ED ATTENDANCE, IN-PATIENT DISCHARGE AND OUT-PATIENT LETTERS POLICY

This policy is currently under review and should be continued to be used. If any queries or concerns, please contact Steve Jackson, Consultant Physician & Chief Medical Information Officer

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<th>Approved By:</th>
<th>Policy &amp; Guidelines Committee</th>
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| Author / Originator(s): | Steve Jackson, Consultant Physician & Chief Medical Information Officer  
Rebecca Broughton, Head of Outcomes & Effectiveness |
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**Review date and Details of changes made during review:** N/A – New Policy

**Key Words:**

Letter  
Discharge letter  
Outpatient letter  
GP Letter  
ED letter
INTRODUCTION

1.1 This document sets out the University Hospitals of Leicester (UHL) NHS Trust’s Policy and Procedures for the content and timing of Emergency Department (ED) attendance, in-patient discharge and out-patient clinic letters.

1.2 The Royal College of Physicians’ (RCP) have reviewed and revised their standards for the clinical structure and content of inpatient records and these were published in July 2013. These include best practice guidance in respect of discharge letters.

1.3 One of the aims of UHL Discharge Policy (2011 Policy Ref B2/2003) is to ensure: Highest standards of communication within the multi-disciplinary team, between primary and secondary care, and with colleagues in social care and the independent sector.

1.4 Standard 28 of the UHL Discharge Policy states:

- A copy of the discharge letter should be ready 24 hours before discharge wherever possible.
- The letter should be given to the patient at the time of discharge with opportunity to discuss the content and ask questions.
- The discharge letter should be used to confirm the patients'/carers' understanding of their condition, treatment and care needs at the time of discharge.

1.5 Standard 34 of the Discharge Policy is:

- The nurse discharging the patient from the ward will provide and explain any written information specific to the patient condition (including, GP letter) and must ensure that the patient and/or carer receives instructions on any care required after discharge; understands the information provided regarding the expected signs to look for and when and who to contact for help and advice.

1.6 Standard 36 of the Discharge Policy is:

- A discharge letter will reach the general practitioner (GP) within one working day of discharge.

1.7 The Standards for the clinical structure and content of patient records developed by the Royal College of Physicians (July 2013) include best practice guidance for Outpatient letters.

1.8 The Department of Health Good Practice Guidelines “Copying letters to Patients” (2003) state

As a general rule and where patients agree, letters written by one health professional to another about a patient should be copied to the patient or – where appropriate, parent or legal guardian.

The general principle is that all letters that help to improve a patient's understanding of their health and the care they are receiving should be copied to them as of right. Where the patient is not legally responsible for their own care (for instance a young child, or a child in care), letters should be copied to the person with legal responsibility, for instance a parent or guardian.
2 **Policy Aims and Objectives**

The aim of this policy is to ensure best practice in ED attendance, in-patient discharge and outpatient letters (letters):

2.1 All letters will contain information in line with the standards set out in this policy and discharge letters with the UHL Discharge Policy (2011 Policy Ref B2/2003).

2.2 All ED attendance and in-patient discharge letters will be issued within 24 hours of discharge and all outpatient letters will be issued within 10 days of the clinic appointment date.

2.3 All in-patient and out-patients should be copied into their letters unless there is a clear reason not to do so (see 7.3) and the content should always have been appropriately discussed with the patient.

3 **Policy Scope**

3.1 This policy applies to all staff involved in the process of creating and issuing of ED attendance, in-patient discharge and out-patient letters within all Specialities of the Trust.

3.2 The content standards in this policy apply to in-patient and out-patient letters and to ED letters where the patient is discharged directly from the Department.

3.3 The principles of this policy should be applied to similar types of letters, eg transfer letters to other hospitals, ‘post in-hospital death’ letters to General Practitioners (GPs).

4 **Definitions**

For the purpose of this policy:

4.1 An **ED letter** is considered to be the letter sent to a patient’s GP following an attendance in ED.

4.2 A **discharge letter** is considered to be the letter sent to a patient’s GP following an episode of care where the patient was discharged following an in-patient admission.

4.3 For the purpose of this policy, an **outpatient letter** is considered to be the letter sent to a patient’s GP following an outpatient clinic attendance.

5 **Roles and Responsibilities**

5.1 **Medical Director**

Has executive responsibility for both the quality of content and timing of letters.

5.2 **Chief Medical Information Officer/Associate Medical Director (CMIO)**

Has corporate responsibility for the quality of content of letters and for supporting relationships between Clinical Management Groups (CMGs) and Information Technology (IT).
5.3 Chief Information Officer

Has responsibility for ensuring the trust’s IT infrastructures meet ED, discharge and outpatient letter requirements, including electronic transmission.

