South East London Integrated Care System

NHS South East London

South east London Outpatient Letter Standards

1. Purpose & definition

A SEL Outpatient Letter is a single, standardised communication from secondary care to primary care, produced following a hospital outpatient attendance. Its purpose is to:

- Communicate the reason for the referral, clinical findings, and outcomes of the consultation.
- Clearly state any actions required, including who is responsible for each action.
- Provide a patient-facing, plain-English summary of next steps and follow-up plans.
- Support safe handover and medicines reconciliation, where applicable.

(Aligned with PRSB intent that one single Outpatient letter 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**: NHS number (or "Not known"), name, DOB, NHS organisation that generated record. (PRSB mandatory demographics.)
2. **Reason for referral**: symptoms and severity of symptoms experienced requiring referral and dates associated with symptoms
3. **Diagnosis**: diagnosis; date(s) of diagnosis. (PRSB: record primary/secondary diagnosis guidance.)
4. **Investigation results & outstanding tests**: only the clinically important results and clear ownership for follow up (who arranges action). If tests are pending, state who is to follow up and by when.
5. **Medication summary**: medications to continue, new meds, changed meds, stopped meds, with *reason* for change and directions; record whether supplied and quantity/duration. (Follow PRSB medicines guidance.)
6. **Allergies & adverse reactions**: explicit statement if none known, or "Information not available" where relevant.

7. **GP Actions box (MANDATORY, visible and separate)**: 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)**: plain English instructions for patient, including follow-up steps and expected symptoms to watch for.
9. **Follow-up / Next steps**: named responsible team/person, timeframe, who arranges (GP or hospital/secondary care).
10. **Contact details for queries**: named contact, team, phone/email, and times available. (Essential for patients & primary care.)
11. **Person completing record**: 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 Outpatient letter is produced and distributed (no separate AVS + Outpatient letter 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 the appointment, 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 after consultation:** The outpatient letter must be sent electronically to the registered GP *and* given to the patient at or before 10 days of the consultation. PRSB and clinician group both stresses timely, single summary delivery.
- **Other recipients:** Community teams / care homes / pharmacies per local trading agreements; all recipients listed on the distribution list.

Commented [CT1]: Discharge? When would the letter be sent?

6. Governance, training & implementation

- Describe audit process
- **Local PSCI oversight:** Place-based Primary–Secondary Care Interface group to own adoption, mapping and trading agreements (clinician group recommendation).
- **Training:** Include outpatient letter standards in inductions and registrar training; focus on purpose and how to write succinct, action-oriented letters. (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 Outpatient letter

Patient name

NHS No

DOB

Appointment date | Completed by (name, role):
Patient summary (2–4 lines, plain English): "You were seen in (insert outpatient service) for (insert symptoms/reason appointment was made). While in our care, we did Y. You were given a diagnosis of Z. You should expect A and need to do B. If you get symptom C contact …"

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

Medications (prescription list):

- [Medicine name (dm+d if available)] & Status: *New / 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 Outpatient letter 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

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

1. **Completion of GP Actions box (%)** - summaries sent with GP Actions box completed (or N/A if no actions are required). *Target*: ≥ 95%. (Clinician group emphasised this as key quality metric.)
2. **Single letter delivered to GP within 10 days (%)** - target ≥ 95%. (PRSB: timely single summary.)

3. **Patient copy provided (%)** - 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 letter present (%)** - patient-facing plain language paragraph included. *Target*: ≥ 90%. (Clinician group priority.)
6. **Outstanding test ownership present (%)** - pending investigations with clearly assigned responsible organisation. *Target*: ≥ 95%.

10. References for development

1. PBRS e-Outpatient letter guides[2]
2. Reference group meeting 24, September 2024
3. HIN led rapid literature review
4. UnBoxed patient user research report

11. Outpatient letter performance scorecard

KPI	Definition/Calculation	Target	Current performance	RAG rating
Completion of GP Actions box	Letters sent with GP Actions box completed (or N/A if no actions are required).	≥ 95%.		
Letter delivered to GP within 10 days	As stated,	≥ 95%.		
Patient copy provided	As stated,	≥ 95%.		
Medication reconciliation completeness	discharge meds coded with status (continued/new/changed/stopped) and **reason for change present.**	≥ 95%.		
Plain-English patient letter present	patient-facing plain language paragraph included.	≥ 90%.		
Outstanding tests and ownership present	pending investigations with clearly assigned responsible organisation. *Note: clinician responsible for ordering the investigation dictates follow up.*	≥ 95%.		

[2] Outpatient letter Standard - PRSB