (n 41 above) paras 3–8.

44 Ibid para 9.

45 Rt Hon Alan Milburn, Secretary of State for Health 2002, 'Speech on the NHS Plan' (House of Commons 18 April 2002).

46 J Roll and K Wright, *The Community Care (Delayed Discharges etc) Bill 4 of 2002–2003* (House of Commons Research Paper 02/66 22 November 2002).

The Wanless Report in 2001 had recommended that the Government look into financial incentives in relation to hospital discharge.[47] Local authorities had received funding to support delayed discharges, but the problem still remained.[48] The Community Care (Delayed Discharges) Act 2003[49] enabled the NHS to charge social services where individuals did not need acute hospital beds but were unable to be safely discharged from hospital without the involvement of local authorities, and consequent delays had resulted. There was some evidence that while, this reduced initial delays, this movement to rapid discharge was then accompanied by a related increase in emergency readmissions.[50]

Ultimately, the 2003 Act was replaced during the Conservative and Liberal Coalition Government (led by David Cameron)[51] by section 74 and schedule 3 of the Care Act 2014 and related regulations. This also included some provision for payments by local authorities. These concerned those patients receiving 'acute care', which was defined as being 'intensive medical treatment provided by or under the supervision of a consultant that lasts for a limited period after which the person receiving the treatment no longer benefits from it'.[52] Excluded from this category was the care of expectant or nursing mothers, mental health and palliative care, short-term home care support, and recuperation or rehabilitation care.[53]

Discharge under the Care Act 2014 provisions was operated by the relevant NHS trust serving notice on the local social services department that the patient was likely to be ready for discharge on a particular date. The social services department was then required within two days to examine the patient's needs. In addition, the NHS issued discharge notices with one day's notice of required discharge. In a situation in which the patient could not be discharged because it was the case that the local authority had not undertaken relevant

47 *Securing our Future Health: Taking a Long-Term View* (The Wanless Report, HM Treasury 2002) para 6.45.

48 See discussion in House of Commons Health Committee Report (n 41 above) pt III, para 6: 'The use of the Cash for Change resources appears to have been successful in enabling authorities to meet the target of a more than 20% reduction in delayed discharges since September 2001. However, we accept that funding activity in this way may not be sustainable or desirable in the longer term, and that the increase of funding to social services of 6% per annum in real terms over the next three years offers a positive opportunity for longer term planning.'

49 Ibid.

50 See further Godden et al (n 40 above).

51 This Government operated between 2010 and 2015.

52 Care and Support (Discharge from Hospital) Regulations 2014, SI 2014/2823, reg 7(6).

53 Ibid reg 7(7).

assessments or put in place arrangements for meeting 'some or all' of the relevant needs, then the local authority would become liable for payments. The difference, however, with the previous legislation was that, while under the 2003 Act such charges were mandatory, this was not now the case.[54] Ultimately, the intention was to foster joint working between the NHS and local authorities. In a situation in which a patient or carer decided to refuse a package which was offered to them, then it was the case that the local authority was no longer liable for the costs.

The effectiveness of the statutory discharge measures and the operation of discharge by NHS and social services in the period between when the 2014 Act came into force and the beginning of the pandemic was subject to criticism. While there was pressure to stop individuals remaining in hospital for longer than clinically indicated, there were also concerns that the process of discharge itself and some related discharge decisions were problematic with, in some instances, patients being placed at risk of harm. The issue of what constitutes a 'safe discharge', while addressed in principle in earlier guidance in 2010 and 2015, was not defined. As Clements et al note, a protocol produced in 2003 set out three criteria which needed to be present for a safe discharge.[55] These were that there was a clinical decision that this patient was ready for discharge, that there was a multidisciplinary team decision also to that effect, and also that the patient was safe to discharge and transfer. Furthermore, these criteria were to be 'addressed at the same time whenever possible'.[56]

The Parliamentary and Health Service Ombudsman's Report of investigations into unsafe discharge from hospital in 2016 stated that:

> Failures in these areas severely undermine people's trust and confidence in the NHS. As the relative of an older woman who complained about her treatment told us: 'Surely when family members have made their concerns 100% clear and a vulnerable, virtually immobile 93-year-old is sent home alone, something is very wrong somewhere.'[57]

The Healthwatch England Report 'Safely home: what happens when people leave hospital and care settings' published in 2015 noted that, of the trusts included in its report, 1 in 10 trusts had not as a matter of routine told carers and relatives that people would be discharged.[58]

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54 Sch 3, para 4(1) provided that 'the NHS body responsible … may require the relevant authority to pay the specified amount'.