5.4 Clinical Management Group (CMG) Clinical Directors and Heads of Service are responsible for ensuring:

The standards for content and timing of letters are met within their CMG / Service

The quality of letters are monitored on an annual basis

Availability of appropriate educational support for doctors creating letters (and other clinical staff where applicable)

5.5 CMG Managers and Service Managers are responsible for:

Ensuring administrative processes are in place to support ED and discharge letters being issued within 24 hours of attendance/discharge and outpatient letters within 10 days of clinic attendance

Ensuring plans are in place to achieve electronic transmission of outpatient letters in line with UHL’s service delivery plan’.

5.6 Consultants are responsible for

a) Providing letters for patients under their care

b) Ensuring that the quality of content within letters meet the standards within this policy

c) Feeding back any content issues to the relevant members of their clinical team and for escalating any issues around timing of letters to the relevant managers.

d) Ensuring in-patient discharge letters (and ED attendance letters, where applicable) are sent within 24 hours of discharge

5.7 All Doctors are responsible for

a) Undertaking appropriate training, i.e. Discharge letter/ICE e-learning module

b) Ensuring the content and generation of all letters meet the standards set out in this policy

c) Checking the content in letters started during admission is still correct at time of discharge letter completion and making amendments as necessary

5.8 Nursing, Therapy and Pharmacy staff are responsible for

a) Completing relevant sections of letters (creating ED letters, where applicable)

b) Ensuring the content and generation of letters meet the standards set out in this policy – where applicable (i.e. Nurse Led or Therapy Clinics, ED Nurse Practitioners)

c) Giving in-patients an opportunity to discuss and ask any questions about the discharge letter content

d) Using in-patient discharge letter to confirm the patients’ understanding of medication and what to expect post discharge – see 6.3.2
5.9 Ward Clerks, Clinic Clerks, ED Receptionists and All Staff entering data onto the Patient Administration System (PAS) and EDIS

a) Entering patients’ details re attendance, admission, transfer or discharge onto PAS or EDIS, within 15 minutes of patient movement.

b) Confirming patient’s name, address and GP details are correct and entered into PAS or EDIS

6 QUALITY STANDARDS – ED ATTENDANCE LETTERS

6.1 Creating and timing of ED Letters

6.1.1 ED letters must be issued within 24 hours of being discharged from the Department

6.1.2 ED letters are currently created from EDIS and are printed off at midnight for both patients discharged from the Department or admitted into UHL/transferred to another hospital.

6.2 Content of ED Letters

6.2.1 The EDIS letter template has the facility for free-text entry which should be used by the practitioner discharging a patient from the Department to inform the GP of additional important clinical information where this is not automatically ‘pulled through’.

6.2.2 All letters for patients being discharged from the Department must include the following:

- Outline of circumstances of attendance and diagnoses given
- Details of requirement for GP follow up or action
- Outcome of relevant ED laboratory tests or imaging
- Details of any follow up arranged by ED
- Details of any stopped or started medications (including rationale)
- Discharge advice given to patient, where appropriate

7 QUALITY STANDARDS – IN PATIENT DISCHARGE LETTERS

7.1 Creating Discharge Letters

a) Patients’ admission details must be entered into PAS before an ICE discharge summary letter can be produced

b) Creation of discharge letters can be started following admission but, wherever possible, they should be commenced within 24 hours of discharge. (Obviously, where patients are discharged on the same day of admission, this will not be possible)

c) Discharge letters must be produced on ICE with the exception of Neonatal, Maternity and Renal Services.

d) These Specialities can continue to produce discharge letters via their Clinical Systems (namely Badger, E3 and PROTON) but must meet the content and timing
standards of this policy and work towards electronic transmission of discharge letters.

e) ICE Discharge Letters will be produced using set templates. Speciality specific or ‘short stay admission’ templates are available via a drop-down pick list.

f) Letters can be created at any time during the patients’ stay in hospital and amendments made to it until final sign-off at discharge. This includes input by the pharmacists and nurses who will need to electronically sign-off the “To Take Out” (TTO) check. TTOs should be ordered 24 hours prior to discharge.

g) The majority of the Discharge Letter fields should be completed before the TTOs can be requested of Pharmacy and must include:
   - Diagnosis
   - Allergies

7.2 Timing of Discharge Letters

7.2.1 ICE generated discharge letters will be electronically transmitted to the GP at time of completion (unless the Practice is not on EMIS or SystemOne)

7.2.2 All Discharge letters must reach the General Practitioner within one working day of discharge. (Non electronic letters within 2 working days)

7.3 Content of Discharge Letters

All discharge letters must contain as a minimum:

7.3.1 **Patient demographics** ie Name, S Number, NHS Number DOB, Address
   - Consultant and Speciality details
   - Name, grade and contact details of the health care professional completing the letter

7.3.2 **General Practitioner**
   - Name of General Practitioner and Practice details
   - Where patients are being discharged to a new address, the patient’s new GP needs to be confirmed prior to discharge and this information entered into PAS. This is essential where patients are being fast tracked or require post discharge review by the GP.

