University Hospitals of Leicester NHS
NHS Trust

DISCHARGE LETTERS, ED ATTENDANCE LETTERS AND OUTPATIENT LETTERS UHL POLICY

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Name of Responsible Committee/Individual:	**Medical Director**
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CONTENTS

Review date and Details of changes made during review:
January 2020 - Changes to system names from PAS to Patient Centre. Changes to Evidence Base as many new standards now in place, such as the Professional Standards Body standards for structure of Health and Care Records and the Data Protection Act 2018. Updating of Outpatient and ED Letter examples.

July 2023 – Updated superseded policy. Update dead links. Addition of day-case discharge letters. Revise 7 working days to 7 calendar days. Update content to refer to Nervecentre rather than ICE for inpatient letters. Update to Compliance requirements

Key Words:
Letter, Discharge Letter, Daycase letter, Outpatient Letter, GP Letter, ED Letter

1.0 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 Professional Record Standards Body published their standards in 2019, Implementation guidance report eDischarge standard https://theprsb.org/wp-content/uploads/2019/02/eDischarge-Summary-Maintenance-Release-Implementation-Guidance-Report-v2.1-23.1.19.pdf and their standards for Outpatient Letters in 2017 https://theprsb.org/wp-content/uploads/2018/02/Outpatient-Letter-Examples.pdf and Emergency Departments https://theprsb.org/standards/emergencycaredischarge/ from 2019.

1.3 The NHS Standard Contract is used to commission clinical services from providers (including NHS Trusts, NHS Foundation Trusts and non-NHS providers such as independent sector hospitals and voluntary bodies). The Contract requirements on Transfer of Care documentation are as follows:

a) following inpatient or daycase care or A&E attendance, to issue a Discharge Summary to the patient's GP within 24 hours; and
b) following outpatient attendance, to issue a Clinic Letter to the patient's GP within 7 calendar days

1.4 One of the aims of the Discharge and Transfer of Care Policy (Going Home Policy) - For Adults Leaving Hospital (Trust Reference 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.

The Discharge and Transfer of Care Policy (Going Home Policy) - For Adults Leaving Hospital policy states:

"A copy of the discharge letter should be ready 24 hours before discharge wherever possible."

"The discharge/ transfer of care letter must be proofread and checked through and given to the patient/carer at the time of discharge with an opportunity to discuss the content and to ask questions."

"The letter should be used to confirm the patient's/ carers' understanding of their condition, treatment and care needs at the time of discharge"

"The nurse discharging the patient should also confirm that the patient and/or carer understands the information provided regarding their condition including expected signs to look for and when and who to contact for help and advice."

"An electronic discharge summary (TTO) will reach the general practitioner (GP) within 24 hours of discharge."

1.5 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 and day-case discharges, and outpatient letters.

2.1 All letters will contain information in line with the standards set out in this policy and discharge letters with the Discharge and Transfer of Care Policy (Going Home Policy) - For Adults Leaving Hospital (Trust Reference B2/2003), the Children's Hospital Discharge Home Policy - For Children and Young People Leaving Hospital (Trust Reference B35/2021), and the Data Protection Act 2018.

2.2 All ED attendance, in-patient and day-case discharge letters will be issued within 24 hours of discharge. All outpatient letters will be issued within 7 calendar 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 Appendix 1) and the content should always have been 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, day-case, and out-patient discharge 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, e.g., transfer letters to other hospitals, 'In-hospital death' letters to 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, or a day-case procedure.

4.3 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 Management & Technology (IM&T).

5.3 Chief Information Officer

Has responsibility for ensuring the trust's IT infrastructures meet ED, discharge and out- patient 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.

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

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 7 calendar days of clinic attendance

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.

5.7 All Doctors are responsible for

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

b) 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

e) Confirming that any GP changes (i.e., where discharge destination is different to admission) are entered into Patient Centre and that this information is correct in the discharge letter before the letter is printed.

5.9 Ward Clerks, Clinic Clerks, ED Receptionists and All Staff entering data onto the Patient Centre or Nervecentre

a) Entering patients' details re attendance, admission, transfer or discharge onto Patient Centre or Nervecentre, as appropriate, within 15 minutes of patient movement.

b) Confirming patients' name and address are correct and entered into Patient Centre or Nervecentre, as appropriate.

6 QUALITY STANDARDS – ED ATTENDANCE LETTERS

6.1 Creating and timing of ED Letters

6.1.1 ED letters must be generated in Nervecentre at the point of discharge or transfer to an inpatient area. The letters are transmitted electronically to the GP Surgery. Copies will be stored in the UHL CITO (Electronic Document Management System).