55 Clements et al (n 7 above) 176–177.

56 Ibid 176.

57 Parliamentary and Health Service Ombudsman, *A Report of Investigations into Unsafe Discharge From Hospital* (2019).

58 Healthwatch, *Safely Home: What Happens When People Leave Hospital and Care Settings Report* (21 July 2015).

In addition, 1 in 8 people discharged had reported being unable to cope on discharge. Similarly, the Red Cross, in its report, *Home to the Unknown: Getting Hospital Discharge Right* in 2019 stated that:

> Some people came home to houses that had not been prepared for their return, with no hot water or heating on. Others returned to homes that were unsuitable or inappropriate for their recovery and their changed or changing needs. This ranged from struggling with a single step up to a front door, to feeling unable to get upstairs to the toilet.[59]

An already problematic situation of undertaking hospital discharge decisions was amplified still further by events during the pandemic. As part of the pandemic planning exercises undertaken in the two decades prior to the Covid pandemic, concerns were raised as to the potentially serious adverse impacts of a major pandemic on health and social care provision.[60] It was suggested as a consequence that provision could be made for some statutory provisions to be suspended or 'eased' during this period, commonly referred to as 'easements' in various guidance documents.[61] Provision was made in the 2020 Act to enable the pausing of statutory obligations concerning NHS CHC and including Care Act 2014 assessments.[62] All NHS CHC assessments were suspended in the early stages of the pandemic and then were restarted from 1 September 2020.[63] When the Guidance was withdrawn on 19 September 2021, it was stated that 'all deferred assessments had been completed'.[64]

The situation was more problematic in relation to suspension of Care Act duties. The guidance required that where higher-level easements were used, such as suspending certain provisions under the 2014 legislation, these needed to be notified to the Department of Health and Social Care.[65] Such higher-level easements were only formally applicable in a very small number of local authorities and for a very short period of time – between April 2020 and June 2020.[66] However,

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59 British Red Cross, *Home to Home to the Unknown: Getting Hospital Discharge* Right (2019) 12.

60 Exercise Cygnus Report: Tier One Command Post Exercise Pandemic Influenza 18 to 20 October 2016 (Public Health England 2017).

61 Ibid 8.

62 Ss 14 and 15 Coronavirus Act 2020.

63 Department of Health and Social Care, Guidance: Reintroduction of NHS Continuing Healthcare (NHS CHC) 21 August 2020 (Guidance withdrawn on 19 September 2021).

64 Ibid.

65 Department of Health and Social Care, *C*are Act Easements: Guidance to Local Authorities (Updated 29 June 2021).

66 Birmingham City Council, Coventry City Council, Derbyshire County Council, Solihull Council, Staffordshire County Council, Sunderland City Council, Warwickshire County Council and Middlesborough Council operated these for one week and then withdrew them.

there is evidence that there were changes in the way in which services were provided in some local authorities even though formal statutory easement practices were not applicable.[67] The statutory easement powers were finally withdrawn in 2021.[68]

Rapid discharge of patients from hospital was seen as a critical measure to facilitate the ability of the NHS to save lives in the pandemic. In March 2020 the need for rapid hospital discharge came into sharp focus. Instructions were issued on 19 March 2020 with the aim of clearing as many hospital beds as possible to provide space for Covid-19 patients.[69] The intention was to free up some 15,000 beds between 19 and 27 March 2020. Both acute and community hospitals were required to discharge all patients as soon as they were clinically safe to do so. Procedures were put in place to facilitate such a rapid discharge. There was to be a clinical review in the early morning ward round to identify those patients who were seen as suitable for discharge. In addition there was to be a review twice per day of all those patients in acute beds to ascertain who was not 'required to be in hospital' and who could be discharged. Within an hour of the actual decision to discharge was made, patients were to be discharged to a designated discharge area and the discharge should happen as soon as possible after that, normally within two hours. Hospitals were to keep a list of those who are subject to discharge and to discharge and report on the number of those patients. Social care personnel were involved in ward reviews. Local authorities deployed teams of social workers to work in hospitals to facilitate discharge. Patients were given information such as the direct number of the ward to call back and get advice. They were also to receive a phone call the following day to provide reassurance and advice.[70] In addition, provision was made to request a follow-up by a community nurse. From April 2020, the discharge to assess process was combined with free care for patients where needed in the form of rehabilitation or reablement for a period of up to six weeks. There was specific government funding put in place to facilitate discharge. In the period between 19 March 2020 to 31 March 2021 the cost of care for persons waiting assessment was covered by an emergency Covid-19 fund of £1.3 billion.[71] There was

67 See further J V McHale and L Noszlopy, Adult Social Care Provision under Pressure: Lessons from the Pandemic (Research Report, University of Birmingham, 2021); and see also J V McHale and L Noszlopy, *Adult Social Care Law and Policy: Lessons from the Pandemic* (Bristol University Press forthcoming 2024).

