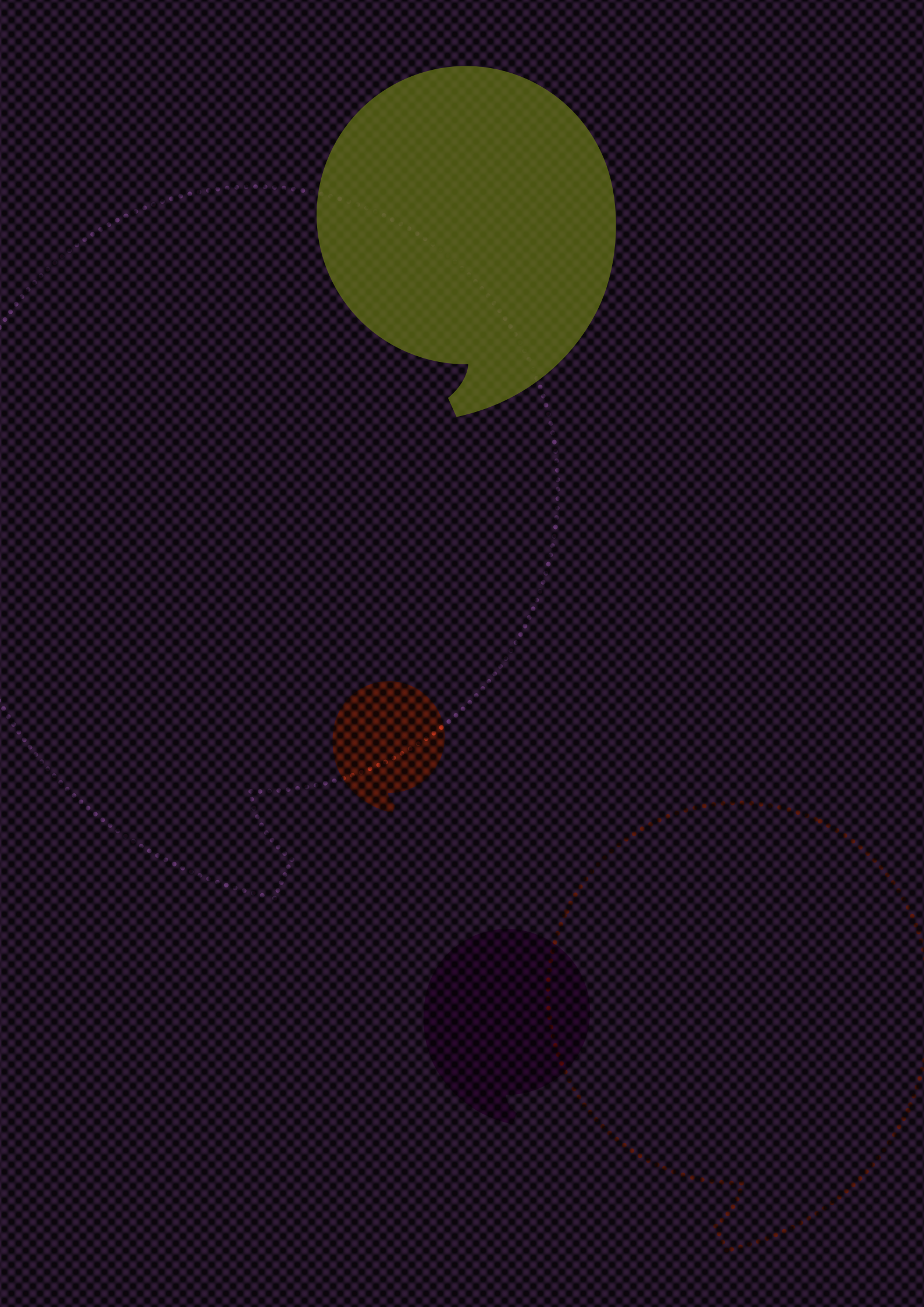
Parliamentary and Health Service Ombudsman

A report of investigations into unsafe discharge from hospital



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Foreword

After a stay in hospital, it should be a relief to get back to the comfort of your own home. But cases we have seen show that this couldn't be further from the truth for some people. These people have been sent home alone unable to cope. They often end up back in hospital, or stuck in hospital because of delays by other services in arranging support or appropriate residential placements.

As the independent organisation responsible for making final decisions on complaints that have not been resolved by the NHS in England, we see the harrowing impact of poorly managed hospital discharges on individuals and their families.

This report focuses on nine experiences drawn from recent complaints we have investigated, which best illustrate the problems we are seeing. The people that have come to us have been badly let down by the system. How else do we describe the actions of a hospital sending a vulnerable 85 year old woman with dementia home without telling her family, despite being unable to feed herself or go to the bathroom? How else do we describe the tragic story of a woman in her late 90s who was discharged without a proper examination, to then die in her granddaughter's arms moments after the ambulance dropped her home?

People told us how their loved one's traumatic experience of leaving hospital, including repeated emergency readmissions, added to their pain and grief. One woman captured the sentiment of many, saying she would be '*haunted for the rest of her life*' by her mother's avoidable suffering before her death.

In our 2011 report on NHS care of older people[1], we found that discharge arrangements could be '*shambolic and ill prepared with older people being moved without their families' knowledge and consent*'. It is disheartening that we continue to see these and other failings regularly in the complaints we receive.

We are aware that structural and systemic barriers to effective discharge planning are long standing and cannot be fixed overnight. Above all, these include the need for better integration and joint working of health and social care services, which have historically operated in silos.

Moreover, the need to reduce the mounting financial and logistical costs to the NHS of delayed transfers of care from hospital mean it is a top priority for policy makers and managers.