6.2 Content of ED Letters

6.2.1 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 Content and Timing of Daycase Discharge Letters are identical to inpatient discharge letters. However, the generation and issuing of daycase discharge letters are performed on ICE owing to the lack of functionality in Nervecentre. Future iterations of Nervecentre will have conditional formatting functionality to allow timely completion of daycase discharge letters.

7.2 Creating Discharge Letters

a) Patients' admission details must be entered into Patient Centre before a Nervecentre discharge summary letter can be produced

b) Creation of discharge letters can be started at any time following admission.

c) Nervecentre Discharge Letters will be produced using set templates. These include frailty, adult anticoagulation, and adult discharge.

d) 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, where possible, 24 hours prior to discharge.

e) The majority of the Discharge Letter fields should be completed before the TTOs

can be requested of Pharmacy and must include:

- Diagnosis
- Allergies

7.3 Timing of Discharge Letters

7.2.1 All Discharge letters must be sent to the General Practitioner within 24 hours of discharge.

7.3 Content of Discharge Letters

All discharge letters must contain as a minimum:

7.3.1 **Patient demographics** i.e., 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 **Clinical Details**

These depend upon the headings of the template being used and may include the information listed below:

- Primary or Working Diagnosis
- 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
- If patients have been taking any antibiotics during their hospital stay it is expected that the details of these antibiotics are communicated to the GP and patient in the letter

7.3.3 **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 Medicines Formulary" http://www.leicestershireformulary.nhs.uk/ and Leicestershire Traffic Light Criteria https://www.lmsg.nhs.uk/traffic-lights/

7.3.4 **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) This can be done via the "Consultant Connect" App

7.3.5 **Actions requested of the GP**

- If none, this should be explicitly stated
- Consideration must be given to the locally agreed transferring care safely guidance.
- GPs should not be requested to follow up outstanding results unless prior agreement sought
- Where patients are identified as being at high risk of readmission (PARR 30 tool score >40), this should be communicated to the GP.

7.3.6 **Patient Information**

- Information that the patient requires, in layman's terms, about their diagnosis and generally what to expect about their progress post discharge. The majority of the Trust's Patient Information is available on https://yourhealth.leicestershospitals.nhs.uk/

7.3.7 **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 –** e.g., Gold Standards Framework commenced
- **DNA CPR** – whether this is for review or is indefinite
- **Allergies – including specific reaction to the medication –** where newly identified or to confirm existing status.
- 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

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

7.3.9 **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

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) whom 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 and any 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 be only 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 becomes available only 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 issue a correction to the previously completed discharge letter. This is done by re-entering the discharge letter and making use of the 'corrections' section of the Nervecentre discharge letter.

7.6 Transmission of Discharge Letters:

All Leicester, Leicestershire and Rutland (LLR) GPs receive their copy of the discharge letter electronically from Nervecentre. This is then placed into the GP's workflow for action and subsequent incorporation into the patient's primary care electronic health record. Please note that the admin process at the GP surgery can take up to 2-3 weeks so the content of the letter may not be seen by a clinician until that time.

Currently, all discharge letters are sent in paper form as well as digitally.

8 QUALITY STANDARDS – OUTPATIENT LETTERS

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 as soon as practicable. They should be written ***to*** the patient and ***copied*** to the GP.

8.1.2 Outpatient letters should be issued to the General Practitioner within 7 calendar days of the patient being seen in clinic.

8.2 Outpatient Letter – Copy for Patient (see Appendix 1)

A **copy of the letter** should be sent to the patient 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

8.3 Content of Outpatient letters

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.

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)

All Outpatient letters should contain as a minimum:

8.3.1 **Patient demographics**

- NHS number, GP details
- Consultant and Speciality
- Name, grade, and registration details of clinician completing the letter
- Name of General Practitioner and details
- Date of Appointment
- Clinic details

8.3.2 **Clinical Details**

Diagnosis (or differential diagnosis) for which the patient is being seen in the clinic.

8.3.3 **Medication**

Medication relevant to the condition for which the patient was being seen in clinic, with any changes to existing medication being clearly indicated

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' https://www.lmsg.nhs.uk/traffic-lights/

List of other medications not relevant to the clinical episode are not required to be present in the outpatient letter.

8.3.4 Details of Any Procedure Performed in Clinic or Planned to be Performed

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 Action requested of/Information for the Patient Any actions discussed and agreed with the patient during the consultation. This should be written in a form that the patient will understand. Please avoid abbreviations and overly technical terms. Consider offering Trust Patient Information relevant to the consultation https://yourhealth.leicestershospitals.nhs.uk/.