68 Coronavirus Act 2020 (Early Expiry) Regulations 2021, para 4.

69 Department of Health and Social Care, 'Coronavirus (COVID-19) Hospital Discharge Service Requirements' (19 March 2020).

70 Ibid para 3.1.

71 See discussion in D Foster, *Coronavirus: Adult Social Care Key Issues and Sources* (House of Commons Library 14 February 2022) para 5.3.

then subsequent funding through the National Discharge Fund until 31 March 2022. The funding was, however, ultimately reduced from a period of six to four weeks. Further funding was announced in autumn of 2023. One concern which has been raised is that of funding being non-recurrent and its impact on planning. The King's Fund Institute, in its 2023 report, notes the words of one respondent from an NHS Trust who stated that:

> All non-recurrent money is effectively useless in my view. Unless you want to pilot something quite whizzy with an uncertain outcome, kind of prove the concept before you then make a case for long-term investment … Non-recurrent money for four months is very hard to use.[72]

These hospital discharge decisions remain the source of incredible controversy concerning the rapid decision to discharge patients. The then Secretary of State for Health and Social Care, Matt Hancock, talked of a 'protective ring' having been cast around care homes.[73] Others have, however, argued that this was far from the case and that rapid discharge decisions in the early weeks of the pandemic effectively 'seeded' the virus into the care homes through the lack of sufficient testing[74] and these discharge decisions were unlawful.[75] The broader issues around these events are currently the subject of the Covid-19 UK Inquiry and go beyond the scope of this article.[76] There were also reports in the early months of the pandemic that in certain areas NHS trusts were discharging patients into hotels,[77] in one report these were called 'Nightingale Care Homes'.[78] It is difficult to evaluate the effectiveness of this as a measure from the information available. However, as we shall see below, the problems in hospital overcrowding led to discharge of patients to hotels in 2023.

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72 A Bayliss, S Bottery, L Tirratelli, S Benniche and L Wenzel, Hospital Discharge Funds: Experiences in Winter 2022–2023 (King's Fund Institute 2023).

73 See UK Covid-19 Inquiry.

74 See eg discussion in M Daly, 'COVID-19 and care homes in England: what happened and why?' (2020) 54(2) Social Policy and Administration 985; S Rajan, A Comas-Herrera and M McKee, 'Did the UK government really throw a protective ring around care homes in the COVID-19 pandemic?' (2020) Journal of Long-Term Care 185.

75 See further *R (Gardner and Harris)* (n 1 above) and V L Moore and L D Graham, 'R (Gardner and Harris) v Secretary of State for Health and Social Care and Others' [2022] EWHC 967: Scant regard for Covid-19 risk to care homes' [2022] 30 (4) Medical Law Review 734.

76 T George, 'Care home being used to look after coronavirus patients leaving hospital' *Manchester Evening News* (4 May 2020).

77 See eg 'Reading Council partners with Holiday Inn to help residents out of hospital' (Reading Borough Council 6 May 2020).

78 H Pidd, 'Care room with a view: UK hotels offer respite to non-Covid patients' *The Guardian* (London 3 May 2020).

Healthwatch, working with the British Red Cross, produced the report '590 people's stories of leaving hospital during Covid-19' which was published in October 2020.[79] The report highlighted a number of advantages to the discharge process which was adopted. These included that of reduced bureaucracy and dedicated funding.[80] There was also more collaboration and 'joined-up' working practices.[81] It noted that information provided regarding the discharge process was clear.[82] There was also praise for the caring nature of the hospital staff. However, despite the rapid discharge processes, in practice delays still remained. These were due to patients having to wait for medication, to problems with transport arrangements, waiting for discharge letters or waiting to see a doctor, all of these being problems which had been highlighted prior to the pandemic.[83] This report also stated that there was no requirement to test on discharge when guidelines came into force until 15 April 2020 and, as they commented, that information, if available, should have been included in discharge information.[84] Sixty per cent of those surveyed had been able to discuss where they were going to be discharged to and were discharged to their preference.[85] Some 28 per cent did not have such conversations regarding placements and what would be their preferred location.[86] There were mixed reports of the ability of families to communicate with hospitals and be involved in discharge decisions.[87] Eight per cent of those surveyed were discharged at night.[88] Of these, some 64 per cent were not asked as to whether they would have liked transport support.[89]

It was also the case that, although the existence of follow-up visits was stressed along with ongoing assessments for health needs, this was not the case for the majority. The British Red Cross 2020 report noted that 82 per cent of those surveyed did not receive a visit from a health or care professional after discharge and some 18 per cent of that group reported that they had 'unmet needs'.[90] An ongoing concern