However, we are publishing these cases to highlight the *human* costs of poorly planned discharge in terms of patient outcomes and experience, and the untold anguish it can cause their families and carers. These make clear that early discharge without the right support can be just as problematic for people as unnecessary delays.

The people whose stories we tell in our report experienced suffering and distress as a result of poor or absent care. Tragically, some have died and their families want to know what has been learned and what will change as a result of their complaints.

By sharing their stories we want to shine a light on the failings that we have seen and contribute to the national debate about how to improve people's experience of leaving hospital. In response to important contributions by Healthwatch England and others, the Department of Health has recently established a national programme board to develop a vision for improving discharge that all health and social care services can share. We ask the Department of Health and the NHS as part of their work in this area to establish the scale of the problems we highlight in this report, and to understand why they are happening so that others do not have to experience such avoidable and unnecessary suffering.

Dame Julie Mellor DBE
Chair and Ombudsman, Parliamentary and Health Service Ombudsman

May 2016

'People told us how their loved one's traumatic experience of leaving hospital, including repeated emergency re-admissions, added to their pain and grief.'

‘We have selected nine of our most serious cases to illustrate the gap we see between established good practice and people’s actual experience of leaving hospital.’

Introduction

The stories in this report highlight the consequences of health and social care organisations failing to manage people’s discharge from hospital.

In 2014-15 we investigated 221 complaints on this issue - an increase of over a third in complaints in the previous year. We upheld, or partly upheld over half of these. This was significantly higher than our average uphold rate of 37% in the same year. As we are the final tier of the complaints system, we only see a fraction of the total number of complaints made to NHS organisations - those cases that it has not been possible to resolve locally. Across the NHS there were 6,286 complaints on ‘admissions, discharge and transfer arrangements’ in 2014-15, a 6.3% increase on the previous year[2].

We have selected nine of our most serious cases to illustrate the gap we see between established good practice and people’s actual experience of leaving hospital. We do not claim that these cases are representative of practices in all hospitals and councils across England.

However, we believe that these serious cases, alongside the volume of cases coming to us, indicate that this is an area that needs attention. This means understanding why good practice is not being followed in order to make sure everyone experiences acceptable standards of care when leaving hospital.

The most serious issues we have seen are:

Issue one

Patients being discharged before they are clinically ready to leave hospital

The most fundamental decision that clinicians need to make is whether a patient is medically fit to leave hospital. Mistakes made at this point can seriously compromise patient safety, leading to emergency readmissions and, in the most tragic cases, potentially avoidable death.

Issue two

Patients not being assessed or consulted properly before their discharge

While a person may be 'medically fit' to leave hospital, they may not be practically ready to cope at home. If a rounded picture of a patient's needs (including their mental capacity) is not established on admission to hospital and then regularly monitored, they could be sent home alone, afraid and unable to cope.

Issue three

Relatives and carers not being told that their loved one has been discharged

When a loved one is admitted to hospital it can be an extremely worrying time. But it can also be highly distressing to find out that an older and vulnerable relative has been sent home alone, without your knowledge, unable to feed and clean themselves. Many relatives are their loved one's carer, so failing to notify them can have a direct impact on the care they provide, and on their loved one's recovery and wellbeing.

Issue four

Patients being discharged with no home-care plan in place or being kept in hospital due to poor co-ordination across services

Lack of integration and poor joint working between different aspects of healthcare, such as hospital and community health services can result in people being discharged without the support they need to cope at home. Equally, lack of co-ordination between health and social care services can lead to lengthy delays in finding suitable care packages for elderly people with complex needs. This means they can be stuck in hospital wards at the expense of their dignity, human rights and independence.

Discharging people when they are not clinically ready to leave hospital clearly compromises patient safety. However, the service failure we see also includes cases where people have been deemed medically ready to go home, but have not received the care they need after this, often down to poor planning, co-ordination and communication.

This causes avoidable distress for patients, their families and carers, which has a negative impact on overall patient experience. As the National Quality Board has noted, across the NHS, '*there is still some way to go before experience is viewed as equal to clinical effectiveness and safety*'[3]. Experience is shaped by the 'relational' aspects of care: how an individual and their family are communicated with, whether they are helped to understand treatment and care pathways, and whether they feel they are treated with dignity and respect.

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.'*

There is no shortage of clear guidance on what effective discharge planning should look like (an overview is provided in the box opposite). Yet our casework shows clear examples of trusts and local authorities failing to put it into practice.

Making sure people leave hospital in a safe and timely way: what should happen?

Best practice guidance has been consistent over the past decade in stating that '*discharge is a process and not an isolated event at the end of the patient's stay*'[4]. The key steps and principles identified to enable appropriate discharge include:

- Starting discharge and transfer planning before or on admission to hospital, to anticipate problems, to put appropriate support in place and agree an expected discharge date.
- Involving patients and carers in all stages of the planning, providing good information and helping them to make care planning decisions and choices.
- Effective team working within and between health and social care services to manage all aspects of the discharge process, including assessments for social care, continuing health care and, where necessary, assessments of mental capacity.
- Community-based health and social care practitioners should maintain contact with the person after they are discharged, and make sure the person knows how to contact them when they need to.

Guidelines published by the National Institute for Health and Care Excellence in December 2015, on transition from inpatient hospital settings for adults with social care needs, also recommend that a single health or social care professional should be made responsible for co-ordinating a person's discharge[5]. The discharge co-ordinator should be the central point of contact for other health and social care professionals, the person and their family during discharge.

The problems we have highlighted from our cases reflect findings from other recent reports on hospital discharge and transfers of care. Healthwatch England's *Safely Home?* report[6] found that one in 10 trusts do not routinely notify relatives and carers that someone has been discharged, and that one in eight people did not feel they were able to cope in their own home after being discharged from hospital. Conversely Age UK estimate that older patients have spent 2.4 million days over the last five years '*stuck in hospital beds*' due to a lack of appropriate social care placements and support[7]. Delayed discharges from hospital are estimated to cost the NHS around £900 million per year.

