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# Resources for Inpatient Doctors



# 1. Background

The national target expectations for sending discharge notifications to GPs has been reduced from 48 to 24 hours. This is essential for ensuring a smooth and coordinated transition of care for service users. By receiving their discharge notification in a timely manner, service users can obtain their medications without delay and begin their recovery in the community. *See wider [Admission, Transfer and Discharge Policy](#) for further context and guidance.*



The information in the Hospital Discharge Form is combined with information pulled from a number of other places in RiO to create an 'editable letter' which is the document sent to the GP and uploaded to RiO as the NODF (Notification of Discharge Form – the four letter code used to upload in RiO).



We plan to gradually change how we enter information into RiO during regular clinical work. The goal is to enter most of the information needed for the discharge letter during the patient's admission, instead of waiting until the time of discharge. This will allow us to create more accurate and timely discharge letters.



Service users have expressed how the discharge process can be stressful, often sudden and lack clarity. Feedback has shown that discharge letters can act as an informative document that allows service users to understand their care and what to expect following discharge. The 'My Safety Care Plan' also acts as a useful document to better inform the service user of the care and recovery, which they should have a copy of before discharge

## **2. Staff, GP and Service User Feedback**

## Staff and GP Feedback

### Junior Doctors/ Pharmacists

- Generally the process feels faster
- The removal of the progress and treatment summary makes it harder for Junior Doctors to refer back to previous admissions if a service user is readmitted - This is now being managed through progress notes, existing records and as part of the follow-up plan

### GPs

- The discharge letter can sometimes lack clarity of what's happened during the admission – the information provided can be long and unnecessary contextual information
- The discharge letter should provide a short, concise summary of the reason for admission, diagnoses, and any changes in medication
- If there are requests for the GP to complete specific actions, they would like to know why, if not already mentioned in the discharge letter

# 2.1 Why this matters: Learning from service users

## Discharge Process

“Not as well as staff think I am” “More Pre-discharge conversations”  
“Lack of follow-through on agreed plans” “No accountability”  
“Poor communication” “Better advance planning with me”  
“Felt rushed” “Had to go to A&E to get support”  
“Didn’t know about HTT” “Lack of community support”  
“Telephone check-in provided limited help” “Chaotic discharge”  
“Be more inclusive, language barriers” “Staff too busy”  
“Transition to community care was disjointed”  
“Felt Abandoned” “Randomly discharged on weekend”  
“Felt unsafe on discharge” “Not involving carer sufficiently”  
“Plan for discharge from B&B was unclear” “Relapsed”  
“Everything feels like a battle” “Loss in trust and faith in staff”  
“Benefit from information leaflet post discharge”  
“Staff not listening” “Repeatedly fell through the cracks”  
“Appointments not organised in community”  
“Need more help navigating system”