79 Healthwatch England and British Red Cross, '590 people's stories of leaving hospital during Covid-19' (2020).
80 Ibid 9.
81 Ibid.
82 Ibid 9.
83 Ibid 26.
84 Ibid 28–30.
85 Ibid.
86 Ibid.
87 Ibid 22.
88 Ibid 13, defined as 'after 8pm'.
89 Ibid 8. Hospital transport systems enabling patients to attend scheduled appointments in hospitals or to facilitate hospital discharge operate separately from standard ambulance services.
90 Ibid 18.

also related to the viability of the care home market itself and whether care homes would have the necessary capacity. Thus, while the Covid pandemic provided on its face a highly effective illustration as to how rapid hospital discharge could be undertaken in terms of patients leaving hospital, it also provided a notable cautionary tale of the risks of rapid discharge processes without facilitating strong support and undertaking very careful risk assessments and the need for follow-up in relation to patients' needs.

HOSPITAL DISCHARGE DECISIONS 'POST PANDEMIC' AND THE HEALTH AND CARE ACT 2022

Reform of the law concerning hospital discharge was introduced in the form of section 91 of the Health and Care Act 2022 introducing a new section 74 into the Care Act 2014. This provision came into force on 1 July 2022.[91] It also needs to be read in conjunction with the Hospital Discharge and Community Support Guidance. This was originally published on 31 March 2022 and was then revised in January 2024.[92] What will this mean for patient choice and ensuring individual wellbeing as required by the Care Act 2014?

Section 74 of the Care Act 2014 as amended by the 2022 Act places a new duty upon NHS trusts and NHS Foundation Trusts to involve carers and patients, including young carers, when undertaking discharge planning.[93] This duty applies where the adult patient is likely to need care and support after discharge and where the hospital Trust considers it appropriate to involve them or their carers in planning for discharge. This should be done as soon as feasible. The current Hospital Discharge and Community Support Guidance places emphasis upon a model best meeting local needs in the light of the affordability of existing budgets.[94] The Guidance also highlights the prospect of access to additional funding mechanisms such as the Better Care Fund, which may facilitate integration of health and social care.[95] The Guidance takes forward the discharge to assess model. The aim is to ensure that existing funding arrangements are put in place in accordance with statutory duties.[96] The aim is to involve multidisciplinary teams in

91 The Health and Care Act 2022 (Commencement No 2 and Transitional and Saving Provision) Regulations 2022, SI 2022/734, s 2(a).

92 Department of Health and Social Care, The Hospital Discharge and Community Support Guidance updated 26 January 2024.

93 Care Act 2014, s 74(1).

94 Ibid.

95 Better Care Fund.

96 In addition to the Care Act and NHS CHC provisions, there is also a need to consider provision of services under the Mental Health Act 1983.

the discharge process and also to work along with social workers. The Guidance also stresses the need for the relevant infrastructure to be developed in local areas to support discharge[97] which can be seen in light of the statutory obligations for NHS and local authorities to co-operate together in safeguarding population health and welfare.[98] It is also stated that discharge 'requires active risk management across the system'.[99] There is also emphasis on the need for information-sharing by NHS and social care teams 'in a secure and timely way to support best outcomes'.[100]

The Guidance states in section 2 that both NHS and local authorities 'should ensure that where appropriate, unpaid carers and family members are involved in discharge decisions'. There is emphasis placed on asking individual who they want to be informed and also included in relation to such decisions and give their consent.[101] It also notes the need for effective systems to be utilised to identify if there are young carers involved and the obligations on local authorities to undertake their statutory obligations to young carers' needs.

At the heart of decision-making is the need to recognise the choice of the person being discharged yet this can also be qualified in a particular situation. The National Health Service Act 2006 also states in section 14Z37 that there is a 'duty as to patient choice' which provides that:

> Each integrated care board must, in the exercise of its functions, act with a view to enabling patients to make choices with respect to aspects of health services provided to them.

The Hospital Discharge Guidance engages with the question of choice. It emphasises the need for early conversations regarding where an individual should be discharged to with discharge planning to begin on either admission or before procedures elective in nature take place.[102]

Discharge planning includes information regarding the range of post-discharge care. The essence of this Guidance, as with the previous Guidance is the aim of discharge 'to the right place, at the right time and with the right support'.[103] Moreover, NHS providers and local authorities are to 'support people to be discharged in a timely and safe way as soon as they no longer require care in NHS acute hospitals, NHS community hospitals and virtual wards', but the Guidance stresses that

97 Department of Health and Social Care, The Hospital Discharge and CommunitySupport Guidance updated 26 January 2024, s 5.