Tackling these delays is understandably a key target for efficiency gains for the NHS. However, there is a growing body of research that suggests hospitals may be inadvertently moving people on from hospital too quickly in order to meet efficiency targets. According to the Kings Fund '*being discharged without proper support is an invitation to relapse, a worsening of their condition and re-admissio*n'[8]. While it is currently harder to capture the precise financial cost of premature discharge, the National Audit Office estimated that emergency re-admissions cost the NHS £2.4 billion in 2012-13[9] .

We recognise there have been a range of recent initiatives to improve the discharge process. This includes specific requirements introduced under the *Care Act 2014,* NHS England's *Patient Safety Alert* on risks arising from breakdowns in communication during discharge, the new NICE guideline[10], and forthcoming Quality Standard on transition between inpatient and community care or care home settings.

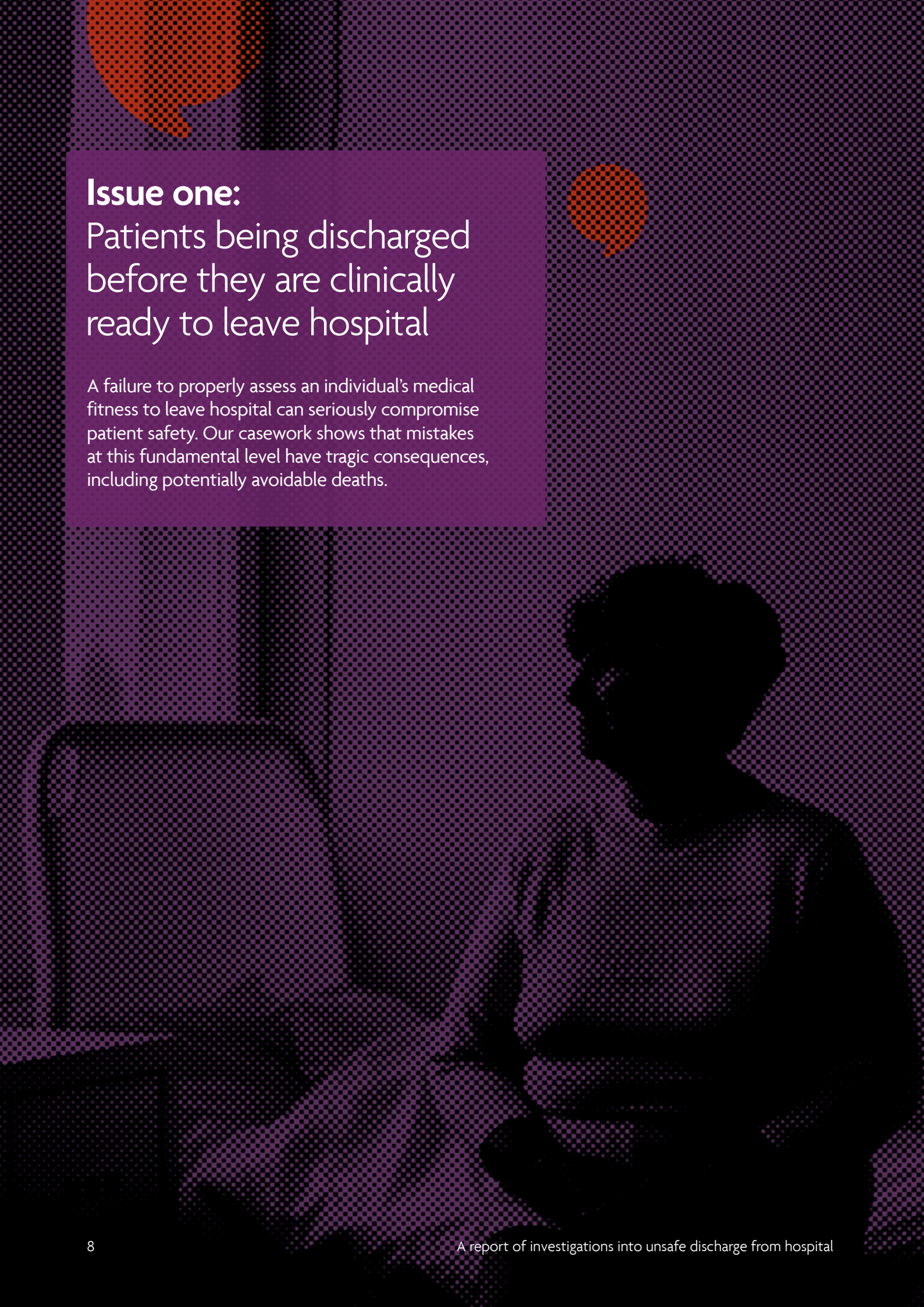
However, we agree with Healthwatch England that '*with all the guidance that is already available, it is not clear why further individual initiatives will make a difference without something more fundamental changing in the system*'[11].

The cases that follow illustrate a range of serious failings across the discharge planning pathway involving a range of health and social care services. While specific guidance is useful, we believe there needs to be system wide leadership and shared ownership across health and social care services to improve transfers of care from hospital. This starts with understanding the scale and root causes of failures to follow established good practice, so that all providers can be brought up to standard.

The Department of Health's recently established national programme on improving discharge provides a vital opportunity for these problems to be addressed holistically[12]. The programme brings together key NHS and social care organisations to develop a vision for improvement, which should enable all health and social care professionals to put the needs of patients and their carers at the forefront of discharge planning. We set out in the conclusion key issues from our casework that should be addressed in developing this vision.