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

8.3.8 In Addition to the Above Mandatory Fields There is an opportunity to write a summary of the consultation, which could include the reasoning behind some of the information given in the mandatory fields.

9.0 EDUCATION AND TRAINING

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

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

10.1 PROCESS FOR MONITORING COMPLIANCE

10.2 Audit standards – see table below

Element to be monitored	Lead	Tool	Frequency	Reporting arrangements	Lead(s) for acting on recommendations
Inpatient and Day-case Discharge Letter Timing - % within 24 hrs	CMIO	ICE/ Nervecentre	Monthly	CMG Quality and Safety Boards (by exception)	CMG/ Heads of Service
Outpatient Letter Timing - % within seven calendar days	Operational Performance Manager	Dit3 Reporting	Monthly	Service and General Managers	Service And General Managers
Primary Care Feedback on timing and quality of discharge letters and their content	CMIO	GP Concerns	Monthly	Transferring Care Safely Board	Head of Patient Experience

11. DOCUMENT CONTROL, ARCHIVING AND REVIEW OF THE DOCUMENT

Archiving of the policy will be via the Policies and Guidelines Library. The policy is to be reviewed in three years or earlier if there is any new national guidance published.

12. 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.

13. EVIDENCE BASE AND RELATED POLICIES

Discharge and Transfer of Care Policy (Going Home Policy) – For Adults Leaving Hospital - Trust Reference B2/2003

PRSB Implementation Guidance Report eDischarge Standard from January 2019 Accessed 19/10/2020. https://theprsb.org/wp-content/uploads/2019/02/eDischarge-Summary-Maintenance-

Release-Implementation-Guidance-Report-v2.1-23.1.19.pdf and their standards for Outpatient Letters 2017 https://theprsb.org/wp-content/uploads/2019/02/Outpatient-Example-Letters-V1.6-12.02.19.pdf and Emergency Departments https://theprsb.org/standards/emergencycaredischarge/ 2019 Accessed 19/10/20

Please write to me 2018 https://www.aomrc.org.uk/reports-guidance/please-write-to-me-writing-outpatient-clinic-letters-to-patients-guidance/ Accessed 19/10/20

NICE Drug Allergy: Diagnosis and Management https://www.nice.org.uk/guidance/cg183 Accessed 9/11/20

Department of Health – "Copying letters to Patients - Good practice guidelines" 2003 (Archived): Section 3 - When letters should not be copied -

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 2018.
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.

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.

Safe haven procedures

3.6 There are some services (for instance Sexual Health 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 Caldecott 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.

APPENDIX 2

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, in-patient, and day-case discharge letters will be issued within 24 hours of discharge

2.2 All outpatient letters will be issued within 7 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

3.3 The Emergency Department do not routinely copy letters to patients, but a copy can be printed and given to the patient prior to leaving if required.

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 agreed actions for patient
- 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
- End of life/palliative care or DNA CPR – where appropriate.

Appendix 3 - ED Attendance Letter Example

Emergency Department
Leicester Royal Infirmary
Infirmary Square
Leicester LE1 5WW
10 Aug 2020

PR JONES
Oakmeadow Surgery
87 Tatlow Road
Glenfield
Leicester
LE3 8NF

Dear Dr JONES

Re: TEST-TESTPATIENT, Kai (Male)
Ida Darwin Hospital, Cambridge Road, Fulbourn, Cambridge CB21 5EE
Date of Birth: 01-Jan-2013 NHS No: 111 222 3333 UHL System No: S2796281

Your patient attended the Leicester Royal Infirmary Emergency Department at 17:10 on 10-Aug-2020

Presenting Complaint	Tingling in thigh
Investigations	No investigations performed
ED Diagnosis	[?] Meralgia paraesthetica - Left
Treatments	No procedures performed
Seen By	
Discharged At	10-Aug-2020 17:23
Departure Destination	Discharge home
Follow-up	No referral
GP Notes	We think that the tingling feeling in your thigh is because of a trapped nerve in your groin. We could not find anything to worry about when we examined you and this is reassuring. You may wish to read about the condition and for this reason we have emailed you a link to a website called UpToDate which has all you would need to know about the condition. If anything which is not part of this condition happens, please discuss this with your GP for further advice.