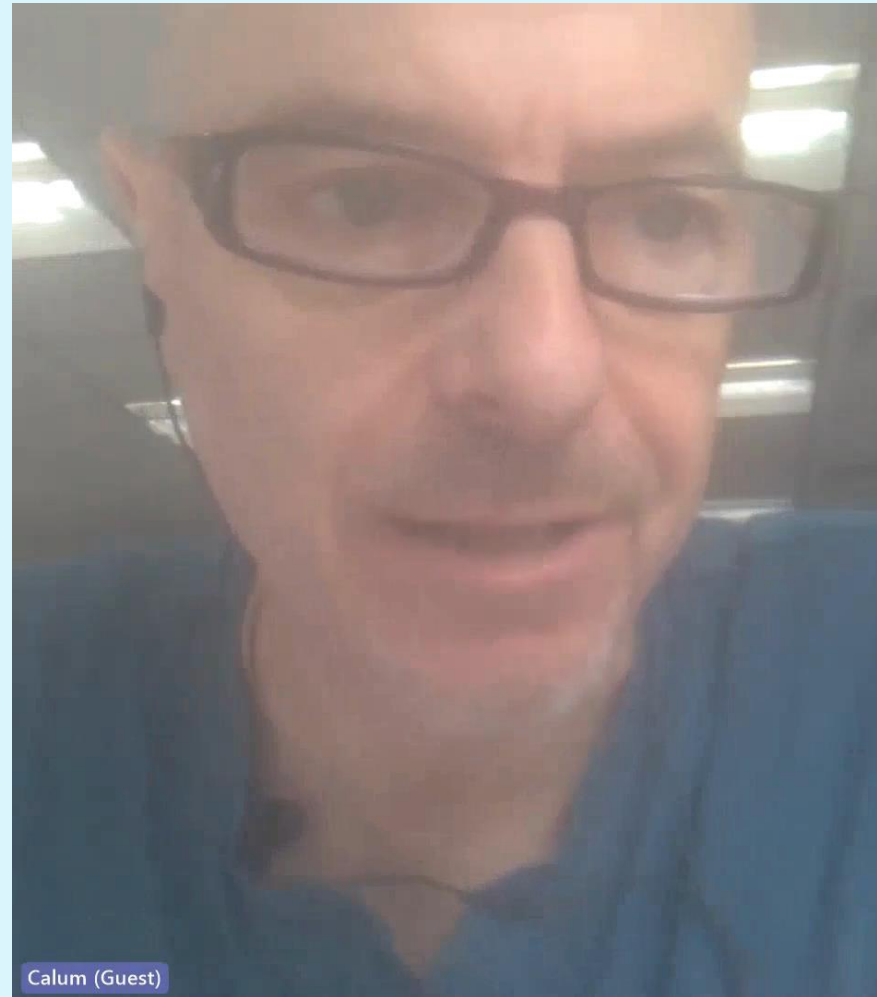
## Discharge Liaison Form

“Missing discharge letter delayed medications”  
“Had to chase for letter” “Did not get a discharge letter”  
“Format is good” “Content written without service user voice”  
“Wording can compound feeling stigmatised”  
“Less jargon” “Staff should incorporate both professional and user perspective to reduce stigma”  
“Discharge letter is very helpful tool”  
“More detail about the follow-up plan so its clear who is responsible and by when”  
“Letters don’t always get to GP electronically”  
“More opportunities to discuss this before discharge”

## 2.3 Why this matters: Service user experience

Video: 2 minutes watch time

Please see the video here: <https://www.elft.nhs.uk/intranet/teams-support-me/corporate-performance/discharge-liaison-form-dlf-project>



## 3. RiO



# 3.1 How to access the Hospital Discharge Form

**Video: 3 minute watch time**

[Click here: How to access the Hospital Discharge Form](#)

The screenshot displays the 'Clinical Portal - Client's View' for a patient named ZZTEST Dummy (Miss), born 21 Mar 2010 (13 years), Female, NHS 726 742 1962. The interface is divided into several sections:

- Clinical Indicators:** Shows a list of indicators with icons for Alerts, Conditions, Allergies, Consent Not Indicated, and Consent Given (4 Oct 2017).
- Case Record Menu:** A tree view containing folders for Case Record, Client Demographics, Documents & Editable Letters, Medical Documentation (Mental Health), Conditions (SNOMED)Diagnosis (ICD10), Risk Information, Physical Health, Recovery Care Pathway Documentation, Safeguarding, Mental Health Act & Mental Capacity Act, Clustering, Client Referrals, Inpatient Management, Client Related Data-Views, CAMHS, Intellectual Disability, Forensic Forms, Specialist Assessments, Assessments, Outcome Measures, and Mental Health Care Management & Reviews.
- Demographics:** A table of patient information including:
  - Full Name (ClientID): Miss Dummy ZZTEST (21049414)
  - Preferred Name: Unknown
  - Alerts: Looked after child, Clinically vulnerable to infection, Asthma, Frequent A/E Attender, Child Protection Plan, Asthma, Communications - do not send text messages, Gender confidentiality issues (see alert text for details), Harassment / Stalking, Learning Disability, may require reasonable adjustments
  - LATEST RISK INFORMATION: 09 Mar 2023 16:34 - Risk Incident
  - My safety is my advance directive: Yes
  - Access to child who has Protection Plan?: Yes
  - Client has a Child Protection Plan?: Yes (Fully validated)
  - Address: 34 Canons Drive, Edgware, Middlesex HA8 7QT
  - Communication Preferences: No interpreter requirement
  - Other Communication Info: 020 7876663663 (Work), 0208 223 1234 (mums no) (Home)
  - Contact Number(s): Unknown
  - Email Address: Not Assessed
  - Does the Client have a Carer?: Not Assessed
  - Dependants: David Fost (Daughter, 22 day(s) old), Drew Banks (Daughter, 15 week(s) old), Zztest Clare (Daughter, 9 years old), Zztest (Brother)
  - Registered GP: UNKNOWN(UNKNOWN PRACTICE)
  - Teams: BD CAMHS ADHD, CH Rehabilitation, Child SLT EY West Ham Lane, Dummy Team 2, DUMMY TEAM 2CN, NH CRT North, NH Early Intervention Service, NH Peri-natal
  - Care Co-ordinator: Temitope (CA) Adedewe
  - Current Care Level: CPA
  - Cluster Status: Cluster 4, review due date 22 Nov 2019 (NEW DRAFT CREATED)
  - Inpatient Status: None
  - School: Alice Model Nursery School
  - Role: Client Only
  - Alternative Legacy CHN RIO ID: 21378010

## 3.2 What RiO forms populate the discharge letter?

Clinical information entered into dedicated forms on RiO is automatically incorporated into the discharge letter. The following list of forms outlined which ones must be completed prior to discharge.