98 National Health Service Act 2006, s 82.

99 2024 Guidance (n 97 above), s 9.

100 Ibid s 11.

101 Ibid s 2.

102 Ibid s 3.

103 Ibid s 4.

'No person should be discharged until it is safe to do so.'[104] As with the previous Guidance Annex B of the latest Guidance sets out four main 'pathways' for hospital discharge which draw upon the approach adopted to discharge categories during the Pandemic.[105] Pathway 0 is seen as essentially straightforward discharge home. This will not require involvement of a Care Transfer Hub. Pathway 1 relates to home discharge coordinated by the Care Transfer Hub which involves, for example, short-term intermediate care for such things as reablement. It can also extend to returning to an existing care home placement where the patient will receive 'time limited, short-term care'.[106] Pathway 2 concerns again discharge coordinated through the Care Transfer Hub 'to a community bedded setting with dedicated health and /or social care and support',[107] this is for a limited time period with the aim of facilitating rehabilitation and recovery. The final category, that of Pathway 3, concerns 'In rare circumstances, for those with the highest level of complex needs, discharge to a care home placement.'[108] Again this is to be coordinated by the Care Transfer Hub.[109] The difference from the previous Guidance was that the earlier version had included the estimated percentage of patients to be allocated to a specific pathway.[110] However, the Guidance does not provide very specific tight time limits for each part of the discharge process in contrast to the approach taken earlier in the Pandemic.

In relation to needs assessments, it is stated in section 8 of the Guidance that:

> It is best practice to determine a person's immediate recovery needs and put in place a plan on how to meet them prior to discharge. It is best practice to initiate assessments of longer-term health and/or social care needs during the period of recovery and complete them only once a point of recovery and stability is reached.[111]

The approach taken in relation to palliative and end of life care assessments can be different, particularly where life expectancy is cut short and in such situations 'personalized care plans' are to be provided and regularly updated.[112] This may mean, for example, that a person

104 Ibid s 7.
105 Ibid annex B.
106 Ibid.
107 Ibid.
108 Ibid.
109 Ibid.
110 In the original Guidance: Pathway 0 was initially anticipated to be minimum of 50% of those discharged; pathway 1, a minimum 45%; Pathway 2 a maximum of 4%; and Pathway 3 no more than 1%.
111 2024 Guidance (n 97 above), s 8.
112 Ibid s 10.

with days to live is discharged with plans for 24-hour nursing care and/or a hospital bed for use at home.

Discharge decisions can be challenging if they lead to disputes as to what ultimate destination for the patient is appropriate. The Guidance states that:

> Even where a professional (including medical professionals and social care professionals) disagrees with a person's choice, in most cases a person who has mental capacity to decide what care and support they would like on discharge will make the final decision. If an individual with the relevant capacity refuses the provision of care then ultimately this decision should be respected.[113]

The need to respect a decision made with capacity is reinforced elsewhere in the Guidance.[114] Interestingly, there is also reference that NHS and social care professionals:

> should ensure that safety netting is provided whereby the individual is provided with advice on discharge. The person should be given the contact details of someone who they can talk to about their discharge and advised to make contact if they are concerned about anything.[115]

It is hoped that these systems do work effectively given concerns noted as discussed earlier in this article suggesting problems in this element of the discharge process.

In terms of choices as part of discharge planning, the Guidance recognises that these are to be seen as those which are "suitable for a person's short-term recovery needs and available at the time of discharge".[116] Early planning conversations are to take place following personalised care principles, with the patient being given support to make such choices. Discharge decisions can be challenging if they lead to disputes between family members as to what ultimate destination for the patient is appropriate. The Guidance states that:

> Where there is disagreement between a person and their unpaid carers or family members and the appropriate professional has no reason to consider that the person lacks capacity to make decisions relevant to their discharge then the matter will need to be resolved, hopefully through informal agreement.[117]

This is an interesting departure from the previous Guidance document which states that:

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113 Ibid s 4.
114 Ibid s 9.
115 Ibid.
116 Ibid s 12.
117 Ibid.

> If there is disagreement between that person and carers and family members—their own decision is to be respected.[118]

There are also other ways in which a choice at this point may be seen as at least constrained. The patient is essentially marooned in hospital. It will be their relatives or friends who will be, for example, undertaking viewings of care homes and then providing that information back to the person in the ward. The precise choice available will be reflected as to whether this is a self-funded service or whether it is funded through social services. The cost of certain care homes may be seen as prohibitive and will not fall within the amount local authorities would fund. Moreover, even if local authority funding is available, care homes may ask relatives to pay an additional sum of money in the form of what is known as a 'top up' fee.[119] The other difficulty is that, due to facilitating a rapid discharge, a patient may be moved to a specific temporary location until a more permanent solution can be found, even though the patient themselves may be unhappy about this.

