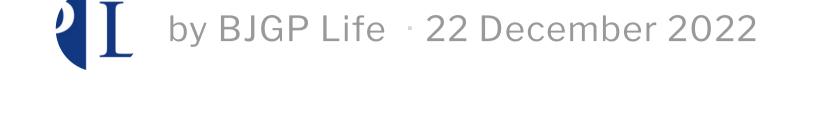
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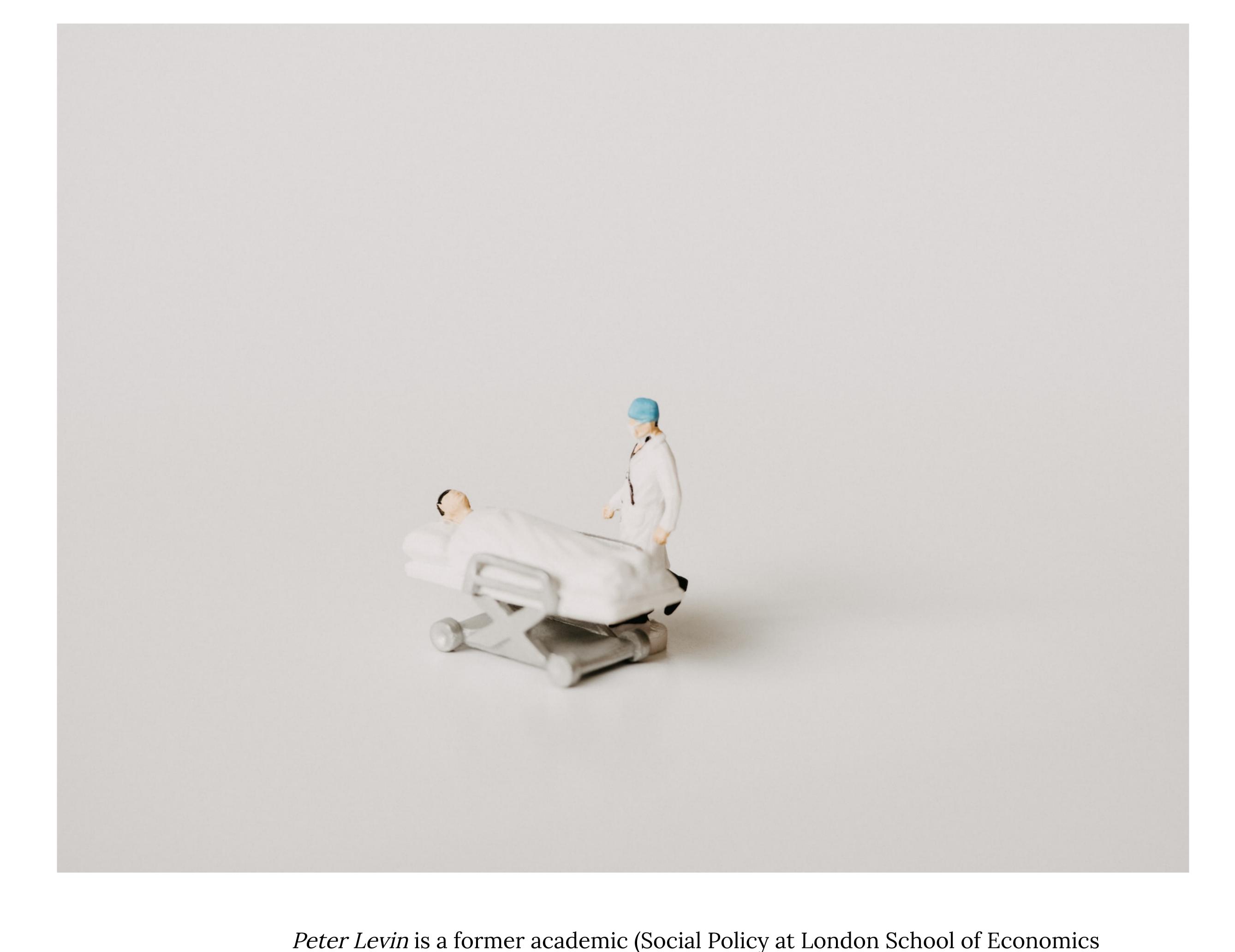
PODCAST

