Patients and their families can have harrowing experiences after discharge from hospital; a Health Service Ombudsman report is calling for improved post-discharge support

Preventing unsafe discharge from hospital

In this article...

- Difficulties patients face on discharge from hospital
- Improving discharge planning
- Cases of poor discharge planning

Author Kathy Oxtoby is a freelance health writer.


A recent report by the Parliamentary and Health Service Ombudsman revealed examples of poor hospital discharge to be considered in light of existing guidance. This article summarises the report's findings and recommendations for good practice when discharging patients.

After a stay in hospital, it should be a relief for patients to return home but a report from the Parliamentary and Health Service Ombudsman (2016) describes extreme cases in which patients and their families have experienced serious problems while waiting for, or after, discharge.

Complaints about hospital discharge difficulties are rising. Across the NHS in England there were 6,286 complaints on admissions, discharge and transfer arrangements in 2014-15 – up 6.3% on the previous year (Health and Social Care Information Centre, 2015). The PHSO – the independent organisation that makes the final decision on complaints that have not been resolved by the NHS in England – investigated 221 complaints on this issue in 2014-15; this was up by more than a third on the previous year. The PHSO upheld, or partly upheld, over half of these complaints.

The report made clear that early discharge without the right support can be as problematic for patients as unnecessary delays, and highlighted the consequences of health and social care organisations failing to manage patients’ discharge from hospital. By sharing these stories, the PHSO aims to shine a light on the failings seen, and help improve patients’ experiences.

Serious hospital discharge issues

- Patients discharged too early
- Patients not assessed or consulted properly before discharge
- Relatives and carers not told their relative has been discharged

Serious discharge difficulties include patients being discharged too early, and not being assessed or consulted properly beforehand.

System-wide leadership and shared ownership across health and social care are needed to improve transfers of care from hospital.

Discharge and transfer planning should be started before or on admission.

Community health and social care staff should maintain contact with patients after discharge.

In this article...

Difficulties patients face on discharge from hospital

Improving discharge planning

Cases of poor discharge planning

5 key points

1. Complaints about hospital discharge are rising according to the Parliamentary and Health Service Ombudsman.

2. Serious discharge difficulties include patients being discharged too early, and not being assessed or consulted properly beforehand.

3. System-wide leadership and shared ownership across health and social care are needed to improve transfers of care from hospital.

4. Discharge and transfer planning should be started before or on admission.

5. Community health and social care staff should maintain contact with patients after discharge.

Discharge can create problems if it occurs before a patient is ready to leave hospital.
patients are discharged they may be unable to feed and clean themselves. Many relatives are carers, so failing to notify them can have a direct impact on the care they provide.

**Patients discharged with no home care plan, or kept in hospital due to poor coordination across services**

Lack of integration and poor joint working between, for example, hospital and community health services can mean patients are discharged without the home support they need. Equally, lack of coordination between health and social care services can lead to 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, human rights and independence.

**Improving discharge planning**

The report highlights that there is no shortage of clear guidance on effective discharge planning. Examples of such are that from the National Institute for Health and Care Excellence (2015) and Maguire (2015). However, the PHSO has dealt with cases it believes show clear examples of trusts and local authorities failing to implement guidance. The problems highlighted in the report reflect findings from other recent reports on hospital discharge and transfers. Healthwatch England (2015) reported that one in 10 trusts do not routinely notify relatives and carers that patients have been discharged, and one in eight patients did not feel able to cope at home post discharge. Age UK (2015) stated that older patients 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. According to the King’s Fund, “being discharged without proper support is an invitation to relapse, worsening of the condition and re-admission” (Maguire, 2015).

Based on its findings from case studies the PSHO has identified best practice to enable appropriate discharge (Box 2). It also calls for system-wide leadership and shared ownership across health and social care services to improve transfers of care from hospital. This approach would start with understanding the scale and root causes of failures.

**The PHSO believes the Department of Health’s recent programme on improving discharge is a chance to address these problems. It brings together key NHS and social care organisations to develop a vision for improvement, to enable all health and social care professionals to put the needs of patients and their carers at the forefront of discharge planning. In developing that vision, the PHSO urges the DH and its partners to assess the scale of the problems highlighted in its report, to identify why they are happening, and to take appropriate action so all patients experience acceptable standards on discharge.**

**References**

Age UK (2015) 2.4m Bed Days Lost in 5 years from Social Care Delays. Bit.ly/AgeUKDelays


National Institute for Health and Care Excellence (2015) Transition between Inpatient Hospital Settings and Community or Care Home Settings for Adults with Social Care Needs. nice.org.uk/hqf2


Tester D (2016) A Step Closer to getting Hospital Discharge Right. Bit.ly/ HWEDischargeRight