The Guidance highlights that choice may also be limited in some situations such as including "times of extreme operational pressures-for example if a level 4 (national incident) is declared".[120] In such a situation the Guidance states that a record should be produced setting out the criteria needing to be taken into account in such a situation.[121] The Guidance also highlights that:

> People do not have the legislative right to remain in a hospital bed if they no longer require care in that setting, including to wait for their preferred option to become available.[122]

The limits of patient choice and that patients cannot insist they remain in their hospital bed where it is not clinically appropriate for them to remain was confirmed in the case of *University College London Hospitals NHS Foundation Trust v MB* in 2022 where a patient was challenging a decision that they should be discharged to local authority accommodation which had been specifically adapted along with a care package.[123]

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118 Hospital Discharge and Community Support Guidance 31 March 2022, 25.

119 Clements et al (n 5 above) paras 9.260–9.266.

120 Ibid para 12.

121 Ibid.

122 Ibid.

123 *University College London Hospitals NHS Foundation Trust v MB* [2022] EWHC 882 (QB). See also the earlier cases of *Barnett Primary Care Trust v X* [2006] EWHC 787 QB and *Sussex Community NHS Foundation Trust v Price* [2016] EWHC 3167.

> The present situation does not involve a comparison of the needs of two identified patients. But the decision to withdraw permission for MB to remain in the Hospital is still a decision about the allocation of scarce public resources. Decisions of this kind are a routine feature of the work of hospitals and local authorities, even when there is no public health emergency.[124]

The court also confirmed that this situation was not changed by reference to the Human Rights Act 1998. Chamberlain J held that when taking into account respect for the patient's rights to home and family life under article 8 of the European Convention on Human Rights reference is made to the margin of appreciation which is 'even wider when … the issues involve an assessment of the priorities in the context of the allocation of limited state resources' and that in this situation evidence was such that:

> the interference was justified in order to protect the rights of others, namely those who, unlike MB, need in-patient treatment. Bearing in mind the broad discretionary area of judgment applicable to decisions of this kind, there is no prospect that MB will establish the contrary.[125]

While the legal position is clear, this perhaps understates the emotional complexity which can arise in relation to some of these decisions. Some individuals may be content for a rapid discharge decision to perhaps an interim care facility: others may indeed find this overwhelming. This decision may also relate to circumstances where a patient when originally entering hospital expected to be discharged back to their own home but where, due to changes in clinical circumstances, this will now not be clinically appropriate. This is likely to be exceedingly emotionally challenging for some individuals. Decision makers need also to always bear in mind the importance to the individual themselves in being able to choose ultimately what is their 'home'. Home is a very powerful concept, as Mallett in her extensive and excellent review of the literature highlights.[126] It can be a haven, a place for family and, critically, a place for self-identity and being. In terms of hospital discharge, we see decisions and choices through a clinical and administrative pragmatic frame. This frame is constrained by resource allocation decisions. Yet, it is the case that decision-making, both in discharge decisions and also in the needs assessment process outside hospital, would be enriched by truly engaging with what the individual patient themselves sees as being 'home'.

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124 *University College London Hospitals* (n 123 above) para 56.

125 Ibid.

126 See further S Mallett, 'Understanding home: a critical review of the literature' (2004) 52(1) Sociological Review 62.

A further issue is the extent to which hospital staff themselves will be happy with this process and indeed the extent to which decisions sit effectively with their professional roles. What was notable was that the Healthwatch and British Red Cross Report findings stated that:

> Hospital staff reported that the removal of patient choice over where they were to be discharged to made them feel uncomfortable, due to their inability to accommodate patient and family preference and some patients being distressed at being placed in unfamiliar settings.[127]

It is too early to say whether this will also be felt under the new Health and Care Act provisions, but this must surely be a real concern and something where there will need to be further review going forward.

Specific reference is also made to discharge decisions concerning persons who may lack mental capacity.[128] If an assessment is made where someone lacks capacity, as the Guidance notes, then the decision taken must be in that person's best interests.[129] The Guidance states: 'No one who lacks mental capacity should be discharged to somewhere assessed to be unsafe, and the decision maker should make a record of the decision.'[130]

Furthermore, it goes on to provide that:

> Onward care and support options which are not suitable (for example, those not considered clinically appropriate) or available (for example, placements which are not available) at the time of hospital discharge should not be considered in either mental capacity assessments or 'best interests' decision making.[131]

Choice is, thus, choice within the options which are determined appropriate and available. The Guidance also makes reference to the fact that an independent advocate appointed under the Mental Capacity Act 2005 may also be involved in this process.[132]