Issue one: Patients being discharged before they are clinically ready to leave hospital

A failure to properly assess an individual's medical fitness to leave hospital can seriously compromise patient safety. Our casework shows that mistakes at this fundamental level have tragic consequences, including potentially avoidable deaths.



Mrs T died in her granddaughter's arms after being discharged too soon with severe stomach pain

What happened

Mrs T, who was in her late 90s, fell ill at home. Her granddaughter called a GP to see her, who diagnosed a bladder infection and also noticed that Mrs T's stomach was swollen. She became unwell overnight so her granddaughter called an ambulance who took Mrs T to hospital. The ambulance crew also noticed Mrs T's stomach was swollen. At the hospital Mrs T was examined by a doctor who ordered a urine test but did not focus on the severe stomach pain she was having. Mrs T was told she had a bladder infection. She was discharged and the doctor advised her to drink more fluids.

Just after the ambulance had dropped her home and left, Mrs T collapsed and died in her granddaughter's arms. A post mortem showed Mrs T had died from an infection in her large intestine and an infection of the tissue that lines the tummy; symptoms of both included abdominal pain.

What we found

Mrs T was very unwell and had the doctor physically examined her stomach, it's highly unlikely that she would have been sent home. If she had been examined, it would have been clear to Mrs T's family that she was very ill and that there was a risk of her dying. Instead she was discharged home where she died suddenly, causing Mrs T's granddaughter a great deal of shock and distress.

> 'Just as the ambulance left, Mrs T collapsed and died in her granddaughter's arms.'

A man died after a hospital failed to treat sepsis appropriately

What happened

Mr L went into hospital with a painful lump on his buttock, and tests showed that it was infected. Doctors tried unsuccessfully to remove fluid from the lump but decided there was no need to send Mr L to the operating theatre to have the lump surgically drained. The hospital discharged Mr L home with antibiotics. He returned to hospital three weeks later with intense pain in his foot and was found to have an infection (sepsis), which had spread. Mr L died four days later.

Mr L's daughter complained to the hospital, because she felt that more could have been done to treat and care for her father and that he should not have been discharged so soon. The hospital acknowledged that the infection had probably originated in the lump on Mr L's buttock. However, it felt this had been treated appropriately and that the infection he had on his second admission was unlikely to have been caused by any treatment he had when he first went into hospital.

What we found

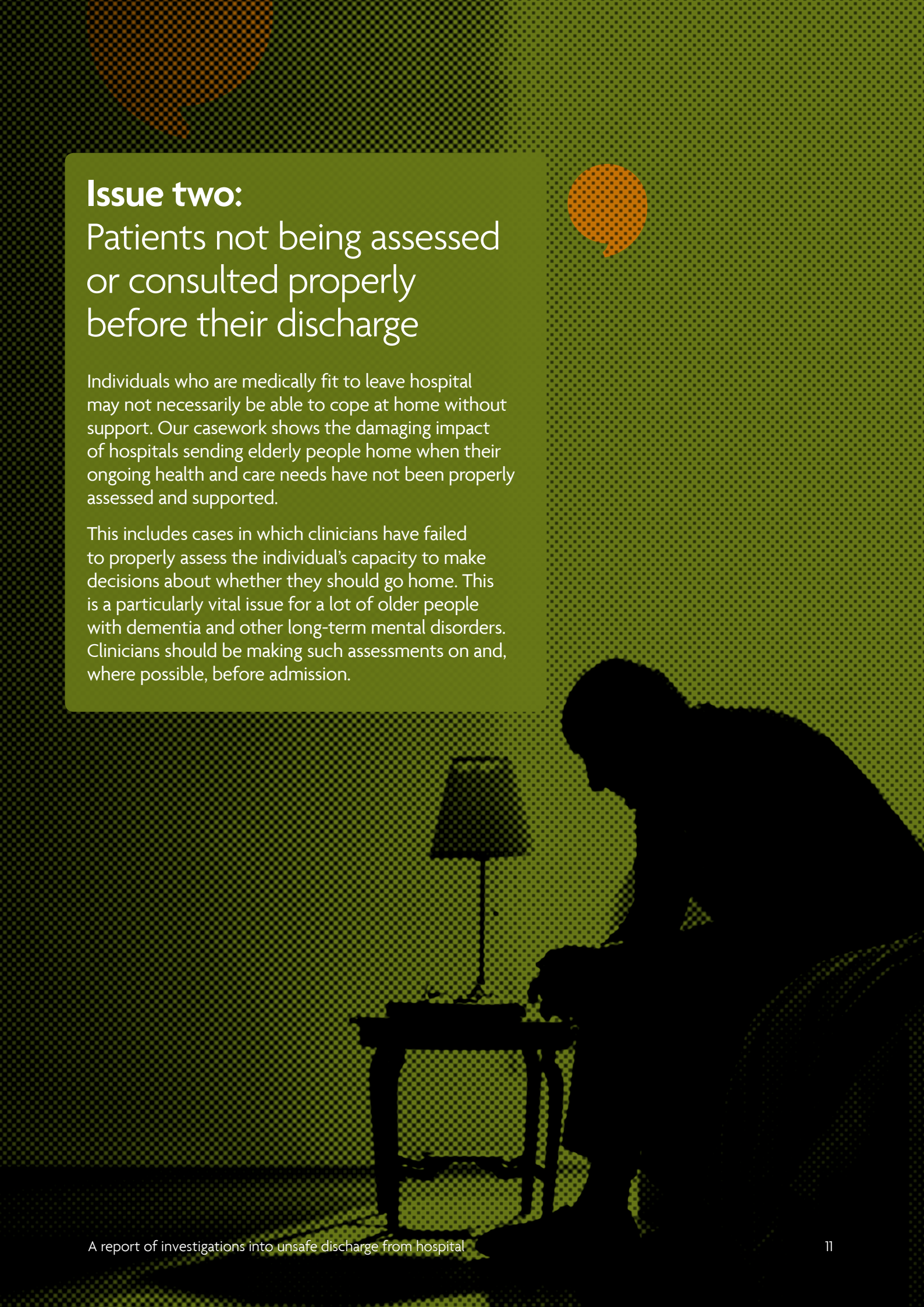
Mr L showed signs of sepsis on his first admission, so he should have been kept in hospital and his lump should have been surgically drained. We felt that had he been treated appropriately, he may not have developed sepsis and died. This failing by the hospital caused Mr L's family considerable distress.

