Herefordshire and Worcestershire Health and Care NHS Trust

CAMHS Quality Improvement
Letter writing in outpatient clinics

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Introduction

In September 2018 the Academy of Medical Royal Colleges published guidance that they hoped would encourage doctors to write most of their outpatient clinic letters directly to patients and send a copy of the letter to the General Practitioners. This is in keeping with Good Medical Practice which states that "you must give patients the information they need or want to know in a way they can understand".

The PRSB (Professional Records Standards body) has also published a new standard for outpatient letters, designed to improve and standardise the content of outpatient letters so that professionals, patients and carers receive consistent, reliable and high quality information. This was endorsed by the Royal College of Psychiatrists. Outpatient letters are the main method of contact and communication between psychiatry doctors and GPs. Well-structured outpatient letters with accurate and relevant information are very important to providing good clinical care.

The PRSB standards were discussed at the CAMHS medical meeting on September 2019. It was agreed that as a service we should be adhering to 17 points that are mandatory in the guidance published by the PRSB:

- **Patient name**
- **Date of Birth**
- **Patient address**
- **GP practice**
- **Responsible healthcare professional**
- **Allocated care co-ordinator**
- **Clinic lead**
- **Date**
- **Time**
- **Diagnosis / presenting difficulty**
- **Current medication**
- **Progress since last appointment**
- **Mental state examination**
- **Risk assessment**
- **Impression**
- **Care plan**
- **Date of any follow up**

The Academy of Medical Royal Colleges guidelines states that outpatient letters should do three main things:

1. Record relevant facts about the patient's health and wellbeing
2. Present information in a way that improves understanding
3. Communicate a management plan to the patient and GP

The PRSB guidance makes a number of statements allowing for local and individual flexibility of the guidelines:

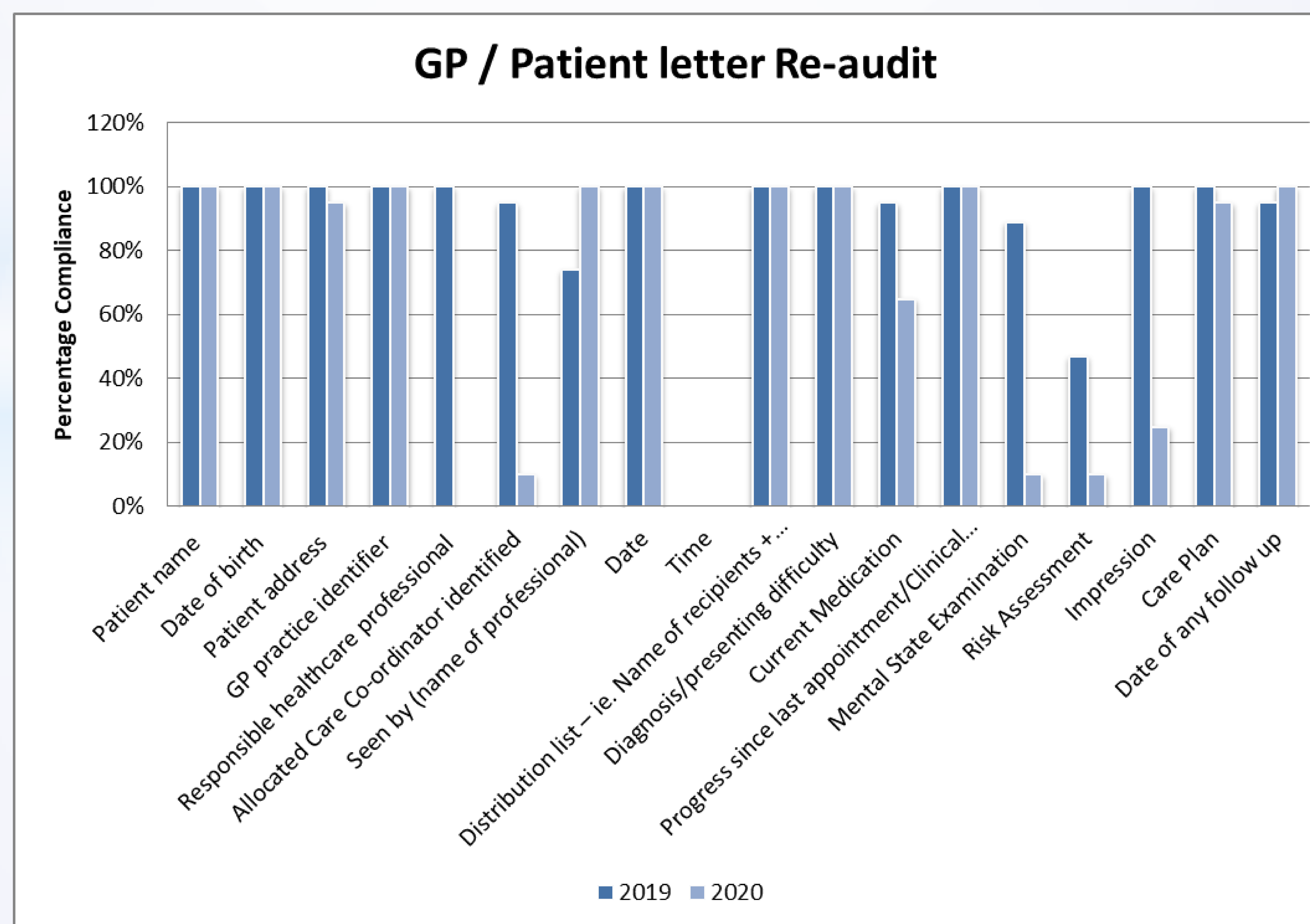
- "Clinicians should always use professional judgement to determine what information should be communicated"
- "Communications should be brief, where possible, containing only pertinent information"
- "Patients (or their designated carer or guardian where applicable) should generally get a copy of communications and so, as far as possible without affecting its efficacy as a clinical communication, it should be written in a way that is understandable to the general public"
- "There may be circumstances where it is not appropriate to provide the patient with a copy of the communication"

