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An evidenced-based strategy for timely delivery of clinical letters

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service by completing an audit of the number of working days for GPs to receive a clinic letter.

**Design/methodology**

Data on how many working days it took for the clinic letter to be sent to the GP surgery post-clinical encounter were collected for the three consultants working in the Adult Intellectual Disability Service, and their associated specialty and trainee doctors. The service provides assessment, treatment and support for people with an Intellectual disability across Cornwall. GPs refer patients to the service by letter or referral form, and these are reviewed at a weekly allocations meeting attended by the multi-disciplinary team. A care coordinator is allocated, and if appropriate an appointment for a medical review is arranged.

Cornwall has a population of around 550 000, largely living in rural areas. The service is split into three localities, each overseen by one consultant, and the secretarial support is one full-time equivalent secretary per consultant area.

As no suitable national standards were found, the local peer group agreed on a realistic aim. The number of working days taken to send a non-urgent clinical letter (this was defined as a letter generated from a pre-booked clinic appointment for a review of a health need) was calculated and recorded on an Excel spreadsheet. For the 2013 data, if a letter took more than five working days to send to a GP, it was noted whether there was a medication change recommended in the letter as this would be considered a potential negative consequence due to the delay. The information on medication change was not repeated for the subsequent two cycles due to a lack of ability to measure its eventual impact of potential harm. A standard of 0–5 working days was chosen by using practical evidence that 0–5 working days following the clinic would be a good benchmark for a non-urgent clinical letter to be dispatched out of the service (see Figure 2 for reasons). Each cycle prior to commencement and at end was reviewed by the medical peer group who ensured transparency of the process in addition to reviewing the suitability of the proposed timelines.

**Data collection**

Three cycles of data collection were completed. The first took place over a one month period in 2013 (86 letters). The second was done in 2014 for three months (261 letters). The third cycle ran for three months in 2015 with 427 letters being sent. Results were grouped into three categories: 0–5 working days, 6–10 working days, and 11+ working days. The results were broken down for each consultant/associate specialist and trainee doctor team.

**Results**

In the 2013 cycle, 50% of non-urgent clinic letters were sent to GPs within five working days (see Figure 1). The range was 0–25 working days. Just over half (53.3%) of the 6–10 working day category contained recommended medication changes, and 39.3% for 11+ working days. The results were fed back to the doctors and secretaries at a team meeting, and two further audit cycles were completed. In the 2014 cycle, 73.56% reached a GP within five working days (see Figure 1) and the range was 0–22 working days. In the 2015 cycle, 73.6% were sent to a GP in 0–5 working days, and the range was 0–33 working days.

**Lessons and limitations**

Performance was improved from the first cycle by feeding back the results to doctors and secretaries in

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**Figure 2. Process of producing clinic letters, which led to 0–5 working days being chosen as the standard, and takes into account the following:**

<table>
<thead>
<tr>
<th>Step</th>
<th>Timeframe</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient seen in peripheral clinics</td>
<td>1-2 days</td>
</tr>
<tr>
<td>Letter dictated and handed to secretary to type</td>
<td>1-2 days</td>
</tr>
<tr>
<td>Letter typed</td>
<td>1-2 days</td>
</tr>
<tr>
<td>Letter reviewed and edited</td>
<td>1-2 days</td>
</tr>
<tr>
<td>Letter sent via secure email</td>
<td>0-1 days</td>
</tr>
<tr>
<td>To account for leave, holidays etc</td>
<td>1 day</td>
</tr>
</tbody>
</table>

**Table 1. The time taken for clinic letters to reach a GP (0–5 working days, 6–10 working days, and 11+ working days).**

<table>
<thead>
<tr>
<th>Cycle</th>
<th>0–5 working days</th>
<th>6–10 working days</th>
<th>11+ working days</th>
</tr>
</thead>
<tbody>
<tr>
<td>2013</td>
<td>50%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2014</td>
<td>73.56%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2015</td>
<td>73.6%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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1. Doeleman.
2. A study by Braun et al.
3. Looking at a standardised letter to improve communication between oncologists and GPs, concluded that using a template letter improved communication with respect to the timeliness of information transfer.