'Mr L showed signs of sepsis on his first admission, so he should have been kept in hospital.'

Issue two:
Patients not being assessed or consulted properly before their discharge

Individuals who are medically fit to leave hospital may not necessarily be able to cope at home without support. Our casework shows the damaging impact of hospitals sending elderly people home when their ongoing health and care needs have not been properly assessed and supported.

This includes cases in which clinicians have failed to properly assess the individual's capacity to make decisions about whether they should go home. This is a particularly vital issue for a lot of older people with dementia and other long-term mental disorders. Clinicians should be making such assessments on and, where possible, before admission.



A frail woman fell several times after being repeatedly sent home against her wishes.

What happened

Mrs Z was an 80-year-old woman who lived alone and had Parkinson's disease and dementia. She had a history of depression and had attempted suicide on several occasions. After initially being admitted to hospital following a fall, she was discharged and readmitted three times over a three-month period.

The first time Mrs Z went to hospital, she asked to be sent home. Due to Mrs Z's dementia, an occupational therapist and physiotherapist both expressed uncertainty about whether she had the capacity to make this decision. Despite this, the hospital did not assess her capacity before discharging her home. Eight weeks later, Mrs Z came back to hospital, following another fall.

A nurse and a social worker were unable to agree if Mrs Z was mentally able to make a decision on whether to go home or go into residential care. Mrs Z herself was unsure and confused as to whether or not to go home. However, the hospital sent Mrs Z home without resolving the difference in opinion between the nurse and the social worker, and without arranging a full assessment of Mrs Z's capacity to make a decision.

Mrs Z fell within hours of returning home. She begged her daughter to send her back to hospital and said that she planned to end her life if she didn't. While in hospital, she told a doctor about her suicidal thoughts and asked to be placed in a care home. For a third time, Mrs Z was discharged without being properly assessed and once home, she fell again. Mrs Z said she would rather die than return to the hospital and so she was admitted to another hospital instead, where she stayed until her death three weeks later.

What we found

We found that the hospital repeatedly failed to properly assess whether Mrs Z was mentally able to decide on her own living arrangements. Mrs Z was discharged home three times, despite her frailty and, on the third occasion, this was done against her will. We concluded that these failings caused Mrs Z and her daughter deep distress. Mrs Z had to endure the upsetting and unpleasant experience of being sent home repeatedly, only to fall or otherwise be unable to cope.

Mrs Z's daughter said she now has nightmares and can't sleep because of what happened to her mother. She said she will be haunted by the way her mother was treated for the rest of her life.

‘She begged her daughter to send her back to hospital and said that she planned to end her life if she didn’t.’

Failings in hospital discharge process meant Mr Y died in pain and discomfort

What happened

Mr Y, who suffered from Parkinson's disease and dementia, was admitted to hospital with a bladder infection. His wife, Mrs Y, originally told the hospital staff that she would take care of him after he was discharged. Later, Mrs Y changed her mind and told the hospital she felt her husband was too unwell for her to be able to care for him properly at home, and hoped that this would delay his discharge.

Four weeks after Mr Y was admitted, the hospital telephoned Mrs Y to inform her that he was medically fit and would be returning home that afternoon. Mrs Y said that she '*begged*' the hospital not to discharge him, but was told that it '*needed the bed*'. Mr Y was subsequently transferred to the discharge lounge at 10am, and an ambulance took him home at 4.50pm.

When Mr Y arrived home, he was unable to walk to the house unaided, and had to be supported by the ambulance crew. He collapsed into a chair, where he slept for the next 36 hours. Mrs Y was unable to rouse him, so she contacted his GP and Mr Y was taken back to hospital. At the time of Mr Y's readmission, it was noted that he had developed a large pressure sore at the base of his spine.

Eight weeks later, Mr Y was transferred to a nursing home. Sadly, he died later that month from heart failure.

What we found

Even though Mr Y was medically fit, the hospital's decision to discharge him when it did was not appropriate. There was no evidence that the hospital discussed Mrs Y's concerns about whether she would be able to care for her husband at home unsupported, and whether Mr Y needed a pressure relief mattress. There was also no evidence that the hospital talked to Mrs Y about why she had changed her mind about caring for her husband at home. Nor was there evidence that Mr Y's views or a social worker's opinion (if Mr Y lacked capacity) on his care package were taken into account, as they should have been.

Although it was reasonable for Mr Y to have been transferred to the discharge lounge to await transport home, there was no evidence that he received any nursing care in the seven hours he remained there. If he had spent those seven hours back on the ward, it is likely that he would have been repositioned regularly. Given that this did not happen, and that Mr Y subsequently spent the following 36 hours sleeping in a chair at home, it was likely that this led to the development of the pressure sore on the base of his spine. It was also likely that, if an appropriate home care plan had been put in place by the hospital, then Mr Y would have been visited by healthcare staff who could have repositioned him regularly, or raised concerns about his lack of movement sooner.

Although we concluded it was unlikely that Mr Y's pressure sore contributed to his death, we felt that it would have caused him a great deal of discomfort and distress in the final months of his life.