7.3.3 **Clinical Details**
   - **Primary or Working Diagnosis** (as confirmed on the consultant ward round)
   - Reason for admission (presenting symptoms) and relevant co-morbidities
   - Key Investigations carried out and comments about important results
   - Outstanding investigations – where applicable
   - List procedures carried out whilst an inpatient
   - Complications of treatment whilst an inpatient

7.3.4 **Medication:**
   - Drugs patient started during admission, reason, duration and review details
   - Drugs patient taking on admission stopped, reason and review (where applicable)
   - Drugs to be continued
   - Details of any review or monitoring required
• For patients with stay less 72 hrs, it has been agreed that it is not necessary to state a full list of unchanged medication.
• Any requests for continued prescribing must be in line with the ‘Leicestershire Traffic Light Criteria’

7.3.5 Follow-up treatment/management plan
• Clearly stating who is responsible for any actions
• To include details of what actions to be taken should problems reoccur
• Where urgent follow up required, the Practice should be telephoned prior to discharge (i.e. Anticoagulation monitoring, End of Life care)

7.3.6 Actions requested of the GP
• If none, this should be explicitly stated
• GPs should not be requested to follow up outstanding results unless prior agreement sought

7.3.7 Patient Information
• Information that the patient requires, in layman’s terms, about their diagnosis and generally what to expect about their progress post discharge.

7.3.8 Where applicable
• Dementia Screening and Risk Assessment, referral for further assessment
• VTE Risk Assessment at discharge and advice on prophylactic measures
• HCAI - Whether the patient has acquired a Healthcare Associated Infection (HCAI) during their admission, such as C Diff or MRSA
• Fitness for Work - Confirm the issue of a “Fit Note” – this should cover the period of time the patient is expected to be off work
• END of Life/Palliative Care – eg AMBER care bundle commenced
• DNA CPR – whether this for review or indefinite
• Allergies – where newly identified or to confirm existing status

7.3.9 Supportive and Palliative Care Approach (SPCA)
In order to support continuity of care between organisations within Leicester, Leicestershire and Rutland, the LLR End of Life Care Board subgroup (June 14) has agreed that the following needs to be communicated as part of the discharge letter - where applicable:

• If a patient has been identified as at risk of deterioration using the ‘Supportive and Palliative Care Indicator Tool’ (SPICT), - this should be recorded in within the ‘Actions requested of the GP’ section
• The Supportive and Palliative Care/End of Life Care section of the ICE template should then be used to inform the GP of:
  • The patient and families understanding of the Supportive and Palliative Care Approach being taken
  • If it has been decided by the clinical team that the Supportive and Palliative Care Approach is not appropriate
• Whether any advance care planning has been undertaken, to include details where readmission would be unlikely to be beneficial and clarify alternative plan for these patients

7.3.10 Acronyms - The use of acronyms for diseases, processes or people should be minimised.

7.3.11 Narrative - Where appropriate a narrative can be inserted

7.4 Discharge Letters - Copy for Patient

7.4.1 A copy of the letter should be given to the patient at the time of discharge with opportunity to discuss content and ask questions (see 1.8).

7.4.2 The letter is to be used to confirm the patient’s understanding of
   a) their discharge medication and possible side effects
   b) who to contact if worried about their condition or treatment after leaving hospital
   c) possible problems or danger signals to be aware of, after leaving hospital plans in place regarding ‘end of life care’ and ‘resuscitation status’ where applicable

7.4.3 Consideration should be given to how the patient will be able to understand the letter content if they have any communication needs (language, visual impairment)

7.4.4 Where patients are unable to read/understand their letter, a copy of the letter should be offered to their carer/relative with the patient’s consent. If the patient lacks capacity, advice and consent should be sought from the lead clinician.

7.4.5 There should be no ‘surprises’. For example, it would be inappropriate to mention a possible malignancy in any letter without having discussed this with the patient/their carer.

