South East London Integrated Care System

NHS South East London

South East London Discharge Summary: Proposed Standards

1. Purpose & definition

A South East London (SEL) discharge summary is a single standardised communication from secondary care to primary care produced after a hospital attendance or admission. Its purpose is to:

- communicate the diagnosis/reason for admission and what happened in hospital,
- clearly state actions required and who is responsible,
- provide a patient-facing, plain-English summary of next steps, and
- support safe handover and medicines reconciliation.

(Aligned with Professional Record Standards Bosy (PRSB) intent that one single discharge summary should contain all pertinent information and be sent to GP and patient.)

2. Structure: required headings

Implementations must support all PRSB headings, but local display order may vary. Below are the *minimum* clinical headings that must be completed (or explicitly stated as "None / Not applicable"):

1. **Patient identifiers**: Include NHS number (or "Not known"), name, DOB, NHS organisation that generated record. (PRSB mandatory demographics.)
2. **Reason for admission**: List symptoms and severity of symptoms experienced requiring admission and dates associated with symptoms
3. **Diagnosis**: Provide diagnosis; date(s) of diagnosis. (PRSB: record primary/secondary diagnosis guidance.)
4. **Investigation results & outstanding tests**: Include only the clinically important results and provide **clear ownership for follow up (who arranges action). If tests are pending, state who is to follow up and by when.**
5. **Medication summary**: Acknowledge which medications are to continue, identify new medication(s), include medication(s) changes with reasons for change, record whether supplied and quantity/duration. Indicate whether the patient has been counselled on changes to the medications. (Follow PRSB medicines guidance.)

6. **Allergies & adverse reactions**: Provide explicit statement if none known, or "Information not available" where relevant.

7. **GP Actions box (MANDATORY, visible and separate)**: Provide explicit, *actionable* items for GP (or "None") with due dates where relevant and the named responsible party for each action (hospital team, GP, patient).

8. **Patient actions / Advice (patient-facing)**: Provide plain English instructions for patient, including counselling to changes in medications, follow-up steps and expected symptoms to watch for.

9. **Follow-up / Next steps**: Include named responsible team/person, timeframe, who arranges (GP or hospital/secondary care).

10. **Contact details for queries**: Include named contact, team, phone/email, and times available. (Essential for patients & primary care.)

11. **Person completing record**: Provide name, role and date/time stamp.

Why: Feedback from clinician reference group valued consistent placement of actions, and named responsibility to avoid workload shifting to primary care. PRSB requires these data models/fields exist and be supported by systems.

3. Presentation & language rules

- **Single summary only:** One patient-friendly discharge summary is produced and distributed (no separate AVS + discharge summary duplication).
- **Dedicated GP Actions box:** Always shown prominently and cannot be removed or hidden by default in the EPR. If there are no actions, explicitly state "None".
- **Plain language for patients:** Each summary must include a short patient-facing paragraph (2- 4 lines) in non-technical language summarising reason for admission, what was done, and next steps. PRSB notes patient should get a copy and communications should be as understandable as possible.
- **Avoid duplication & avoid irrelevant raw data:** Only clinically pertinent investigation results should be included.
- **Template enforcement:** EPR templates should prompt completion of minimum fields and prevent sending unless the *mandatory sections* (including GP Actions box) are completed.

4. Coding & computable data

- **To be considered alongside digital teams-** follow PBRS standards, FHIR technical specification[1]

[1] Transfer of Care message specifications - NHS England Digital

5. Distribution & timing

- **Send at discharge:** The single discharge summary must be sent electronically to the registered GP *and* given to the patient at or immediately after discharge. PRSB and clinician group both stress timely, single summary delivery.
- **Other recipients:** Community teams / care homes / pharmacies per local trading agreements; all recipients listed on the distribution list.