A woman in her 80s was discharged from hospital to an empty house, in a confused state with a catheter still inserted

What happened

Mrs F was 84 years old when she was admitted to hospital with a urine infection. She was seen by a consultant who decided she should stay in hospital for three days so that the infection could be treated and staff could monitor her. Despite this, and for reasons that are unclear, Mrs F was discharged later the same day to an empty home and in a confused state. She had been given no medication and still had a catheter inserted.

Mrs F had no family living close by. If her daughter had not asked a neighbour to call in to see her, there could have been very serious consequences for Mrs F. The neighbour contacted the ward sister at the hospital who said Mrs F should not have been discharged. An ambulance came and returned her to hospital.

What we found

It was wrong to discharge Mrs F against the consultant's instructions. There was nothing in Mrs F's medical notes to explain why the consultant's instructions had been changed or who had changed them. This went against recognised standards about record keeping.

The hospital accepted that Mrs F's discharge was inappropriate, and that there was no documentation about the discharge or who arranged or authorised it. However, it failed to get to the bottom of what had happened.

'Mrs F was discharged later the same day to an empty home and in a confused state.'

Issue three: Relatives and carers not being told that their loved one has been discharged

Almost all of the cases we saw highlight failings in communication between clinicians and patients' families. The knowledge that a loved one has been sent home alone and experienced potentially avoidable suffering is extremely distressing for relatives.

Department of Health guidance is very clear that carers should be involved in all stages of the discharge planning process, given good information and helped to make care planning decisions and choices[13].

A hospital transferred a distressed elderly woman to a nursing home and only informed her family a few hours before her discharge

What happened

Miss G was admitted to hospital in winter after a fall. She stayed in hospital until early spring the following year, when she was discharged to a nursing home. Miss G initially refused to be discharged. The Trust did not tell any members of Miss G's family about its decision to discharge her until the morning of the day she was to be discharged.

She was agitated when an ambulance arrived to take her to a nursing home. Eventually she calmed down and agreed to leave hospital in the ambulance. Miss G was discharged in a dishevelled state with a cannula (tube) still in her arm.

What we found

The hospital did not respond appropriately to Miss G's initial refusal to be discharged. The staff should have tried to persuade her to leave, and raised the matter with a doctor or senior member of staff. Instead, a nurse inappropriately said something to the effect of: 'Miss G still has to be discharged'. Staff should have told the family about the decision to discharge Miss G before it happened.

'Miss G was discharged in a dishevelled state with a cannula (tube) still in her arm.'

‘She found that her mother had been left with no food, drink and bedding, unable to care for herself or get to the toilet.’

85-year-old woman with dementia was sent home despite being unable to look after herself or get to the toilet

What happened

Mrs K, an 85-year-old woman who suffered from dementia, was taken to hospital after she experienced vaginal bleeding. Following examinations and blood tests, the hospital sent her home.

Mrs K was transferred to the acute medical unit to wait for an ambulance. An ambulance was booked at 8.48pm; Mrs K's medical notes showed this was before she had expressed her preference to go home. It arrived at 11pm. Although the hospital had been unable to reach Mrs K's son to let him know that they planned to discharge his mother, it let Mrs K go home.

The following morning Mrs K's daughter, Mrs G, visited her at home. She found that her mother had been left with no food, drink and bedding, unable to care for herself or get to the toilet.

What we found

While Mrs K may have been medically fit to be discharged, the hospital failed to consider whether it was safe to send her home when it did. There was no evidence that as part of its decision, the hospital had considered whether Mrs K's home was an appropriate environment to send her back to. We also found that the hospital failed to make sure that appropriate care was available to Mrs K when she arrived home.

Although Mrs K wanted to go home, and had the capacity to decide to leave hospital, by sending her home in an ambulance at 11pm the hospital failed to act in line with its own policy of not discharging older patients after 10pm. The decision to discharge also appeared to have been reached before discussions about this took place with Mrs K. In addition, when the hospital was unable to reach Mrs K's son to inform him that his mother was being discharged, it did not then attempt to contact her daughter – even though her contact details were also available in Mrs K's clinical records.

Considering these factors, we found that the decision to discharge Mrs K was inappropriate, and that the hospital failed to take the right steps to safeguard a vulnerable patient. This led to Mrs K being discharged without the support she needed.

Issue four:
Patients being discharged with no home-care plan in place or being kept in hospital due to poor co-ordination across services

Our casework shows that poor service co-ordination and provision can not only affect people's health but also undermine their dignity and human rights. If people do not have a home-care plan in place, they can be left unable to eat or go to the toilet. Equally if suitable care home placements are not readily available, people can be stuck in hospital wards for weeks and even months at a time.

This experience is extremely distressing for anyone but especially for those with conditions such as dementia. People with such conditions may lack capacity and can be subject to restrictive care arrangements if they exhibit challenging behaviour while in hospital. Such arrangements can amount to a person being deprived of their liberty, which is why it is essential that they are authorised according to relevant legislation and guidance, specifically designed to provide legal protections for vulnerable people.

In our casework we found that division between different aspects of health care, such as acute and community health services can result in people being discharged without the support they need to cope at home. Equally lack of co-ordination and collaboration between health and social care services can result in lengthy delays in finding suitable care packages for older people with complex needs. This means they can be stuck in hospital wards at the expense of their dignity and independence.

Elderly man with dementia was locked on a psychiatric ward for over nine months

What happened

Mr A had vascular dementia and a personality disorder. After a series of incidents at his care home, he was admitted to a psychiatric ward where he remained as an inpatient for two years. Once Mr A was considered fit to be discharged from the psychiatric ward, discussions about discharge arrangements began between the hospital and the council.