7.5. Further Discharge letter

A further discharge letter should only be rarely required. However, one may be needed if the case is complex and a definitive opinion requires the analysis of results of additional information which only becomes available after discharge.

7.5.1 Where this happens - the discharge letter produced at the time of the discharge should indicate such a letter will be forthcoming and this second letter should reach the GP within 10 working days

7.5.2 It may also be necessary to reissue discharge letter to correct the previous one. – The second letter should clearly state that it is a correction.

7.6 Transmission of Discharge Letters:

Most Leicester, Leicestershire and Rutland (LLR) GPs receive their copy of the discharge letter electronically as soon as the ‘Print and Complete icon’ is activated. This is then incorporated into the patient’s primary care electronic health record.

Owing to the fact that some GPs are not able to receive electronic letters from ICE, currently all GPs also receive a paper copy (one of the 4 default copies printed when the ‘Print and Complete icon’ is activated). Non LLR GPs will also require a paper copy.
8.1 Creating and Timing of Outpatient Clinic Letters

8.1.1 Ideally outpatient letters should be created at the end of the outpatient clinic consultation but where this is not possible letters should be dictated or typed directly into ICE within 2 working days of the clinic.

8.1.2 Outpatient letters to the General Practitioner must be issued to the General Practitioner within 10 days of the patient being seen in clinic.

8.2 Outpatient Letter – Copy for Patient

A copy of the letter should be sent to the patient at the time of sending the original to the GP unless:

- The patient has been given a copy in the clinic
- the patient has explicitly said they do not wish to receive a copy
- it has been agreed by the CMG Board that patients should not be routinely given copies of their clinic letters where special safeguards for confidentiality may be needed
- where the clinician feels that it may cause harm to the patient or where the letter includes information about a third party who has not given consent
- See Appendix 1 for more details as taken from the Department of Health guidelines on ‘Copying of Letters to Patients’ 2003.
- Consideration should be given to how the patient will be able to understand the letter content, particularly if they have any communication needs (language, visual impairment)
- The content of the outpatient letter should always have been appropriately discussed with the patient and there should be no ‘surprises’. For example, it would be inappropriate to mention a possible malignancy in any letter without having discussed this with the patient.

8.3 Content of Out-patient letters

All Outpatient letters should contain as a minimum:

8.3.1 Patient demographics
- NHS number, GP details
- Consultant and Speciality
- Name and grade of doctor completing the letter
- Name of General Practitioner and details
- Date of Appointment
- Clinic details

8.3.2 Clinical Details
Diagnosis (or differential diagnosis)
Any procedures undertaken
Investigations and results, where applicable
Outstanding investigations/results
Planned procedures and details of consent discussions

8.3.3 Medication –
Current medication details to include:
Relevant drugs patient taking, reason and review (where applicable)
Drugs started or changed with reason, duration and review details
Any review or monitoring of current medication required

GPs should not be requested to initiate new treatments and any requests for continued prescribing must be in line with the ‘Leicestershire Traffic Light Criteria’

8.3.4 Patient Information - A clear summary of the outcome of the clinic should be documented in terms the patient will understand, to include details of any changed or new medication.

8.3.5 Follow-up treatment/management plan - clearly stating who is responsible for any actions and to include details of what actions to be taken should problems reoccur.

8.3.6 Fitness note – Where applicable, confirm the issue of a “Fit Note” – this should cover the period of time the patient is expected to be off work

8.3.7 Actions requested of the GP
If none, this should be explicitly stated

8.3.8 Speciality Standards
If more detailed standards are required at Speciality Level (eg key investigations, post operative management plans) these must be approved by the Head of Service and appended to this policy for local dissemination.

8.4 Standards for Transmission of Outpatient Clinic Letters
8.4.1 UHL is working towards electronic transmission of outpatient clinic letters and all Specialties are required to have plans in place to achieve this.

8.4.2 Whichever process is used for creating outpatient letters, all services are required to ensure that their letters meet both the content and timing standards set out in 7.1 to 7.3 above.

9.0 Education and Training

9.1 An ICE discharge summary e-learning module is available on e-UHL for medical staff. This is being updated to include both discharge and outpatient letters and will be available to both Consultants and junior medical staff.

9.2 Discharge communication relating to ‘end of life’ needs will be included in the DNA CPR training programme.
9.3 IT related training requirements for outpatient letters will need to be identified by each speciality Head of Service and Service Manager, dependent upon the process used.

9.4 Appendix 2 is a summary of the Standards for ease of reference.

9.5 Appendices 3 - 6 are ‘mock’ ED, Discharge and Outpatient Letters in order to provide examples of how the relevant sections should be completed.