6. Governance, training & implementation

- **Local PSCI oversight:** Place-based Primary–Secondary Care Interface group to own adoption, mapping and trading agreements (clinician group recommendation).
- **Training:** Include discharge-summary standards in inductions and registrar training; focus on purpose and how to write succinct, action-oriented summaries. (Local PSCI teams to manage)
- **EPR configuration:** Configure Epic/EPR templates to enforce mandatory fields (esp. GP Actions), make GP Actions box non-deletable, and provide a patient plain-lang paragraph generator or template suggestions.
    - Primary care digital collaboration group

7. Example SEL discharge summary

Patient name

NHS No

DOB

Discharge date | Completed by (name, role):
Patient summary (2–4 lines, plain English): “You were admitted for X. While in hospital we did Y. You should expect Z and need to do A. If you get symptom B contact …”

Diagnosis / reason for admission: [SNOMED code] & short text.

Medications (discharge list):

- [Medicine name (dm+d if available)] & Status: Indication for *New Drug / Changed / Continued / Stopped*; Dose directions; Reason for change; Quantity supplied (e.g., 28 tablets / 30 days).

Allergies: [List or “No known drug allergies” / “Information not available”].

GP Actions (boxed & prominent):

1. [Action text] - Responsible: [Hospital team / GP / Patient]; By: [date or timeframe].
   (If none: “No GP actions required”.)

Patient actions / Advice: [Plain English bullet points].

Pending investigations / Results to follow up: [test] - Responsible: [Hospital / GP] By: [date].

Follow up appointment: [Team / clinician], Date/How arranged (if arranged).

Contact for queries: [Name / Team / Tel / Email / times].

8. Minimum dataset

For each discharge summary the system should capture these structured elements (these form the auditable fields):

- ☐ Patient NHS number, name, DOB, contact.
- ☐ Date/time of discharge & name of person completing summary.
- ☐ Primary diagnosis (SNOMED) + secondary diagnoses (SNOMED) or symptom if diagnosis not yet confirmed.
- ☐ Medications: for each med - name (dm+d if possible), status (continued/new/changed/stopped), reason for change, directions, quantity/duration, whether supplied.
- ☐ Allergies/adverse reactions (or explicit “None known” / “Information not available”).
- ☐ GP Actions: text of action, due date (if applicable), responsible party (hospital/GP/patient).
- ☐ Patient actions/advice (plain English snippet).
- ☐ Pending investigations with ownership.
- ☐ Distribution list.

9. Key Performance Indicators (KPIs)

Governance: Governance: audit reviewed by borough-based PSCI group. Quarterly audit reports submitted to SEL-wide PSCI interface leads.

1. **Completion of GP Actions box (%)** - numerator: summaries sent with GP Actions box completed (or explicitly “None”), denominator: total discharge summaries. *Target*: ≥ 95%. (Clinician group emphasised this as key quality metric.)

2. **Single summary delivered to GP within 24 hours (%)** - target ≥ 95%. (PRSB: timely single summary.)

3. **Patient copy provided at discharge (%)** - target ≥ 95%.

4. **Medication reconciliation completeness (%)** - discharge meds coded with status (continued/new/changed/stopped) and reason for change present. *Target*: ≥ 95%.

5. **Plain-English patient summary present (%)** - patient-facing plain language paragraph included. *Target*: ≥ 90%. (Clinician group priority.)

6. **Outstanding test ownership (100%)** – Origin of investigation dictates responsibility for follow up. Follow up plans clearly stated. *Target*: ≥ 95%.

10. References for development

1. PBRS e-discharge summary guides[2]

2. Reference group meeting 24, September 2024

3. Health Innovation Network (HIN) led rapid literature review

4. UnBoxed patient user research report

11. Discharge summary audit performance audit scorecard

KPI	Definition/Calculation	Target	Current performance	RAG rating
Completion of GP Actions box	summaries sent with GP Actions box completed (or N/A if no actions are required).	≥ 95%.		
Single summary delivered to GP within 24	As stated,	≥ 95%.		
Patient copy provided at discharge	As stated,	≥ 95%.		
Medication reconciliation completeness	discharge meds coded with status (continued/new/changed/stopped) and **reason for change present.**	≥ 95%.		
Plain-English patient summary present	patient-facing plain language paragraph included.	≥ 90%.		

[2] eDischarge Summary Standard - PRSB

Outstanding tests and ownership present	pending investigations with clearly assigned responsible organisation. *Note: clinician responsible for ordering the investigation dictates follow up.*	≥ 95%.		