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PUBLIC SERVICES OMBUDSMAN FOR WALES
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Response by the Public Services Ombudsman for Wales to the Health, Social Care and Sport Committee's inquiry into hospital discharge processes

I am pleased to have the opportunity to respond to the Health, Social Care and Sport Committee's inquiry into hospital discharge processes.

Overview

My role

As Public Services Ombudsman for Wales (PSOW), I investigate complaints made by members of the public who have suffered hardship or injustice through maladministration or service failure on the part of a body in my jurisdiction, which essentially includes all organisations that deliver public services devolved to Wales. These include:

- local government (both county and community councils)
- the National Health Service (including GPs and dentists)
- registered social landlords (housing associations)
- the Welsh Government, together with its sponsored bodies.

I am also able to consider complaints about privately arranged or funded social care and palliative care services and, in certain specific circumstances, aspects of privately funded healthcare.

My thematic report: Home Safe and Sound Effective Hospital Discharge (2018)

Healthcare is consistently the most common subject of complaints received by my office – amounting last year to 41% of all complaints. Unsurprisingly, three of the four thematic reports published during my term of office have focused on the healthcare system.

In November 2018, I published a thematic report Home Safe and Sound: Effective Hospital Discharge. The report contained a thematic analysis of 16 cases investigated by my office between 2015 and 2017 to provide a snapshot of concerns about patient discharge from hospital. I identified five main themes:

1. Inadequate senior doctor and consultant involvement in the discharge process
2. Lack of effective communication in and between hospitals and with community services
3. Lack of effective planning of patient discharge
4. Lack of effective organisation in the care and discharge of patients
5. Failure to include and involve appropriate family members and/or carers in the discharge process

Following this thematic analysis, I recommended that health boards, GPs and local authorities should ensure that:

- when appropriate, senior doctors are involved in the discharge process;
- medical staff receive appropriate training so that they fully understand discharge policies and procedures;
- appropriate assessments are undertaken before discharge and planning for discharge puts the patient at the centre of the process;
- there is effective communication between and within primary and secondary care organisations, and with social services departments;
- the patient and appropriate carers/family members are involved in the discharge process and that relevant information is shared with them during the discharge process.

Overview of my casework since 2018

The number of complaints received and closed by my office about appointments, admissions and discharge and transfer procedures has not changed significantly over recent years. This subject continues to represent about 5% of my new health-related complaints.

Since 2017/18, I have seen some increase in the number of times that discharge issues were raised in complaints, either as the main or secondary subject:

- 2017/18: 20
- 2018/19: 37
- 2019/20: 31

Themes

My 2018 thematic report highlighted a selection of cases closed before July 2017. I can draw attention to a number of themes recurring in the cases that I have closed since, many of which mirror the themes identified in the 2018 thematic report:

- Inadequate review and assessment prior to discharge

  In a number of cases, the available evidence was not taken into account

when making discharge decisions; the assessments prior to discharge were not conducted to the appropriate extent or not conducted at all. At times, this led to problems for others in arranging post-discharge care.

For example, before Mrs X was discharged, there should have been Occupational Therapist and home care assessments and a Multi-Disciplinary Team meeting held to determine Continuing Health Care funding arrangements. The lack of these meetings meant that, other than medication, no assistance was available for Mrs X at home (201606802).

- Failure to include and involve appropriate family members and/or carers in the discharge process

  In a number of cases, I have seen a lack of good communication between the body and the patient and their relatives. Again, at times this was seen to lead to complications in post-discharge care.

  For example, I found that it was inappropriate for Mr Y to have been discharged home as he and his family did not have full knowledge and understanding of his clinical condition and prognosis. The lack of communication meant that Mr Y's family were denied the opportunity to be involved in making choices about his discharge and were ill-prepared to cope with Mr Y's deteriorating health at home (201801418).

- Lack of effective organisation in the care and discharge of patients

  Continuing the theme identified in the thematic report, I still see failings in efficient record keeping and provision of timely discharge notifications and medical handover notes. In some cases, patients were discharged with incorrect paperwork or with no written information at all. Such failures can damage the continuity of patient care following their hospital discharge.