10.0 PROCESS FOR MONITORING COMPLIANCE

10.1 Audit standards – see table below

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10.2 Process and timescales for monitoring compliance

10.2.1 Audits will be carried out annually as a minimum

10.2.2 Heads of Service will be responsible for ensuring the audit takes place within their Service and for acting on results.

10.2.3 Each Ward (Discharge letters) and Speciality (Outpatient letters) will be expected to audit a minimum of 10 discharge and 10 outpatient letters and the results of the audit to be reviewed at Speciality meetings and reported to the CMG Board.

10.2.4 ED will be expected to audit a sample of letters containing free text / without free text.
11. **DOCUMENT CONTROL, ARCHIVING AND REVIEW OF THE DOCUMENT**

This is a new policy. Archiving of the policy will be via Sharepoint. The policy is to be reviewed in 18 months time or earlier there is any new national guidance published.

12. **LEGAL LIABILITY**

The Trust will generally assume vicarious liability for the acts of its staff, including those on honorary contract. However, it is incumbent on staff to ensure that they:

- Have undergone any suitable training identified as necessary under the terms of this policy or otherwise.
- Have been fully authorised by their line manager and their Directorate to undertake the activity.
- Fully comply with the terms of any relevant Trust policies and/or procedures at all times.
- Only depart from any relevant Trust guidelines providing always that such departure is confined to the specific needs of individual circumstances. In healthcare delivery such departure shall only be undertaken where, in the judgement of the responsible clinician it is fully appropriate and justifiable - such decision to be fully recorded in the patient’s notes.

It is recommended that staff have Professional Indemnity Insurance cover in place for their own protection in respect of those circumstances where the Trust does not automatically assume vicarious liability and where Trust support is not generally available. Such circumstances will include Samaritan acts and criminal investigations against the staff member concerned.

Suitable Professional Indemnity Insurance Cover is generally available from the various Royal Colleges and Professional Institutions and Bodies.

For advice please contact: Assistant Director - Head of Legal Services on Ext 8585

13. **EQUALITY IMPACT ASSESSMENT**

13.1 The Trust recognises the diversity of the local community it serves. Our aim therefore is to provide a safe environment free from discrimination and treat all individuals fairly with dignity and appropriately according to their needs.

13.2 As part of its development, this policy and its impact on equality have been reviewed and no detriment was identified.

14. **EVIDENCE BASE AND RELATED POLICIES**

Department of Health “**Copying letters to Patients**” Good practice guidelines 2003

**UHDL DISCHARGE POLICY** For Adult Patients Leaving Hospital Oct 11 – Sharepoint - Policy Ref B2/2003

3.0 When letters should not be copied

3.1 There may be reasons why the general policy of copying letters to patients should not be followed. These include:

- where the patient does not want a copy
- where the clinician feels that it may cause harm to the patient or for other reasons
- where the letter includes information about a third party who has not given consent
- where special safeguards for confidentiality may be needed.

Patients who do not want a copy

3.2 Examples of why people may not want a letter could include:

- they feel they already have the information (for instance, a care plan as part of the Care Programme Approach)

- there are problems of privacy at home (for example for young people)
- there is domestic violence or information not known to a partner or other members of the household

- they do not feel able to accept a diagnosis
- they feel they are criticising the doctor by wanting to see a copy letter. (In such cases, the support of the clinician could be important in helping the patient obtain better information about their care and treatment.)

Harm to the patient

3.3 Giving of "bad news" is not in itself enough to justify not copying a letter.

The pilot studies showed that it is sometimes the case that health professionals are anxious to protect patients, who themselves often wish to have as much information as possible, even if it may be ‘bad news’ or uncertainty.

3.4 In some cases involving particularly sensitive areas, however, such as child protection or mental health problems, it may not be appropriate to copy a letter to the patient, although the patient has the right to request access under the Data Protection Act 1998.

Unless the health professional's judgement is that there might be a serious possibility of harm to the patient, it is up to the patient to decide whether they wish to receive a copy of a letter. (See paragraphs 4 to 4.16 for a more detailed discussion on issues around consent to receipt of letters.)
**Third party information**

3.5 It will not be appropriate to copy a letter which contains information about a third party, who has not given permission for this use of the information, unless the information was originally provided by the patient. (See paragraphs 4.7 to 4.9 for further information on this aspect of data protection.)

**Safe haven procedures**

3.6 There are some services (for instance STD clinics) where there are special arrangements for protecting confidentiality. For instance, information may not routinely be recorded in patients’ GP records. The implications of someone else seeing a copy letter about treatment by such a service may be serious for the patient, and should be discussed if the patient wants a copy sent by post. There is provision under Caldicott5 arrangements for ‘safe-haven’ procedures.