- 1** Information entered into the **Clinical Assessment Form** in the Medical Documentation Folder will be automatically pulled to populate the 'circumstances of admission' and 'mental state examination' sections on the discharge letter. It is expected that the admitting doctor will complete this form on admission. ***During early deployment, this loop may not have been closed, and these two fields may need to be completed before the editable letter can be generated.***
- 2** **Blood and ECG results** in the Investigations form in the Physical Health folder. Completed by Junior Doctor
- 3** **Blood pressure and BMI data** in the Observations and Measurements form in the Physical Health folder. Completed by Ward Nurse
- 4** **Smoking, diet, exercise and alcohol intervention information** in the Lifestyle form in the Physical Health folder. Completed by Ward Nurse
- 5** **The new Hospital Discharge form** found in the Medical Documentation folder which gathers information on treatment during admission, discharge medication and discharge plan. It is anticipated that this be completed during the discharge ward round. Completed by Junior Doctor

# 3.3 Editable letter template

Contents derived from the following forms:

Clinical Assessment form

Investigations form

Observations and Measurements form

## DISCHARGE LIAISON FORM

RIO Number:	NHS Number:					
Admission Date:	Discharge Date and Time:					
CONSULTANT:	CARE COORDINATOR:					
ON CPA? CPA	Subject to 117?					
<b>ADMISSION AND TREATMENT SUMMARY</b>						
Circumstances of admission presenting complaint						
Mental State Examination on Admission appearance and behaviour						
<b>PHYSICAL HEALTH INFORMATION</b>						
Blood tests carried out HbA1c (mmol/mol): 40.44						
Blood test comments						
ECG tests carried out						
ECG comments						
Blood pressure Last BP date: 27 Jun 2022 BP: 112/72						
BP intervention, BMI, BMI related lifestyle interventions	Smoking status, Smoking interventions					
<b>PRIMARY DIAGNOSES</b>						
<b>ALLERGIES</b>						
<b>MEDICATION ON DISCHARGE</b> Hospital only drugs will need to be added to the patients GP record for information, these include CLOZAPINE and any long-acting depots that are prescribed and administered in secondary care						
Drug Name	Route	Dose	Direction	No of days supplied	Hospital to continue	GP to continue prescribing
test med	None	None	None	None	None	None
<b>MEDICATIONS CHANGED DURING THIS ADMISSION</b>						
Validating pharmacist:	Date/time of validation:					
<b>FOLLOW UP PLAN</b>						
Discharge Care Plan						
GP Follow-up Plan						
DOCTOR COMPLETING FORM	NAME AND POSITION	DATE				

**Case Record Menu**

- [-] Case Record
  - [-] Client Demographics
    - River View
    - Progress Notes
    - East London Patient Record (HIE)
    - RIO Patient Record Summary
    - Liaison Psychiatry Form
  - [-] Documents & Editable Letters
    - Document List View
    - Document Upload
    - Editable Letters