How effective the new statutory provisions will be in facilitating rapid discharge from hospital while facilitating patient choice as far as possible remains to be seen. The early period of the legislation was not propitious. Hospitals in winter 2022–2023 were again overwhelmed by the numbers of patients with consequent shortages of available beds which led to the Government announcing that it was providing:

> up to £200 million of additional funding to immediately buy short-term care placements to allow people to be discharged safely from hospitals

127 Healthwatch England and British Red Cross (n 79 above) 25.
128 2024 Guidance (n 97 above), s 9.
129 Ibid.
130 Ibid.
131 Ibid.
132 Ibid.

into the community where they will receive the care they need to recover before returning to their homes.[133]

Further evidence of the demands experienced by hospitals in winter 2022–23 was demonstrated in press coverage at that time which included January 2023 reports that in a number of areas in England – those of Bristol, Cornwall and Devon – individuals were being discharged into hotel accommodation, so called 'care hotels'.[134] Bristol, North Somerset and South Gloucestershire Integrated Care Board indicated that these would be operational until the end of March 2023, provided by Abicare – a registered provider of home care services – and also NHS rehabilitation and primary care staff. It will be interesting to see if this is followed in the future.[135] The Health Foundation, in its March 2023 report 'Why are delayed discharges from hospital increasing? Seeing the bigger picture', indicated that far from the position improving, delayed discharges were increasing.[136] It noted that in December 2022 there were 13,000 beds occupied by patients who were fit for discharge of the approximately 100,000 beds in English hospitals, and this was a 57 per cent increase compared with 2020. It found that the key issue in delay was not in fact social care with the percentage of patients who were still waiting for social care remaining at around 37 per cent between February 2022 and December 2022. The Health Foundation saw the issue of delayed discharge being related to a range of reasons which it suggests relate to NHS pressures which in turn impact on capacity to undertake discharge assessments, plans and co-ordination of discharge itself. The report said that a high level of bed occupancy and pressures on non-acute care, along with discharge processes operating sequentially rather than in parallel, were inhibiting the discharge process.[137]

A further very important issue highlighted in earlier reports and events, as noted above, is the need to ensure that discharges are safe. The Guidance emphasises that discharges should be safe, and there is to be 'active risk management across the system'. It acknowledges

133 Department of Health and Social Care, Helen Whately MP and Rt Hon Steve Barclay MP, 'Up to £250 million to speed up hospital discharge' (Press Release 9 January 2023).

134 Denis Campbell, 'Hospitals in England discharging patients into '"care hotels"' *The Guardian* (London 5 January 2023).

135 It is interesting that the fact that these hotels are part hospitals/care facilities as well as hotels is highlighted in reviews in Trip Advisor in relation to one of the hotels in Plymouth which was included as a 'care hotel'. See 'Half hotel/half hospital' and 'Fine, but be aware it's a part time hospital'.

136 F Cavallaro, F Grim, L Allen, J Keith and C Tallack, 'Why are delayed discharges from hospital increasing? Seeing the bigger picture' (Health Foundation 3 March 2023).

137 Ibid.

that there were problems in the past regarding discharge but states that 'individuals and local factors will determine how best to manage risks'.[138]

Safety is clearly critical to ensure that there is not a repeat of some of the unsafe discharge decisions highlighted, for example, in the Healthwatch and British Red Cross report discussed above. It is, of course, important that these decisions are rooted in clinical considerations and not unduly influenced by other policy concerns. In April 2023, Portsmouth NHS Trust faced a media backlash after offering 'Easter goodies' to staff who facilitated rapid discharge of patients in the lead-up to Easter and the planned junior doctors strike in early April, with nurses in the trust expressing anxiety about the prospect of patients being discharged before they were ready.[139] There will be an inevitable concern to ensure that rapid discharge is not in the future associated with emergency readmission, which in itself can impose notable strains on the NHS.[140] The issue of safe discharge was again highlighted in a Healthwatch survey (published in November 2023) of 583 people – patients and carers – who had been involved in hospital discharge in the previous 12-month period.[141] This gave further illustrations not only of continued delayed discharge but of lack of reablement support and patients being discharged in the early hours of the morning in freezing conditions with no care from relatives or others being put in place.

CONCLUSIONS

As we have seen, policy decisions regarding the approach taken to hospital discharge decisions have a long and problematic legacy. While the Covid years facilitated fast discharge from NHS hospitals, they also raised challenging questions as to the nature of safe and effective discharge decisions. Moreover, as we have seen, 'fast' does not necessarily equate with effective discharge if it ultimately results in unduly rapid readmission to hospital. The need for safe discharge

138 2024 Guidance (n 97 above) 22.

