Arrangements for hospital discharge from in-patient treatment

Information as at January 2023

Admission to hospital

If a LBMP patient is admitted to any local hospital for in-patient treatment, the Health & Social Care coordinators at Dorset HealthCare's Bridport Hospital 'Hub' will know this via daily email information from the hospital, its Multidisciplinary Team (MDT) meetings, and Hub meetings. LBMP receives the same daily spreadsheet showing its patients that are admitted. The Practice also gets notified by the hospital on admission via its SystmOne. If such an admission is emergency, not planned, the hospital concerned would be expected to email the Hub and LBMP.

During treatment

To track developments:
(a) *Dorset County Hospital*. The Health & Social Care coordinators can access the hospital's electronic system, and the hospital's discharge coordinator works closely with them. Progress is checked daily.
(b) *Yeovil Hospital*. The Health & Social Care coordinators have some access to the hospital's electronic system, and check progress daily.
(c) *RD&E, Exeter*. The Hub has no access to RD&E electronic system, so Health & Social Care coordinators cannot track progress unless the hospital communicates or the Hub finds it necessary to ask. The Hub staff are currently 'escalating our request for access to the RD&E system as we agree that it would be good for equitable service across our patch.'
(d) *Poole, Bournemouth hospitals.* Very few local patients go there. Arrangements as for RD&E.

Discharge from hospital

If a patient is discharged from hospital with no follow-up needed, the hospital sends electronically a Discharge Summary to the GP detailing the completed treatment and any changes in medication etc. This is processed by the Practice staff; the Hub is not notified.

If a patient is discharged home with follow-up required:
The key role of the Health & Social Care coordinators at the Hub is to ensure timely liaison with the Community teams (Community Nursing Team, Integrated Community Rehabilitation Team, Community Mental Health Team) and with Dorset Adult Social Services. Daily meetings in the Hub discuss service availability and allocate support if possible.

(e) Dorset County Hospital. The discharge coordinator prepares a 'D2A' (Discharge to Assessment' form) detailing treatment completed and any 'care package' required following discharge. The Health & Social Care coordinators arrange the necessary support via, for example, the Community Nursing Team, Integrated Community Rehabilitation Team, Adult Social Care, GP, Social Prescribers ….
(f) *Yeovil Hospital*. Similar to Dorset County Hospital, using the D2A form.
(g) *RD&E, Exeter.* The hospital should complete a D2A form and should inform the the Health & Social Care coordinators at the Hub so that support can be implemented. (NB: If a patient is registered at LBMP but resident in Devon, any Adult Social Care support must be from Devon, not Dorset, Social Services.)
(h) *Poole, Bournemouth hospitals.* Arrangements as for RD&E.

LBMP will also receive discharge summaries directly from the hospital.

Additional note regarding hospital out-patient consultations

Reports on these consultations should be sent promptly by the hospital to the GP and to the patient.

In September 2018 the Academy of Medical Royal Colleges recommended that hospital doctors should write outpatient letters directly to patients, copying in the GP.
The Academy said that 'This reverses the traditional approach of writing to GPs and (sometimes) copying in the patient. … It reflects statements about patients' rights in the NHS Constitution, and GMC guidance on good medical practice. … Patients become primary recipients of information about themselves [not] bystanders in their own care, watching passively while professionals talk to one another above their heads. … Doctors who have adopted the practice say their communication style has become more patient-centred. GPs find the letters easier to understand and spend less time interpreting the contents for the patient.'