The council decided that Mr A was '*beyond social care*' and refused to fund a dementia care nursing home for him. Despite a series of discharge planning meetings between hospital and local authority staff, it was nine months before a suitable nursing home was found for Mr A.

During this time Mr A was stuck in the locked psychiatric ward without the hospital going through the necessary procedure to see whether this was a deprivation of liberty or not. One of his advocates said this made Mr A feel imprisoned.

What we found

A local authority cannot distance itself from its responsibilities because it considers a person's needs or behaviour to be too challenging or complex. Yet by refusing to find a care home for Mr A on the basis that he was beyond the help of social services, this is effectively what the local authority was trying to do.

Attempts by the hospital to try and engage senior managers at the local authority were unsuccessful. Without active input from the local authority it took the hospital longer to find an appropriate placement for Mr A and its job was made much harder as a result.

The delay in finding a care home for Mr A meant the hospital kept him locked on its psychiatric ward without carrying out necessary checks to see if this action meant he was being deprived of his liberty. If the hospital had gone through this process, it would have found that he was indeed being deprived of his liberty and the correct procedure for authorising such restrictive care arrangements would have taken place. That procedure includes a system for reviewing care plans and introducing less restrictive options, including supported access to the community.

Without this review, Mr A was left feeling '*like a prisoner*' for over nine months, adding to the distress and anxiety he was experiencing.

93-year-old woman soiled her bed and then refused to eat or drink after being discharged without mobility support

What happened

Mrs E was a frail 93-year-old woman, with limited mobility and multiple medical problems. She lived at home but was dependent on the support of her family and a privately funded carer, who assisted with routine personal and household tasks.

District nurses referred Mrs E to the Trust's A&E because she had cellulitis (an infection of the skin and the tissues just below the skin surface) of the left leg and had become less mobile. The Trust discharged Mrs E six days later, arriving home at 9.30pm. The live-in carer and the ambulance crew helped her to bed.

According to Mrs E's family she remained in bed, unable to get up until her daughter arrived back at the house at 11.30am the following morning. By this time she had soiled herself and was extremely distressed. She refused to eat or drink because she was unable to get to the toilet.

Mrs E complained about the Trust's management of her discharge. She said that the circumstances of her discharge and the immediate aftermath were extremely distressing for her and the traumatic experience contributed to an accelerated deterioration in her health.

What we found

There was an incomplete assessment of Mrs E's needs on discharge, including a failure to obtain relevant information from Mrs E's family and carer, as required by relevant guidance. There was also a lack of co-ordinated discharge both in terms of communication between staff within the hospital, district nurses and the intermediate care team, which provides clinical support to help people stay at home rather than be admitted to hospital.

This resulted in a lack of appropriate equipment being in place when Mrs E returned home. The Trust made the problems worse when it discharged Mrs E late in the evening.

The failings in the management of Mrs E's discharge caused her needless distress, anxiety and loss of dignity. However, it was not possible to prove that Mrs E's deterioration in health and admission to a nursing home were caused by failings in the discharge process.

‘According to Mrs E’s family she remained in bed, unable to get up until her daughter arrived back at the house at 11.30am the following morning.’

Conclusion

The people featured in this report all experienced care that falls well below established good practice and in some cases statutory requirements. We found that while some people suffered because of avoidable clinical errors, the majority suffered because they did not have the support they needed despite being deemed medically ready to go home.

Our casework on hospital discharge illustrates how failures in communication, assessment and service co-ordination are compromising patient safety and dignity, undermining patients' human rights and causing avoidable distress and anguish for their families and carers.

To summarise we highlight three key areas that warrant particular attention:

1. **Failures to check people's mental capacity and offer legal protections for those who lack capacity**

   Guidance on discharge planning is clear that people's consent to discharge arrangements must be obtained in line with the relevant legislation and guidance. Their mental capacity should (when in doubt) be assessed and recorded, and care arrangements that deprive people of their liberty should be identified and authorised according to the deprivation of liberty safeguards. These safeguards were designed to protect people's dignity and human rights; healthcare professionals should be expected to familiarise themselves with these safeguards as part of their professional duty. It is therefore, deeply worrying that hospitals are not recognising when they are depriving people of their liberty.

2. **Carers and relatives not being treated as partners in discharge planning**

   Failures by hospitals to notify family members that relatives are being discharged are common features of these cases. Families and carers often play an important role in their loved one's recovery process. Therefore, it is vital that hospitals treat them as partners throughout the discharge planning process and don't treat their involvement as an afterthought.

‘we know that complaints about discharge arrangements have increased recently’

3 Poor co-ordination within and between services

Poor co-ordination of the discharge process has led to delayed transfers of care, poor or absent care and emergency re-admissions. Our casework exhibits a lack of joint working at various points across the discharge process: within hospital teams, between acute and non-acute NHS services and between health and social care services. Integration has, of course, been a long-standing policy objective of all governments for many decades but this has proved difficult to put into practice. The new care models programme, at the centre of the *NHS Five Year Forward View*, offers a significant opportunity to break down historic barriers to the way care is provided in England. It is therefore, important that the government uses learning from the new care model pilots, and other recent integration initiatives, to improve people’s transfer of care from hospital.

As the final tier in complaints process we on only see a fraction of the total number of complaints about NHS organisations. However, we know that complaints about discharge arrangements have increased recently, and that the cases we have identified are illustrative of problems highlighted by a number of recent reports by national health bodies and organisations representing vulnerable people.

In response to a clear consensus on the need for system wide leadership on this issue, the Department of Health has recently established a national programme to develop a vision for improving discharge.