Local consideration is needed as to how particularly sensitive information (and related copy letters) can be channelled to patients through the ‘safe-haven’ point or other secure means in an NHS or Primary Care Trust, or general practice.
SUMMARY OF POLICY STANDARDS FOR
ED, DISCHARGE & CLINIC LETTERS

1 SCOPE
1.1 These standards apply to all staff involved in the process of creating and issuing of ED attendance, in-patient discharge and out-patient letters within all Specialities of the Trust.

2 TIMING
2.1 All ED and in-patient discharge letters will be issued within 24 hours of discharge
2.2 All outpatient letters will be issued within 10 days of the clinic appointment date.

3. PATIENT INFORMATION
3.1 All in-patient and out-patients should be copied into their letters unless there is a clear reason not to do so.
3.2 In-patient and out-patient letters should include information that the patient requires, in layman’s terms, about their diagnosis and management plan should be included

4 CLINICAL CONTENT
4.1 ALL LETTERS
- Outline of circumstances of attendance/admission
- Diagnoses given and relevant procedures
- Outcome of relevant investigations
- Details of any stopped or started medications, including rationale
- Details of follow up arrangements
- Details of requirement for GP follow up or action
- Fitness for Work - Confirm the issue of a “Fit Note”- which should be for the length of time the patient is expected to be off work

4.2 IN-PATIENTS ONLY – WHERE APPLICABLE
- END of Life/Palliative Care or DNA CPR - whether this for review or indefinite
Emergency Department  
Leicester Royal Infirmary UHL Trust  

LEICESTER

Dr A EXAMPLE  
ANYTOWN MEDICAL PRACTICE  
ANYTOWN STREET  
LEICESTER  
LE0 000  

January 19, 2015

Dear Dr EXAMPLE

Re: JOE BLOGGS; 1 ANY STREET, LEICESTER, LE99 9LE, Date of Birth: 00.00.00  Hospital Number: S00000000

Your patient attended the Leicester Royal Infirmary UHL Trust on 32 DEC 2014; 00:00

The presenting complaint was: CHEST PAIN

The following investigations were carried out: BLOOD CHEM PATH//BM-1/2-  
BLOOD COAG/D-DIMER -2-  
BLOOD FBC/HAEMATOL -2-  
ECG -1-  
RAPID X-RAY -2-

The A&E diagnosis was: NON CODED DIAGNOSIS – A TYPICAL CHEST PAIN  
CARDIO-VASCULAR – ATRIAL FIBRILLATION AND FLUTTER RESPIRATORY – ASTHMA

The following treatment was given: DRUBFLOX DRUG PO -2-  
ZERO ADVICE -0-  
ZERO OBS RECORDED -1-

At the conclusion of treatment the patient was: DISCHARGED HOME: Departure Ready Date/Time: 0 JAN 2015 00:00  
Actual Departure Date/Time: 0 JAN 2015 03:10

Follow up: GP

Additional Information: This gentleman was sent here by primary care because of his chest pain. This pain had been present all day and did not appear cardiac in nature. There was nothing sinister about the description of the chest pain. Examination and investigations including troponin,
chest x-ray and ECG were all unremarkable. I have reassured him that it is very unlikely that there is anything serious causing his chest pain and that it should just settle over the next few days. He is aware of the fact that if he gets worse he will return to the emergency department. I have advised him to stop smoking and have referred into the quit smoking service. He was noted to be in atrial fibrillation and so I have asked him to come and visit you at the surgery to discuss how best to manage this.

Yours sincerely

STEVE JACKSON
CONSULTANT
University Hospitals of Leicester NHS Trust
Adult Acute Medical Unit / Short Stay Medical Unit Discharge

!!!NOT FOR USE IN CHILDREN'S HOSPITAL!!!

<table>
<thead>
<tr>
<th>Presenting Complaint</th>
<th>Headache</th>
</tr>
</thead>
<tbody>
<tr>
<td>Main Diagnosis on Discharge</td>
<td>Headache of unknown aetiology</td>
</tr>
<tr>
<td>Co-morbidities</td>
<td>Type 2 diabetes</td>
</tr>
<tr>
<td></td>
<td>Obesity</td>
</tr>
</tbody>
</table>

**Admission Notes including Key Investigations**

Paragraph Header will be amended to say:

Admission Notes including Key Investigations (Results are available for viewing in the ICE system. If you require support accessing results in ICE please contact your Practice Manager or HIS service Desk)

History of headache does not suggest anything sinister. Routine blood is normal. No Imaging performed.

