Audit of End of Individual Therapy Letters in the Gaskell and Macartney House Specialist Psychotherapy Services

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Introduction

End of therapy letters aim to improve communication and collaboration between GPs and therapists with the ultimate aim being to provide better care to patients. Such letters help in recording relevant facts about patients' therapy, present information in a way which improves understanding, and helps in communicating a management plan to the patient and their General Practitioner. Such letters can also be used as a record of therapy received by the patient.

There are no common standards available for recording information in end of therapy letters in GMMH (Greater Manchester Mental Health NHS FT) or Royal College of Psychiatry guidelines. We therefore developed local departmental standard for end of therapy letters. To do this we drew information from local trust guidelines on record keeping [1], from The British Psychological Society [2], the Academy of Royal College Guidelines on writing outpatient letters [3] and from previous audits conducted on this subject [4].

Aim

The aim of this audit was to review the quality of end of individual therapy letters sent to GPs using a set of locally agreed standards.

Methods

End of therapy letters were retrospectively extracted from the electronic patient records (PARIS and Amigos). The information was anonymised and recorded on to Microsoft Excel, which was also used for calculating the percentages of letters meeting each individual standard.

All the patients who started individual psychotherapy at Gaskell and Macartney House (Specialist Psychotherapy Services within GMMH) from 01/01/2018 to 30/06/2018 were included in the audit. Patients who started group psychotherapy were not included. Soon after the conclusion of the audit, Macartney House merged with Gaskell House.