Aims and Hypothesis

- Assess the outpatient letters written by medical staff at CAMHS, Redditch, to find out if they adhere to the standards set out by the Academy of Royal Colleges and the Professional Records Standards Body (PRSB).
- Determine if the above standards are clinically relevant and consider locally agreed guidelines for medical letter writing to CAMHS patients in the trust.

Method

The first 20 outpatient letters written in June 2019 were reviewed and the content was compared to the standards. This was re-audited in June 2020



Results

The re-audit showed good recording of core information and medication changes. Letters communicated the fundamentals of consultation and follow up plans were clear. It found poor performance in recording of time (10%), current medication (65%), mental state examination (10%) and risk assessment (10%).

Anecdotally, it was noted that many letters were quite lengthy which detracted from the clarity of information being communicated.

Discussion

Following review of the results, it is felt by the Worcestershire CAMHS medical team that some information required by the PRSB standards might not be relevant for inclusion in a letter to the GP. It is also felt that the Mental State Examination may contain information which might harm the therapeutic relationship with the patient. It is noted that the standards are not relevant to electronic records which automatically record some data. It is agreed that compliance with documentation of risk assessment should be improved where appropriate.

Conclusion

We propose locally agreed guidance for Worcestershire CAMHS medical teams. This guidance would consist of direction to write letters to patients as well as directions for content of letters. There is currently no available guidance from other sources or trusts for comparison.

Where possible, letters should be written to the young person but the scribing clinician should consider each case on an individual basis. Content should include basic information as set out by the PRSB. NHS number should be included. Guidance for clinical information is as follows:

- **Diagnosis/ Presenting difficulty -** This should include a diagnosis that will be recognised by the GP and an explanation if the patient does not have a good understanding of the meaning of their diagnosis
- **Current medication -** Brand names can be included if better understood by the patient, avoid Latin (e.g. say "one at night" instead of ON) and include indication if necessary for the patient
- **Clinic summary -** Avoid jargon and abbreviations, keep concise and relevant, use short sentences and one topic per paragraph. It may be helpful to check documents with the Flesch Reading Ease score
- **Mental state examination -** This might be better included in the clinic summary rather than as a formal assessment, if formally written then alternative heading would be more appropriate such as "how you are today"
- **Risk assessment -** It would be helpful to include this as a section, but again with an alternative title such as "concerns" and this does not need to include absence of irrelevant risk
- **Impression -** Should be understandable by patient and ideally include their understanding
- **Care plan -** Clear bullet points agreed with the patient
- **Follow up -** Clear detail

References

- Academy of Medical Royal Colleges. *Please, write to me. Writing outpatient clinic letters to patients Guidance*. September 2018.
- General Medical Council. *Good Medical Practice*. March 2013
- Professional Records Standards Body. *Outpatient letter V2.1*. December 2019.
- Flesch, Rudolf. *How to write plain English*. University of Canterbury. 1979