  For example, Mr X's discharge letter had not mentioned his post-operative pneumonia or pain control problems. This led to difficulties in obtaining repeat prescriptions (201605066).

  I also want to highlight that in a number of cases I found that record keeping standards were inadequate or records were missing. This made it difficult for me to arrive at a definitive view about appropriateness of discharge. However, it also affected the experience of the patients.

  For example, a lack of documentation regarding Miss B's observations following her scan under sedation was contrary to good practice. This meant that Mrs A was left with uncertainty as to whether her niece was fit enough to be discharged (201707743).

  On this note, I would like to draw the Committee's attention to my thematic report Justice Mislaid: Lost Records and Lost Opportunities published in March 2020, I published (also in Easy Read). The report highlighted a sample of cases considered where health and social care records have been mislaid or lost.

- Lack of effective planning of patient discharge and effective communication in and between hospitals and with community services

  My casework since 2017 has continued to highlight examples of failings in planning of post-discharge care, including planning of liaison between medical and community support services. In some cases, the care plan was not agreed; follow-up appointments have not been made and discharge was completed without any referral or liaison with medical or community services.

  For example, poor communication between staff regarding whether Mr C would stay locally or return to England, led to delays in follow-up treatment and Mr C having to find a local GP himself (201705880).

- Complaint handling

  In addition to the themes identified in my thematic report, in a number of cases issues around discharge were exacerbated by inadequate complaint handling by the bodies concerned, with the complaints either not investigated or considered with unacceptable delay.

In some cases, several failings related to discharge compounded each other, amounting to a particularly negative experience for the complainant.

For example, in one case (201805301), Mrs C, an elderly, vulnerable complainant who suffered sustained pelvic fractures and an injury to her elbow, was discharged without any senior orthopaedic review. There were failings during the assessment undertaken by the Occupational Therapy team prior to discharge and there was no adequate follow-up.

In another case (201701616), Ms A experienced difficulties and delays in receiving necessary aftercare arrangements following her discharge from detention under the Mental Health Act (MHA). As a result, Ms A remained an inpatient at the Hospital for almost a year after her discharge from detention, on a locked rehabilitation ward with other patients detained under the MHA.

My recommendations

When I identify failings by public bodies, I can issue recommendations to remedy injustice. As part of that, I can recommend process review or staff training to support systemic improvement of public services. In 2019/20, about 20% of all my recommendations fell into this category. For example, I recommended that a Health Board,

- reviews guidelines to determine the standards of its discharge letters (201605066)
- reminds relevant hospital staff of the need for early engagement with district nursing staff to plan patient discharge (201704795)
- reminds staff of the importance of ensuring patients are formally reviewed by a senior team member before they are discharged (201702952)

- reminds staff to undertake and document appropriate mental health assessments prior to discharge and to undertake an audit to ensure such actions were taking place (201701491)
- considers how it could improve its communication and discharge process for 'holiday' patients when they required further acute care (201705880).

As will be clear from the above, in many instances maladministration in discharge procedures can be avoided not by developing additional process or guidance, but rather by the correct application of the existing ones. Indeed, in several cases I recommended that a Health Board introduces a discharge checklist to ensure all relevant actions have been taken before patients are discharged (e.g. 201707595; 201707449).

Discharge practices and Covid-19

Normally, complaints about maladministration and service failure by public service providers are not raised with my office immediately after the person affected becomes aware of the issue. Instead, I expect the issue to be raised in the first instance with the body concerned. Possibly for this reason, I have not yet seen many complaints affected by the Covid-19 pandemic. Of such complaints received so far, none have related to discharge practices. I will continue to monitor the complaints where Covid-19 arises as a factor and would be happy to update the Committee in due course, once more evidence becomes available.

Closing remarks

I trust that you will find my comments useful. Should you wish to discuss any of my points further, please do not hesitate to contact Ania Rolewska, my Head of Policy (ania.rolewska@ombudsman.wales).

Nick Bennett

Public Services Ombudsman for Wales

June 2020

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