The patient has attended the Emergency Department on 1 occasion(s) in the last 2 years

10-Aug-2020	Tingling of thigh

Yours Sincerely,
ED Consultants
Leicester Royal Infirmary
Emergency Department

Copy to GP
TEST ICE

NHS number: Hospital Number: S2795033

University Hospitals of Leicester NHS Trust

Adult Acute Medical Unit / Short Stay Medical Unit Discharge Summary

NOT FOR USE IN CHILDREN'S HOSPITAL

Patient Identification

TEST ICE
ANYWHERE
ANYWHER
E STREET

ANYWHERE

Admission Date	15/01/2024 14:59
Admission Source	Usual place of residence
Admission Method	Emergency - A+E Dept.
Discharge Date	15/01/2024 21:10
Sex	Female
Date of Birth	15/11/1960
Marital Status	NotSpecified
NHS number	
Hospital Number	S2795033

Presenting Complaint - Headache

Main Diagnosis on Discharge - Headache of unknown aetiology

Co-morbidities (e.g., Previous Medical Conditions)

Type 2
diabetes
Obesity

Admission Notes including 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:
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 are 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 gets 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.

[691806/4]

Appendix 5 – Inpatient Discharge Letter

Adult Discharge

Printed 18/07/2023 16:15 by JacksonS

Name	Hospital Number	NHS Number	DoB	Sex	Current Ward/Bed	Campus
XXTESTPATIENTL, One Imt Test	S3302321		01/01/1983 (40y)	M	zLGH GHIS Test Ward	LGH

Adult Discharge Await ward dispense

Created: 13 Jul 2023 14:18 by NCTest Cons - Consultant

	Name	Value
New	Admission Type	Emergency / Unplanned
New	Admission Reason	Weight loss and palpitations
New	Diagnosis	Thyroid storm
New	Follow Up / Appts / Procedures	Dr Jackson endocrinology clinic in about 6 weeks - organised
New	Inpatient Management	Managed with steroids, beta blockers and Propylthiouracil with good effect
New	Considerations for GP	Please continue the Propylthiouracil until further notice
New	Dementia Screen	Not applicable
New	VTE Reassessed	Yes - no ongoing VTE prophylaxis required please reassess if going to a new hospital
New	Other Diagnosis / Comorbidities (e.g. Previous Medical Conditions)	Hypertension
New	Information for the Patient / Carer / Plans for Future Care	You were very unwell when you came in to hospital. This was because you had a very overactive thyroid gland. We are glad that you feel better now. You will need to be on the new medication, Propylthiouracil, for about 18 months. Dr Jackson will see you in his clinic sometime within the next couple of months and you will receive an appointment for this in the post. It would be very helpful if you could have a blood test using the form that we gave you before you left hospital for this purpose, ideally a week or so before the hospital appointment with Dr Jackson. If you have any further questions please feel free to contact Dr Jackson's secretary on 0116258 8304.
	Allergies	No known allergy
New	Medical Certificate (Fit Note) Offered to Patient?	No
New	TTO Inpatient	Propylthiouracil 100mg tablets
New	Discharge Pathway	a) Pathway 0 - Discharge to a domestic home. No active support needed from health and social care once home
New	Discharge Destination	Own Home
New	Discharging Specialty / Department	Acute Medicine
New	Discharge Date	18 Jul 2023
New	Permission to view Enhanced SCR	Yes - Patient gave consent

Appendix 6 - Outpatient Letter

Hospital No: S1234567
NHS No: 800-111-1234
Clinic: LBSNJ5AF 31/07/2020
Dictated: 31/07/2020

University Hospitals of Leicester NHS Trust
Loughborough Hospital
Hospital Way
Loughborough
Leicestershire
LE11 5JY

Telephone: 01509 564999

11 August 2020

PRIVATE AND CONFIDENTIAL
MRS K DUCK
10 MORPETH GARDENS
SHEPSHED
LOUGHBOROUGH
LEICESTERSHIRE
LE11 9XY

Dear MRS DUCK,

Re: KATHY DUCK (DOB 11/05/1964)
10 MORPETH GARDENS, SHEPSHED, LOUGHBOROUGH, LEICS LE11 9XY

Diagnosis
Thyrotoxicosis

Medication for this episode
Carbimazole 5mg daily - stopped today

Follow up
Nil

Action requested of GP
Nil

Action requested of patient
Please have one blood test in six weeks and another blood test six weeks after that using the enclosed forms

It was nice to have a chat with you today. As I explained over the telephone, it is worth stopping the Carbimazole now as the current episode of the overactive thyroid is probably over. We will need to confirm or refute this by you having two blood tests as above, and I have enclosed two forms for this purpose. If you don't hear from me, you can assume that both these blood tests are normal, and if either is abnormal, I will write to you with advice.

If you ever have symptoms of an overactive thyroid again, then it is worth asking your GP to repeat your blood test just to check, but you don't need any more routine blood tests after the two above, unless I ask you to have more.
Warm regards.
Yours sincerely,
Approved electronically
Dr Steve Jackson
Consultant Physician and Chief Medical Information Officer
Copy to:
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GENERAL PRACTITIONER