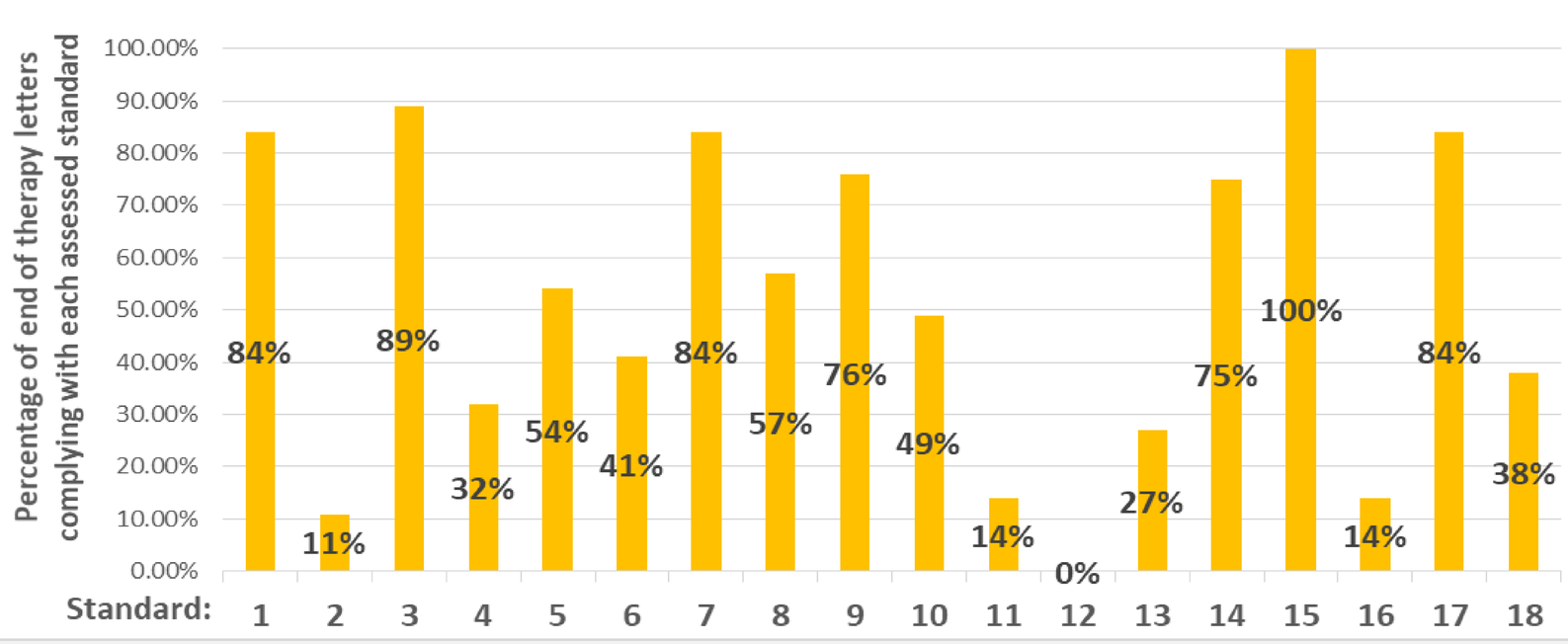
Results

We manage to identify 42 patients who started individual psychotherapy during the specified period. 20 patients were from Gaskell House and 22 from Macartney House. From the 42 patients, 8 were offered psychodynamic therapy and 34 Cognitive Analytic Therapy. Five patients did not have an end of therapy letter completed on the electronic record so in consequence, we ended up reviewing 37 end of therapy letters.

We noticed that in 51% of the end of therapy letters audited, the therapy was delivered by trainees (either psychotherapy or psychiatry trainees).

Results

Compliance with standards for end of therapy letters:



Standards:

1. Type of therapy offered was stated
2. The frequency of therapy was stated
3. The planned duration of therapy was stated
4. The start date of therapy was stated
5. The end date of therapy was stated
6. The presenting problems / complains were included
7. There was an elaboration on how the patient engaged in the therapy process / how the patient used therapy
8. Patient's attendance during therapy was elaborated on
9. Outcomes of therapy were elaborated
10. A short psychological formulation was present
11. A summary of the risk assessment was included
12. If risks are identified, a management plan was present
13. Options for sources of available support post therapy were included
14. Post therapy review was mentioned (if applicable)
15. Reasons for the early termination of therapy were mentioned (if applicable)
16. End of therapy letters should have a Flesch readability score of 60% or over
17. Letters should be written in appropriate language (avoiding technical terms, acronyms, speculation, language that may give offence or generate misunderstanding, presenting the therapist's or patient's opinions as concrete facts)
18. End of therapy letter should be sent to the GP within 2 weeks from the last scheduled therapy appointment

Discussion

Out of the 37 end of therapy letters, a majority listed the type (84%) and duration (89%) of psychotherapy provided.

On most occasions, it is usual practice for psychotherapists to write a letter to the GP once psychotherapy starts and this could be a possible explanation for lower compliance for listing the therapy start date (32%) and for presenting complaints (41%). In most cases, therapy offered was weekly, so perhaps this would explain the low compliance for stating this information.

Short psychological formulations are usually present in assessment letters and this might be a possible explanation for low compliance with this standard.

The outcome of therapy, the patient's attendance and engagement / use of therapy were commented on in most cases, which could be useful information to have, especially if those patients are re-referred for further psychotherapy.

Risk assessment documentation had a low compliance possibly because a majority of patients did not present with many associated risks, although in 2 situations there were active risks present and there was no management plan detailed.

84% of letters were written in appropriate language (e.g. avoiding technical terms, acronyms, unnecessary speculation etc).

Only 14% of letters had a Flesch readability score of ≥60 (written in plain English and being easily understood). We set this score because in most situations, patients were copied into the end of therapy letters sent to the GPs. The average Flesch readability score for the letters audited was 49 (considered difficult to read).

Only 38% of letters were sent to the GP within 2 weeks.

Conclusions

This audit highlighted the need for local guidance/templates for clinicians writing end of therapy letters to encourage uniform practice. This is particularly important since in over half of the cases, the therapy was delivered by trainees. Following this audit, such guidance has been drafted. This guidance discusses the purpose of end of therapy letters in different situations and circumstances. It also recommends the inclusion of certain information in a standardized format.

We also discussed the possibility for the end of therapy letters to be addressed to patients and copying in their GP, whenever possible

We are planning to conduct a re-audit after this guidance has been applied

References

(1) Greater Manchester Mental Health NHS Foundation Trust. Health Records Management Procedure, Version 1.0

(2) The British Psychological Society. (2002, may). Guidelines on Confidentiality and Record Keeping. Retrieved from http://www.bps.org.uk

(3) Academy of Royal Colleges. Please, write to me. (n.d.). Retrieved May 5th 2019, from www.aomrc.org.uk: http://www.aomrc.org.uk/wp-content/uploads/2018/09/Please_write_to_me_Guidance_010918.pd

(4) Lancashire Care NHS Foundation Trust, 2017. Audit of End of Therapy Letters. Khushbakht Ghazanfar, Alison Summers, Swapna Kongara