This rightly brings together organisations across the NHS and local government, and provides an opportunity to develop a holistic approach to improving patient outcomes and experience of hospital discharge. In developing the vision, the Department of Health and its partners should assess the scale of the problems we have highlighted, identify why they are happening and take appropriate action so that all people experience acceptable standards of care on leaving hospital.

End notes

1 Parliamentary and Health Service Ombudsman (2011), *Care and compassion? Report of the Health Service Ombudsman on ten investigations into NHS care of older people.*

2 Health and Social Care Information Centre (2015), *Data on Written Complaints in the NHS 2014-15.*

3 National Quality Board (2015), *Improving experiences of care: Our shared understanding and ambition.* The National Quality Board brings together the Department of Health, NHS England and key health stakeholders.

4 Department of Health (2010) Ready to go: Planning the discharge and transfer of patients from hospital and intermediate care

5 NICE (2015) Guideline on Transition between inpatient hospital settings and community or care home settings for adults with social care needs

6 Healthwatch England (2015), *'Safely home: What happens when people leave hospital and care settings?'* Healthwatch England Special inquiry findings.

7 Age UK press release issued on 17 June 2015. 4m bed days lost in 5 years from social care delays, available at www.ageuk.org.uk/latest-news/archive/bed-days-lost-social-care-delays.

8 David Maguire, (2015), *Premature discharge: is going home early really a Christmas gift?* The Kings Fund Blog - www.kingsfund.org.uk/blog/2015/12/premature-discharge-from-hospital.

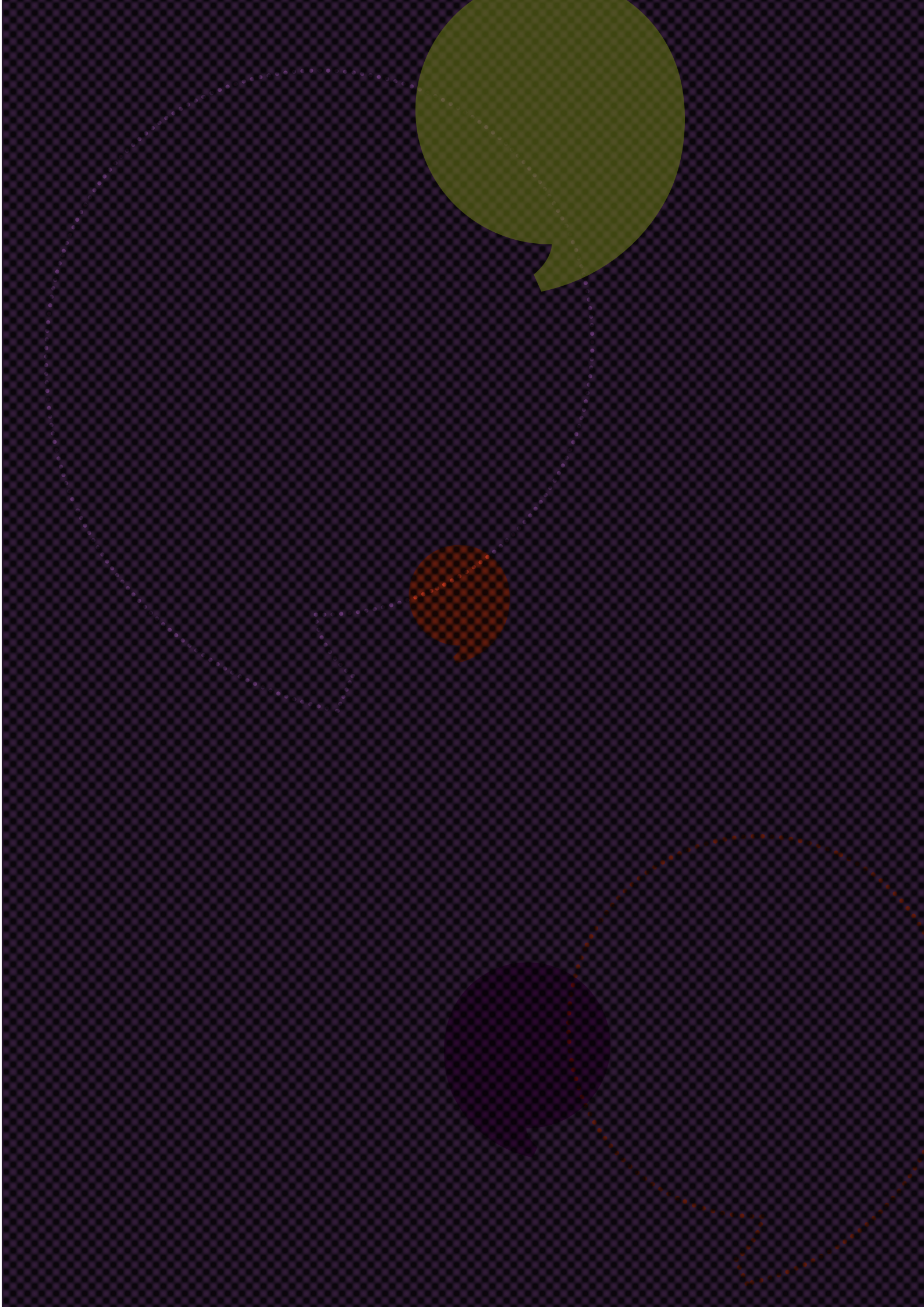
9 National Audit Office (2013), *Emergency admissions to hospital: managing the demand.*

10 NICE (2015), *Transition between inpatient hospital settings and community or care home settings for adults with social care needs.*

11 Healthwatch England (2015), *'Safely home: What happens when people leave hospital and care settings?' Healthwatch England Special inquiry findings.*

12 Healthwatch England (2016) A step closer to getting hospital discharge right - www.healthwatch.co.uk/news/step-closer-getting-hospital-discharge-right

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



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