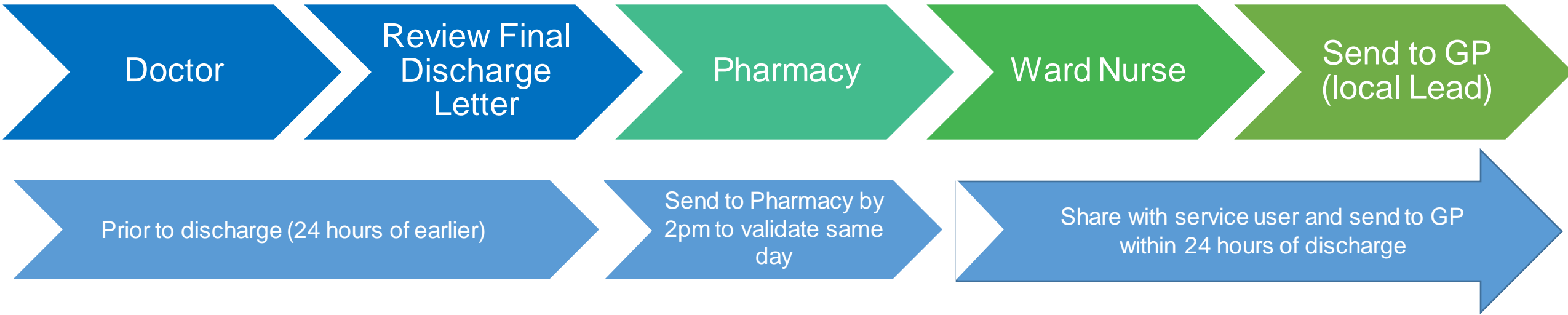
Letter Type Please Select v

The editable letter can then be generated and sent to the GP. The editable letter is titled “\*\*Discharge Liaison Form” and should be found close to the top of the list as shown below. *Note: access to the editable letter is assigned on an individual basis. We hope we have assigned this letter to everyone who needs it but if you don't see it then please contact the RiO Helpdesk via the Service Now portal and we can get this swiftly corrected.*

Lifestyle form

# 4. Process

# 4.1 Recommended process flow



- The Junior doctor will complete the "Hospital Discharge" form.
- Junior Doctor to ensure that all the information on the form is correct including admission and discharge date.

- Establish or follow existing governance process for reviewing final discharge letter. Use 'DLF Data Report' to view contents of complete form.
- Doctors are responsible for the quality and accuracy of the discharge letter prior to pharmacy sign off and/or admin sending to GP
- Junior Doctor or the Consultant will email Pharmacy to notify pharmacy that their form is ready for validation

- Ward pharmacist will validate the form and digitally sign. **Please note that the pharmacist will just be reviewing medication and allergies.**
- Pharmacy will validate medication on the same day if received **before 2pm.**
- Ward pharmacist will use editable letters to create the discharge liaison letter (see email below for guide on how to complete this)

- **Gold standard is a copy of discharge letter printed and given to patient**
- Patient to be given medication, which has been sense checked by Ward Nurse
- Patient discharged

- Depending on the borough the ward administrator, Pharmacist, or Doctor will send the discharge letter to the GP.
- **Please note, it is the Junior Doctors responsibility to check the final letter before it is sent to the GP and ensure all quality checks have been completed**

# 5. Good Practice

# 5.1 Learning from discharge letter audits

Good Practice	Areas for further training
<p><b><u>Quality of written information</u></b></p> <ul style="list-style-type: none"> <li>Evidence of clear &amp; concise summary related to circumstances of admission and key relevant information pertaining to the admission itself within in the 'circumstances of admission' section</li> <li>Clear and concise follow up plan section for community teams and GPs</li> </ul> <p><b><u>Completeness of information</u></b></p> <ul style="list-style-type: none"> <li>Physical health information and interventions completed within dedicated forms rather than progress notes</li> <li>Key medication changes highlighted where appropriate</li> </ul>	<p><b><u>Quality of written information</u></b></p> <ul style="list-style-type: none"> <li>clarity of written information in relation to the circumstances of admission section is variable. <b>33%</b> had the full assessment automatically inserted from the MSE and admission summary included without any further review to check its relevance, quality, grammar and format before being submitted to GP.</li> </ul> <p><b><u>Automation issues</u></b></p> <ul style="list-style-type: none"> <li><b>18%</b> of discharge letters checked in the audit had information from previous admissions (out of date). In some cases it was been 5 years old. Emphasises the need for robust governance structures to check the editable letter before it is uploaded or review whether information should not be automated going forward.</li> </ul> <p><b><u>Governance</u></b></p> <ul style="list-style-type: none"> <li>Variability in review process of discharge notifications. Where doctors are involved in submitting discharge notifications directly to the GP, the information included has been clearer and more concise.</li> </ul>

**\*Audit included 30 Discharge letters. 5 from each borough after launch of the new form**

# 5.2 Good Discharge Letter Example

Clear and concise summary related to the circumstances leading to the admission and key information during the admission. It should make for clear reading, written in past tense. The clinician has taken time to reorganise the section as sometimes the automation of this section can result in unnecessary content being added. It is the responsibility of the doctor to view the completed discharge letter before it goes to the service user and GP, to ensure high quality

Physical health information and interventions completed within dedicated forms and **not** in progress notes

## DISCHARGE LIAISON FORM

RIO Number:	NHS Number:
Admission Date:	Discharge Date and Time:
CONSULTANT:	CARE COORDINATOR:
ON CPA?	Subject to 117?