**Medical Certificate (Fit Note) offered to Patient (Y/N)** - No

**Information / Advice given to parents / Carer**

We not sure why you have a headache, but we are as sure as we can be that there is nothing serious causing it. There is no reason to keep you in hospital any longer. We would recommend you go home and take some simple painkillers over the next few days as required. If the headache get significantly worse or you start vomiting please call 111 for further advice. Otherwise, if it is still present in 2 weeks' time, please make an appointment to see your GP for further advice.

**Follow Up Plans (UHL & Other agencies)** - None

**Nurse Discharge Check (e.g. TTO's checked, drugs discussed with patient/carer)**

No TTOs prescribed or required. Regular medicines that remain the same as pre-admission are returned to the patient if the patient stay is less than 24 hours.

**Bleep or Contact Number** - Ward 15, LRI 0116 2586940

**Drug Allergy Status** - None

**Medication Changes (Differences between drugs on admission and on discharge)**

NO CHANGES TO REGULAR MEDICATION

**ACTION REQUESTED of GP (Including referral to specialist)**

Please see advice to patient above.
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<thead>
<tr>
<th>TEST ICE</th>
<th>NHS number:</th>
<th>Hospital Number:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>52795033</td>
</tr>
<tr>
<td>Consultant</td>
<td>DR S JACKSON</td>
<td></td>
</tr>
<tr>
<td>Ward</td>
<td>LRI WD 15 AMU Bal L5</td>
<td></td>
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<tr>
<td>Specialty</td>
<td>General Medicine</td>
<td></td>
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<tr>
<td>Letter Ref</td>
<td>691806/4</td>
<td></td>
</tr>
<tr>
<td>Date Printed</td>
<td>02/02/2015 11:30</td>
<td></td>
</tr>
<tr>
<td>Signed</td>
<td>aehall [System Administrator]</td>
<td></td>
</tr>
<tr>
<td></td>
<td>jacks [UHL Consultant]</td>
<td></td>
</tr>
</tbody>
</table>

[691806/4]
University Hospitals of Leicester NHS Trust  
Adult Inpatient Discharge Summary

Reason for Admission - Shortness of breath.

Main Diagnosis at Discharge
Heart failure secondary to probable recent acute coronary syndrome.

Other Diagnoses
Type 2 diabetes, poorly controlled
Hypertension
Dyslipidaemia
Obesity

Inpatient Management/Events/Complications/Operations/Risk Factors
This lady presented with a few days' history of shortness of breath at rest on a background of unlimited exercise tolerance. There had been a few hours of cardiac sounding chest pain preceding the breathlessness. She was managed for her heart failure and discharged asymptomatic.

Key Investigations (Imported Results are correct at the time the letter is produced, please check for later updates/corrections)
Paragraph Header will be amended to say:
Key Investigations (Results are available for viewing in the ICE system. If you require support accessing results in ICE please contact your Practice Manager or HIS service Desk)
Chest x-ray and echocardiogram consistent with biventricular failure.
ECG showed Q-waves in anterior leads.
Troponin elevated.
HbA1c 10%

Co-morbidies (e.g previous medical conditions) - As above

Planned Outpatient Investigations/Other Management - None

Healthcare Related Infections (eg MRSA, CDIFF, VRE or Other (Please Specify)) - None

VTE Assessment on Discharge Done
There is NO Need to Continue Antithrombotic Measures/Medication

All patients who are on an oral anticoagulant are to be referred on the day of discharge from any UHL Ward to the UHL- Community Anticoagulation Service via iCM. Please confirm that this has been done - Not Applicable

Medical Certificate (Fit Note) offered to Patient (Y/N)

[691820/2]

https://ice.xuhl-tr.nhs.uk/icedesktop/dotnet/icedesktop/PrintManager/PrintManagerHu... 02/02/2015
Fitness note provided for 4 weeks.

Information for the patient/carer/Plans for future care
Your shortness of breath was caused by what we think was a heart attack. This was the cause of the chest pain. We think this happened a few days before you came into hospital. We have put you onto some tablets to help with the breathlessness and to try to prevent another heart attack. Please carry on with these tablets until we meet in clinic in 4 weeks' time. Take things easy until we meet again, building up your exercise level slowly such the you are walking up to 2 miles per day by the time you return to clinic. If you get any more chest pain, use the GTN spray. If the pain continues despite using the spray 3 times, call 999. We have put you onto insulin and given you the contact details for the diabetes nurses. Their number is (0116) 258 4919. If you need help with the insulin then please don't hesitate to call them. They will call you in a few days to check how you're getting on. Good luck with quitting cigarettes. Finally, we have asked your GP to check your kidney blood test in 2 weeks' time. Please discuss this with him to ensure it happens.