OPINION

'Medically fit for discharge' does not mean 'fit to go somewhere else'



HOME



https://spr4cornwall.net recent analysis of official data by *The Guardian* claimed to show that on average 13 600 beds in NHS hospitals across England are occupied

every day by patients whom doctors say are 'medically fit for discharge'

and Political Science) who lives in Cornwall. You can find their blog at:

(MFFD).¹ People in government and managers in acute hospital trusts have jumped to the conclusion that these patients are ready to go home or to move to a care home or nursing home, blaming the social care system for not providing the resources that patients need to make that transition. But their conclusion does not necessarily follow from the MFFD data. The problem is that the MFFD figures are based wholly on applying clinical criteria, set out in

official guidance issued by the Department for Health and Social Care,² that are all to do with

For example: Does the patient require intensive treatment unit "... patients in or high-dependency unit care? Or oxygen therapy, intravenous hospital for fluids, or medication? Has the patient undergone lower limb

the patient's treatment and recovery. These criteria come in the form of questions.

surgery within 48 hours? Or thorax-abdominal/pelvic surgery within 72 hours? Or is the patient within 24 hours of an invasive procedure, with attendant risk of acute lifethreatening deterioration? If the answer is 'no' to all of these questions then 'acute hospitals must discharge all persons who no longer meet these criteria as soon as they are clinically safe to do so'.3 The problem here is that patients in hospital for treatment, especially older people living with frailty, not only receive treatment for the ailment that they present: they experience what is known as hospital-acquired deconditioning (HAD). The physical manifestations of HAD are

experience what is known as hospitalacquired deconditioning."

treatment...

well-known: loss of muscle strength, balance, and mobility, for example. Less well-known are the psychological manifestations, although these are very apparent in patients' stories: confusion, fear, anxiety, low morale, and lack of interest and motivation. It comes as no surprise that discharge teams have sometimes been found to overprescribe the amount of care that a patient approaching discharge will need on leaving, or that families who witness the damage to physical and mental health that their relative has suffered, come to feel they may not be able to cope with them at home.

well be the best-equipped person to oversee their transfer ... " As we see, then, the criteria to reside are wholly centred on the treatment that a patient has received: they take no account whatsoever of HAD's physical and psychological consequences

"If the patient has a GP who has cared for him or her over a long period and

possibly overseen their recovery from previous treatments, that GP may

reside and is labelled MFFD must by definition be ready to go home or to move to a care home or nursing home. But there is a case to be made that the best judge of how a patient will recover after treatment and fare at home or in a care home or nursing home will be someone who knows that patient

well. If the patient has a GP who has cared for him or her over a long period and possibly

overseen their recovery from previous treatments, that GP may well be the best-equipped

person to oversee their transfer out of the acute hospital, whether to their own home, a care

for the patient. So it certainly cannot be said that a patient who meets none of the criteria to

home or nursing home, or to a local community hospital that provides convalescence facilities. Another possibility would be for the local primary care network to employ specialists in the transfer of patients back to their home community. People with a grasp of the benefits of continuity of care would be far better suited to this role than hospital clinicians whose vision is necessarily confined to episodes of treatment, and who leave to others the task of helping patients to recover from HAD.

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Competing interest

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Peter Levin is a committee member at West Cornwall HealthWatch.

https://spr4cornwall.net/wp-content/uploads/Hospital-Discharge-Service-20-August-2020-Hospital_Discharge_Policy-1.pdf (accessed 13 Dec 2022).

3. HM Government. Hospital discharge service: policy and operating model. 2020.

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