139 J McKay, 'Hospital faces backlash after offering chocolates to discharge patients rapidly' (*Nursing Notes* 7 April 2023).

140 This in turn relates to questions as to factors which correlate with emergency re-admission which is a complex issue. In addition it has been argued that lower rates of emergency admission were also related to patients' ability to access their GP surgery by phone and their ability to see their preferred GP; and see also the findings of the Health Foundation in its briefing, S Deeny, T Gardner, S Al-Zaidy, I Barker and A Steventon, *Reducing Hospital Admissions by Improving Continuity of Care in General Practice* (Health Foundation 2017).

141 'NHS urged to do more to help patients leave hospital safely' (*Healthwatch Blog* 20 November 2023).

in general is critical, and this remains an ongoing concern as reports such as those of Healthwatch and the Red Cross have highlighted. The question of effective resourcing for this exercise is, in addition, clearly critical with the need for appropriately planned funding. Linked to this is the importance of reablement in attempting to avoid subsequent readmission, and this in turn relates to whether there are effective resources made available in the community for this to be undertaken at a time when there are notable staffing shortages in health and social care.

The various legislative measures over the last two decades regarding hospital discharge only address one part of the issue. Hospital discharge decisions are not simply a question of procedures to move people beyond the walls of a hospital as fast as possible once it is clinically determined that they should no longer remain there, but relate to a myriad of other issues. Why did the patient receive hospital treatment, and, indeed, could this have happened earlier but in a community setting through the work of general practitioners (GPs)? NHS workforce capacity remains a real challenge with a shortage in the number of GPs and other health and social care professionals.[142] As the King's Fund has noted, the number of NHS hospital beds has itself halved over the last 30 years in a period of increasing population growth.[143] As we have seen, since the 1970s concerns have been raised in relation to the challenges which may result from an ageing population with complex comorbidities but, despite large amounts of academic engagement, there is a still a lack of comprehensive effective policy to address this question. While people who are 60 years old may no longer be generally regarded as 'elderly', the broader question of how to facilitate healthy ageing remains.[144] Access to social care itself is a major concern. The provision of social care by local authorities has been exacerbated by some 13 years of austerity policies from central government,[145] and the financial position of some local authorities in relation to delivery of services is at a critical level.[146] Whether

142 'The GP shortfall in numbers' (Health Foundation 30 June 2022); see also H Alderwick and A Charlesworth, 'Editorial: A long term workforce plan for the English NHS' (2022) British Medical Journal 377:o1047.

143 L Ewbank, J Thompson, H McKenna, S Anandaciva and D Ward, 'NHS hospital bed numbers: past, present, future' (King's Fund Institute 5 November 2021) originally published in 2017 and updated in both 2020 and 2021.

144 See eg University of Birmingham Policy Commission, Healthy Ageing in the 21st Century (2014).

145 S Warren, 'Austerity 2.0: why it's critical for our health that the government learns the lessons of Austerity 1.0' (King's Fund Institute 1 November 2022).

146 See eg B Rose, 'Bristol care proposals: disabled people fear losing right to live at home' (*BBC News* 22 September 2023); J Murray, 'Birmingham city council declares itself in financial distress' *The Guardian* (London 5 September 2023).

establishing Integrated Care Boards and the broader work of Integrated Care Partnerships in facilitating the work of health and social care will by itself be enough remains to be seen. It is notable that very similar arguments and expectations around integration of health and social care were advanced in the 1990s and early 2000s in relation to Primary Care Trusts.[147] As the Health Foundation report of March 2023 notes, currently the overall broader pressures facing NHS hospitals on a day-to-day basis may mean that in practice this also constrains the ability to undertake rapid discharge.[148]

Finally, where the Health and Care Act 2022 model of discharge to assess may also be particularly problematic relates to what can be tensions between rapid discharge needs and respecting individual patient choice. Lacking full autonomy in relation to discharge decisions, albeit that these may be a temporary move into a specific care setting, can be seen as being very disorientating and frightening for both patients and families. The use of 'care hotels' brings other challenges as to whether individuals will effectively rehabilitate in such an environment. It remains unclear as to whether the push to rapid discharge will lead to more disputes over whether discharge of certain patients should actually take place.[149] When we consider how hospital discharge decisions are undertaken, we need to engage further with the fact that these decisions are not simply a matter of making hospital beds available for others but are critically part of personal choice and the question of choosing 'home'.

147 House of Commons Health Committee Report (n 41 above).

148 Cavallaro et al (n 136 above).

149 Healthwatch England and British Red Cross (n 79 above) 25 found that: 'Care home staff often encountered families refusing to accept their relatives discharge placement as they found it difficult to explain that people no longer had a choice about where they went to after leaving hospital.'