**ADMISSION SUMMARY**

**Circumstances of admission**  
 was brought by the police into A&E because she was feeling suicidal. She was diagnosed of PTSD. She was discharged from the ward in February 2023 but did not engage further with CIMHS when she was referred. She was prescribed Olanzapine 5mg and Mirtazapine 15mg both at night. She is not currently taking any medication. She presented to be stressed with her accommodation situation which is her main stressor. She is hearing voice but telling her positive things to do. She felt disappointed that there was no follow up by the mental health team when she was discharged from the hospital. She said her room is not lightened up and she lives like a prisoner. She stated that due to everything going on at the moment for her she has missed her exams which is really painful and struggle to come to term with that news.

**Mental State Examination on Admission**  
 She maintained eye contact throughout the conversation. She was fluent and coherent in her speech, there was no delay in speech. She was low in mood and angry with the feeling of committing suicide. She had the understanding of her current situation and agreed to start her medication after picking it up today from her GP.

**Risk:**  
 She is a risk to self  
 risk to others is low

**PHYSICAL HEALTH INFORMATION**

**Blood tests carried out**  
 Discharged prior to completion

**ECG tests carried out**  
 Last ECG done: 23 May 2023  
 ECG Result: Normal

**ECG comments**  
 Sinus Rhythm  
 Rate- 72

QT- 411  
 QTc- 450

**Blood pressure**  
 Last BP date: 23 May 2023  
 BP: 116/61

**BMI**  
 BMI: 24.03  
 Height: 179  
 Weight: 77

**BMI related lifestyle interventions**  
 Diet Intervention: Intervention not required  
 Exercise Intervention: Intervention not required

**Smoking status**  
 Smoking status: No

**DIAGNOSES**  
 F61X - Mixed and other personality disorders  
 History of F431 - Post-traumatic stress disorder

**ALLERGIES**  
 NKDA

**MEDICATION ON DISCHARGE**  
 Hospital only drugs will need to be added to the patients GP record for information, these include CLOZAPINE and any long-acting depots that are prescribed and administered in secondary care

Drug Name	Route	Dose	Direction	No of days supplied	Hospital to continue	GP to continue prescribing
mirtazapine tablet	po	15mg	night	7	No	Yes, weekly
olanzapine tablet	po	5mg	night	7	No	Yes, weekly

**MEDICATIONS CHANGED DURING THIS ADMISSION**  
 Nil - recommended medication from last admission

Validating pharmacist: \_\_\_\_\_ Date/time of validation: \_\_\_\_\_

**FOLLOW UP PLAN**

**Discharge care plan**  
 Discharge to CIMHS  
 - consider psychology management  
 Crisis Plan aware

**GP follow-up plan**  
 please continue with above medications  
 please provide weekly prescriptions

Key medication changes and any important high-risk medications highlighted

Clear and concise follow up plan section for community teams and GPs. This box should also be used to detail any pertinent information related to the admission that might provide useful context for the plan and recommendations to the GP



# 5.3 How to understand & monitor your wards performance using Power BI Reports

**Video: 1:40 minute watch time**

[Click here: How to monitor performance through PowerBI](#)

The screenshot displays the Microsoft Power BI Home interface. At the top, there's a search bar and navigation icons. The main content area is divided into two sections: 'Recommended' and 'Recent'.

**Recommended Section:** This section features five report tiles arranged in a row. Each tile has a placeholder image with a Power BI icon and a title below it. From left to right, the titles are: 'ELFT Adult MH Analytics', 'ELFT Adult MH Analytics', 'ELFT Children's Services Analytics', 'ELFT Children's Services Analytics', and 'ELFT Community Health Analytics'.

**Recent Section:** This section contains a table of recently accessed reports. The table has columns for Name, Type, Opened, Location, Endorsement, and Sensitivity. There are three rows of data.

Name	Type	Opened	Location	Endorsement	Sensitivity
ELFT Adult MH Analytics	App	3 minutes ago	Apps	—	—
ELFT Children's Services Analytics	App	11 days ago	Apps	—	—
ELFT Community Health Analytics	App	14 days ago	Apps	—	—

# 6. Recommendations

# 6.1 Recommendations for directorate teams



Establish a way for doctors to view the completed discharge letter before it goes to the service user and GP, to ensure high quality



Develop the discharge plan during the ward round or pre-discharge meeting, so that all information is captured in advance



Coproduce the discharge plan with the service user, prior to discharge, and use this opportunity to ensure contact information is up-to-date for the 72-hour follow-up



Use the data in PowerBI at ward level to view performance



Provide the “My Recovery Plan” to the service user at the point of discharge, together with the discharge letter as per the guidance in the [‘Admission, Transfer and Discharge Policy’](#)



Consider creating an information leaflet or ward poster that helps explain the support available from community services following discharge



Explore expanding the peer support offer on wards to help the transition from hospital to community care settings