HDP06
Ymchwiliad i brosesau ryddhau o'r ysbyty
Inquiry into hospital discharge processes
Ymateb gan Goleg Brenhinol Meddygon Teulu Cymru
Response from Royal College of General Practitioners

Dr Dai Lloyd MS
Chair
Health, Social Care and Sport Committee
Senedd Cymru / Welsh Parliament

Dear Dr Lloyd,

Hospital discharge processes

Thank you for inviting the views of the Royal College of General Practitioners (RCGP) Wales with regard to the Committee's enquiry into hospital discharge processes. RCGP Wales represents a network of around 2,000 GPs, aiming to improve care for patients. We work to encourage and maintain the highest standards of general medical practice and act as the voice of GPs on resources, education, training, research and clinical standards.

Safe and successful discharges are essential for the continuation of care of patients in their own homes or near their own homes after an acute episode necessitating admission to hospital. This is recognised by NICE (Transition between inpatient hospital settings and community or care home settings for adults with social care needs NICE guideline [NG27]) The guidance says patients should be discharged from hospital at the right time, to the right place and in the right way – whether that is to their own home or a community or care home setting. This ethos mirrors the statements that can be found in the SAFER Patient Flow Guidance that offers solutions to possible problems that can interfere with safe discharges

Such problems have been previously highlighted in Wales in the Health Inspectorate Wales (HIW) report of 2018 which when looking at hospital discharges found that the quality of discharge information impacted on patient care because of both content and timeliness. Also, in 2018 the Academy of Medical Royal Colleges in Wales (AMRCW) identified ten themes across the primary secondary care interface which had inherent problems. One of these themes was deemed to be discharges (and outpatient letters) which identified delays in sending information (either poorly written or incomplete) To our knowledge, there has been no further such work done in Wales since that time.

RCGP has produced specific guidance on post discharge planning and advice in areas such acute kidney injury but we are not aware of any other guidance for disease specific groups which could aid discharge planning. It would be worth adding that discharge planning for the last days of life is often well coordinated being characterised by personal contact between discharging teams and GPs

As GPs, we are less likely to be aware of delayed discharges than failed discharges. Though the Parliamentary and Health Service Ombudsman's report of 2016 is some time ago the reasons behind a failed discharge recorded then are largely those which happen today. These largely fall into four categories:

- Patients being discharged before they are clinically ready to leave hospital
- Patients not being assessed or consulted properly before their discharge
- Relatives and carers not being told that their loved one has been discharged
- Patients being discharged with no home-care plan /poor co-ordination across services

Though our members feel that these sorts of cases are in the minority there is no mechanism as far as we know whereby a readmission of a patient within 24 hours of discharge has data collected in a way that identifies the cause and can thus help prevent it happening again.

Similarly, GPs will have little knowledge of how effectively the discharge has adhered to the SAFER guidance. What is clear to our members is that in the minority of cases in which problems do occur the experience of patient and their families can be quite traumatic; this experience being magnified by the fact that many patients leave hospital less mobile, less independent and less confident. Readmission often compounds these feelings. Another issue that may play a role in this is the readiness for patients' relatives to accept responsibility for their loved ones returning home. Whilst discharge teams should recognise the value of carers and families as an important source of knowledge about the person's life and needs recognition must also be given to the fact that sometimes families have acted as unrecognised carers and their needs should be considered, particularly if a discharge is curtailing a hidden or unrequested need for respite.

We feel that such failed discharge instances are in the minority now compared to 2018 because of increasing use of electronic discharges via the Welsh clinical gateway. Additionally, the role of the community resource teams mitigates against failed discharges though patients often report they would like such services to be provided for a little longer. These teams are particularly essential to safe discharge given the fact that in SAFER guidance Clinical Criteria for Discharge (CCD) should include physiological and functional criteria, but not focus on medically 'optimising' a patient or returning them to their pre-admission baseline thereby allowing for a period of post-hospital recovery and rehabilitation.

Should you or the Committee wish to discuss any points raised in this response further, please do not hesitate to let us know.

Best wishes,

Dr Robert Morgan

RCGP Wales Vice Chair, Policy