Practice One

Incoming Letter Protocol

Introduction

This protocol is to give guidance on a new system of processing incoming letters within the practice. All letters that the practice receives (whether this is post or electronic mail) need to be dealt with:

- Safely
- Efficiently
- Appropriately
- Timely

Aim

For the admin team to be able to understand the main body of each letter that comes into the practice so they can make a calculated decision of the action that they need to take.

Categories

The three decision branches we have decided to use within the practice to identify the course of action for each letter are:

- ***Dr Action*** – For the doctor to action
- ***Dr Aware*** – For the Dr to be made aware of
- ***File*** – File straight to the patients record

Each letter needs to be coded with a stamp to define which action has taken place. This will ensure that no letter will has been missed and any learning objectives from coding may be achieved moving forward.

Any process that the admin team carry out must be stated on the letter in order for the GP to see what action has taken place so far. This will prevent any extra work for the GP e.g.

- Coding
- Inviting the patient in for bloods/review
- Medication reviews
- Contact with the patient for any reason

Analysis of Data

Various departments send differing information onto the practice. It is crucial to read the entire letter and analyse what the letter is asking. The most common types of letter that can be filed 90% of the time include

- Minor Injuries Letters
- A+E
- Normal results (e.g. X-Rays, endoscopies)
- Physiotherapy Discharge
- Wellbeing (Live well)
- Maternity Screening Reports
- Normal baby hearing tests

These letters usually inform us of very little data that the Dr cannot learn anything from or they inform us that everything is well for the GP's information only.

The majority of letters received are from:

Consultants: Consultant letters are often sent on the back of an outgoing referral informing the GP of the findings or actions that have taken place or the need to in the future. They can also report on planned and unplanned admissions, below is a list of the majority of consultants that we receive information from:

- Rheumatology
- Ophthalmology
- Oncology
- Urology
- Orthopaedics
- Paediatricians
- General Surgery
- Dermatology
- Cardiology
- Neurology
- ENT
- Physician
- Physiotherapists
- Vascular
- Gastroenterology
- Obstetrics and Gynaecology
- Haematologist

Services and Specialists within the Community: The community usually inform the practice of an outcome of a service/review that they have been involved in with our patients. Again usually they send us letters for information only but often ask the practice to take some form of action (prescription changes, referrals, reviews.) Examples of these types of services are below:

- Epilepsy Specialist (medication changes/ reviews
- Diabetic (eye screening reports/med changes)
- Movement Disorder Clinic
- Pharmacy Reviews
- Physiotherapy Direct (usually informing of outcome)
- Maternity (progress of pregnancy etc.)
- Emotional Wellbeing
- Community Drug and Alcohol Team
- District Nurses
- Nutrition and Dietetic Service
- Police (firearms)
- Audiology
- CMHT (community mental health team)
- CAMHS (child and adult mental health services)
- Mental Health Services (East House)
- Single point of Access
- Pain Management Service
- Bladder and Bowel Health

Out Of Hours: Out of hours letters are usually what they say. These are usually letters sent to us relating to activity that has taken place out of practice hours (evening, overnight, early morning and weekends) These types of letters usually inform us of what the presenting condition of the patient was at the time of the call and what process they followed.

- Duty Doctor Out of hours
- Yorkshire Doctors
- NHS 111 Pathway reports
- A + E

Hospitals - Often sending Discharge letters, A+ E letters and treatment request notes. Also informing of procedures that have taken place in hospital, and sending follow up advice.

- Scarborough Hospital
- Hull Royal Infirmary
- Castle Hill Hospital

- Spire - Hull
- Bridlington Hospital
- Alfred Bean
- LGI (Leeds General Infirmary)

There is often different contrast in the information that is sent by any of the above which identifies why it is crucial that every letter must be read properly to send the letter in the right direction.

Methods

Although there is no direct method in deciding what action to take with each letter, each decision must be based upon the content within, and what information the letter is portraying.

Assessing each letter involves looking at the:

- Condition/diagnosis presented
- Seriousness of the condition/diagnosis
- History the patient has of the condition
- Involvement that the GP and other clinicians have with the patient relating to the said condition.
- Amount of information relating to the condition/diagnosis
- Actions need to be taken regarding the condition e.g. prescription, referral, bloods, review by G.P etc.
- Further actions that may be needed by secondary care or a service provider
- Potential safeguarding issues that need to be identified
- Need to code the letter

Using the above pointers will help ensure that each letter is dealt with efficiently, accurately and safely to the most appropriate clinician/member of staff. Due to the nature of this work any hesitance or queries **MUST** be addressed by either seeking a second opinion or forwarding onto the Doctor to gain feedback on what the correct process should be.

This protocol has been created to give guidance when processing incoming letters and will be reviewed in 12 months time to update any changes that may have occurred or any new measures that need to be addressed.

(This system works well for our practice. We have been using this system for nearly 6 x months with fantastic results. Every practice is different and therefore we hold no responsibility, nor liability for any practice that wishes to use this system within their practice.)