HUMBERSIDE LMCs

The professional voice of general practice

Hospital Discharge Letters to GPs

Practice Management

Minimum Acceptable Standards

Importance
A patient episode cannot be regarded as complete until the GP receives an adequate communication. The LMC believes that the priority given by hospital doctors to discharge letters may be low. GMC guidance makes it clear that communication with other doctors is an integral part of essential medical care. The Trust should consider completing the writing of a discharge letter along with, as opposed to after, other discharge procedures.

Addressing
The letter needs to go the patient's current General Practitioner. Many letters are sent out weekly by the Trust to incorrect addresses. Unless this is corrected it is unlikely any other quality improvements can by implemented. It also represents a massive breach of patient confidentiality.

Discharge sheets
These should contain an accurate discharge medication list and principle diagnosis**.**
The discharge medication list should be legible, clearly differentiate between acute and continuing medication, and contain detailed instructions where appropriate (e.g. reducing/increasing doses). It must also contain a named doctor who can be contacted for clarification if necessary. This would ideally be sent electronically.

Time for receipt
Procedures should be implemented to allow receipt of the letter at the GP's surgery no later than 3 weeks after discharge

Ideally, the full letter should reach the GP before repeat medication is required, as GPs are in an indefensible medico legal situation if they treat without full information. This can only be achieved once 28-day discharge prescribing is implemented, but the three-week standard should be put in place now for when this happens.

Content
A balance needs to be struck between detail and clarity. In general, a thoughtful shorter letter is preferred to the "computer-generated dataset transfer" approach

This is an area where it will be impossible to please everyone, especially as some consultants use the discharge letter to also act as a summary of the episode within the hospital record. However, GPs are overwhelmed with correspondence and sometimes the depth of detail obscures important facts.

Completely computer generated letters, such as those from A&E, are not adequate as some degree of explanation or elaboration is always required.

Specific requests for action requiring patient participation
Where a GP is requested to perform a particular action, such as a follow-up blood test if appropriate or prescription, the patient must be aware of this and instructed to contact the surgery

Sometimes letters contain requests such as those detailed above that are never actioned because the patient does not approach the surgery. It is neither safe nor reasonable to expect GPs to pro-actively chase patients to ensure the completion of hospital treatments. Hospital doctors have a duty to ensure that the care they judge to be required is

followed, and although GPs recognise that some follow-up is best performed in the primary care setting, nevertheless the responsibility for ensuring that this happens must rest with the initiating doctor.

Where patients themselves need take action the fact that they are aware of this should be included in the letter. (e.g. "Mr. X ought to have his cholesterol checked in 3 months and he has been told to contact the surgery")

Signatures
All letters must be signed before dispatch**.** The signature on a clinical letter is not just a courtesy, but is an acknowledgement that the letter has been read since typing and that the writer can vouch for the accuracy of the information. All GPs have examples of transcription errors in letters that have either not been signed, or clearly not been read before signing. As fewer staff with formal medical secretary qualifications are employed the potential for adverse events increases, as does the importance of the final signature to indicate accuracy of and responsibility for the letter's contents. Electronic letters are acceptable if they have an electronic tag and audit trail to verify that the doctor has signed it.

Copying of clinical letters to patients
Where clinical letters are copied to patients, the responsibility for dealing with queries arising from the letter must rest with the writer and not the recipient.

This letter has been copied to you for information only. If you have any queries about the content of this letter please contact *named person* **on** *telephone number* **during normal office hours.**

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The Humberside Group of Local Medical Committees Ltd

Albion House
Albion Lane
Willerby
Hull
HU10 6TS

01482 655111
humberside.lmcgroup@nhs.net
www.humbersidelmc.org.uk

@HumbersideLMC. Follow us for news and updates.