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Clinic letter roundabout | Original short report

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Table 1. Examples of good practice and practice that needs improving

<table>
<thead>
<tr>
<th>Good practice</th>
<th>Practice needing to improve</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dictating letters</td>
<td>Typing letters after receiving tapes</td>
</tr>
<tr>
<td>Tape received in office</td>
<td>Use of technology such as Trust-provided shared drives for remote access of typed letters</td>
</tr>
<tr>
<td>Typing returned to clinician</td>
<td>Clinician checking letters after they have been typed and acknowledging/informing of their availability to dispatch</td>
</tr>
<tr>
<td>Letters emailed to GP</td>
<td></td>
</tr>
</tbody>
</table>

Table 2. Recommendations for good practice

1. Trust guidelines to be drafted to stipulate timeline for non-urgent clinical letters to reach the GP. Service lines will need to:
   1. Gain a baseline of current timelines and activity.
   2. Have an understanding of the workplace.
   3. Peer group to agree on measurements and standards based on patient and GP need and resources. Understanding that patient and GP satisfaction is paramount and is built in at every step of the enterprise’s process. An example is figure 2

2. Plan implementation:
   - Discuss at next doctors’ meeting how best to ring fence admin time for clinicians.
   - Look to employ technology such as using safe Trust shared drives for remote access.

3. Implement learning and re-examine for gaps.

4. Present and share findings/discuss with colleagues.

5. Look at devising a standardised clinical letter template.


7. Re-evaluate in 1 year.

8. Re-structure secretarial support to maximise efficiency.

Conclusion

The implications of clinical letters not reaching GPs in a timely manner are significant. This tardiness of communication, especially where medication changes are involved, has implications for patient safety, satisfaction, and utility of resources, and needs addressing. Table 2 shows recommendations for good practice.

Secretarial support structure has recently been addressed to achieve maximum efficiency. Clinician time may need to be better organised to allow time to check letters. A way of speeding up the process could be the use of standardised letters. Among suggestions for improvement in the Farquhar study,1 were universal electronic patient records, which both clinicians and GPs could access. More realistically, Trust guidelines on how quickly non-urgent clinical letters should be sent to the GP, would be a good start in helping reducing avoidable harm.

There is an expectation from the public for the medical profession to provide robust regulation. However, regulators such as the GMC cannot make value-based judgement on harm and professional performance without clarity of accepted standards. Failure to develop such standards especially in routine clinical areas such as communication between specialists and GPs could leave patients exposed to continued poor performance. Clinicians and Trusts too, without the right frameworks, would be exposed to higher risk of litigation.9
Dr Corson is a Specialty Doctor in Psychiatry, Claire Hargreaves, Sarah Grimshaw, Joanna Wiggins, Sarah Mitchell, Ruth Toon and Claire Palmer are all medical secretaries, Dr Cox, Dr Wilkinson and Dr Laugharne are Consultant Psychiatrists, Dr Pretorius is a Specialist Trainee year 4 in Psychiatry and Dr Rohit Shankar is a Consultant in Adult Developmental Neuropsychiatry, all at Cornwall Partnership NHS Foundation Trust.

Declaration of interests
None declared.

References

POEMs
Patient Orientated Evidence that Matters

SSRI use during pregnancy may increase risk of speech/language disorders in offspring

Clinical question
Does the use of a selective serotonin reuptake inhibitor during pregnancy increase the risk of speech/language, scholastic, and motor disorders in offspring?

Reference

Synopsis
These investigators assessed data obtained from various national registries in Finland on all singleton live births between January 1996 and December 2010. At follow-up most children were 9 years or younger, including the mean ages at diagnosis of 4.43, 3.55, and 7.73 years for speech/language, scholastic, and motor disorders, respectively. Pregnancy and SSRI exposure was determined using additional information from a drug reimbursement register covering more than 99% of prescription drug purchases. The exposure group included children (n = 15,596) of mothers with depression or another psychiatric disorder who made at least 1 purchase of SSRIs between 30 days before pregnancy and delivery. The nonexposed group included children (n = 9537) of mothers with depression or another psychiatric disorder with no history of any SSRI purchase during pregnancy (unmedicated group). An additional control group included children (n = 31,207) of mothers without a psychiatric diagnosis or a history of purchasing any antidepressants or antipsychotics during pregnancy (unexposed group). Outcomes related to language and speech disorders, motor disorders, and scholastic achievement were adjusted for sex, previous births, marital status, socioeconomic status, gestational age, other drug exposures, smoking, paternal and maternal age, and family history of psychiatric diagnoses. Offspring in both the SSRI-exposed group and the unmedicated group were at a significantly increased risk of speech and language disorders only compared with offspring in the unexposed group. There were no overall significant differences in any of the outcomes between children in the exposed group and the unmedicated group. In subgroup analysis, however, the risk of speech/language disorders in offspring of mothers with at least 2 SSRI purchases during pregnancy was significantly increased compared with the unmedicated group. Women with the most severe depression may be more likely to fill treatment prescriptions and thus the increased risk of speech/language disorders in their offspring is confounded by more severe maternal depression rather than by medication exposure.