Follow Up Plans (UHL & Other agencies)
4 weeks Dr Smith cardiology clinic. We have organised this. Diabetes nurse will call you within one week and Dr Jackson has organised a diabetic clinic appointment within the next 2 months.

Has a referral been made via iCM to the STOP SMOKING SERVICE? (Smoking is the single biggest cause of morbidity and preventable death in the UK)
1. Yes – patient is a current smoker and I have referred the patient via iCM to the Stop Smoking Service

Dementia Screen (all patients admitted as an emergency, aged over 75)
National Dementia CQUIN Screen N/A (2)

Nurse Discharge Check (e.g. TTO’s checked, drugs discussed with patient)
TTO Checked and Medication Explained by Discharging Nurse 1: Helen Jones

Drug Allergy Status - None

Medication Changes (Differences between drugs on admission and on discharge)
Ramipril, furosemide, bisoprolol, aspirin started for primary diagnosis. Insuman basal started for diabetes.

ACTION REQUESTED of GP (Including referral to specialist)
Please recheck the urea and electrolytes in 2 weeks to check that the ramipril is safe. Discharge creatinine was 124.

TTOs

<table>
<thead>
<tr>
<th>TTO Drug</th>
<th>Dose</th>
<th>Frequency</th>
<th>Route</th>
<th>Duration</th>
<th>GP Action</th>
<th>Source</th>
<th>Signatory</th>
<th>Amended</th>
</tr>
</thead>
<tbody>
<tr>
<td>BISOPROLOL</td>
<td>2.5 mg</td>
<td>OD</td>
<td>PO</td>
<td>continue</td>
<td>Continue</td>
<td>Pharmacy Main</td>
<td>jacksons</td>
<td></td>
</tr>
<tr>
<td>INSULIN INSUMAN BASAL (SOLOSTAR PEN)</td>
<td>20 units</td>
<td>BD</td>
<td>SC (bolus)</td>
<td>Continue</td>
<td>Continue</td>
<td>Pharmacy Main</td>
<td>jacksons</td>
<td></td>
</tr>
<tr>
<td>METFORMIN</td>
<td>1000 mg</td>
<td>BD</td>
<td>PO</td>
<td>Continue</td>
<td>Continue</td>
<td>Pharmacy Main</td>
<td>jacksons</td>
<td></td>
</tr>
<tr>
<td>RAMIPRIL</td>
<td>10 mg</td>
<td>OD</td>
<td>PO</td>
<td>Continue</td>
<td>Continue</td>
<td>Pharmacy Main</td>
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<tr>
<td>FUROSEMIDE (FRUSEMIDE)</td>
<td>40 mg</td>
<td>OD</td>
<td>PO</td>
<td>Continue</td>
<td>Continue</td>
<td>Pharmacy Main</td>
<td>jacksons</td>
<td></td>
</tr>
</tbody>
</table>

Checked By: jacksons, 16/01/2015 10:04

Dr AJH SHARP
SOUTH WIGSTON

Consultant
Dr S JACKSON
Ward
LRI WD 38 Win L6
TEST FICTITIOUS
HEALTH CTR.
80 BLABY ROAD
SOUTH WIGSTON
LEICESTER
LE18 4SE

NHS number: 9999999999
Hospital Number: 52243438
Specialty General Medicine
Letter Ref 691820/2
Date Printed 02/02/2015 11:35
Signed aehall [System Administrator]
jacksions [UHL Consultant]

[691820/2]
Dear Dr Recipient,

Many thanks for referring this 32 year old lady. You noted a high prolactin of around 1500 when she came along to your surgery with a 4 month history of having had no periods and having noted milk production from both breasts. Her pregnancy test was negative. She has had no symptoms to suggest any significant enlargement of her pituitary gland. She is otherwise well with no previous medical history, no regular medication and no family history of note. She has three children and has no plans for future pregnancy. On examination, she has normal visual fields to confrontation. I have organised a scan of her pituitary gland. As soon as she has had this, she should start cabergoline and I have prescribed the first month for her. I will see her again as above, with a repeat prolactin blood test a week or so beforehand, to review the situation.

Yours Sincerely,

Dr Sender
Telephone 0116 XXXXXX
Fax 0116 YYYYYY
Email drsender@uhl-tr.nhs.uk

Copy to Patient