A close-up photograph of a doctor's torso. The doctor is wearing a white lab coat over a light blue shirt and a blue tie. A black stethoscope is draped around their neck. They are holding a black tablet with both hands. The tablet screen is white and displays the following text:

Clinic Letters

Prioritising their timely accurate creation

by Dr. Anna Bayes

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Executive Summary

Always seen as the poor relation of the discharge summary, outpatient clinic letters are now receiving more attention than ever. Previously their place at the bottom of the typing queue led to huge delays in their delivery often with backlogs of weeks or months. This added to and perpetuated the burden of lost sets of patient records and the ensuing associated clinical risk.

The value of these letters to hospital clinicians has been well known as the first port of call before meeting a patient for the first time. Unlike the handwritten part of the medical notes, they are legible, dated and it is usually known who has written them. Consequently, they are regarded as an accurate recording of what occurred during the patient visit from a medico-legal point of view. GPs too see them as the vital link to what happened to their patient whilst in someone else's care and what the management plan is.

Their quality has always been variable but they always remained low on the radar of hospital managers. At last, their time has come. The importance of delivering a quality and timely discharge summary was coupled with its use by clinical coders to generate revenue for the inpatient stay. Now clinic letters are being financially tagged and the pressure is on to facilitate their production. In parallel, trusts are looking for novel ways to improve documentation and hence clinical safety, increase efficiency with a focus on staff productivity and reducing waste.

Here we review the stakeholder context of clinic letters and the technological tools that are revolutionising their production.

About the Author

Anna Bayes is a prize-winning hospital doctor with eleven years' consultancy experience including eight years working on the NHS National Programme for IT (NPfIT). She has deep and extensive hands on knowledge of clinical engagement, clinical safety, clinical governance, contractual requirements design and delivery as well as management level experience in strategy generation, detailed requirements analysis, change management, process improvement and business development activities.



Clinic Letters – who are they for?

The clinic letter has been a long standing feature of any hospital or clinic based outpatient appointment. Originally letters were an opportunity for the clinician to report back to the referrer on the patient whom they had been asked to see. Today, however, there are many more stakeholders in the average clinic letter (See figure1) and their purpose is multi-fold.

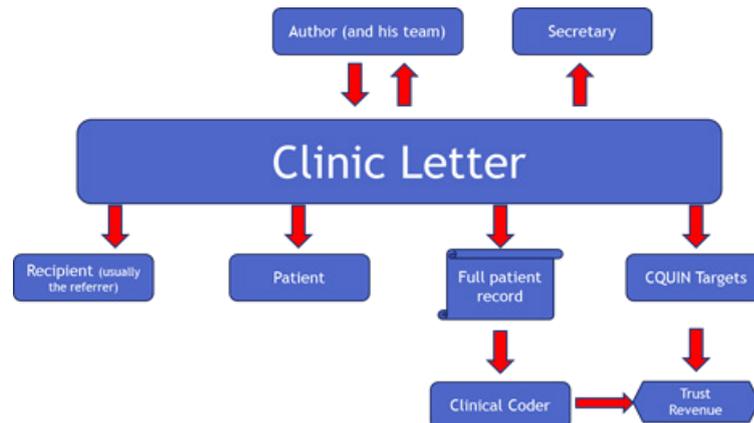


Figure 1 - Clinic Letter stakeholders

The recipient

Generally speaking, most clinic letters are addressed to the patient's GP, who in most cases has referred the patient to the clinic in the first place. The purpose is to inform the GP of the outcome of the visit. Some letters will state symptoms and signs noted, investigations that have been requested, results that have become available, diagnoses if they have been made and the management plan. Of course, this is a generalisation and in many cases, the GP may not have referred the patient and indeed, the reaching of a diagnosis and management plan may take many visits.

The author

Although, the letter may be addressed to the GP, most hospital practitioners see the clinic letter as an aide memoire for the visit to remind the author or the next member of the team, what has happened and the proposed management plan. As one hospital consultant described it: "It needs to pass the 'Locum Test' – If Larry Locum is covering my clinic, he needs to know relevant history, examination findings, investigations and management plan – ideally all from the most recent clinic letter."

As a succinct summary of the last outpatient visit, the previous clinic letter is the initial document within a chunky set of notes for a clinician to read prior to reviewing a patient in clinic. Not only is the letter legible but if it is good, will let the clinician know what to expect and what the treatment plan was, making it easier to spot any changes in the patient when he/she enters the room. Indeed, on occasions when the medical record cannot be found, the commonest practice across trusts is to print copies of the most recent clinic letters, if they can be found. As more trusts have introduced electronic solutions, the printing of these letters is becoming less essential as shared drives, document management solutions and attachments to electronic patient records are becoming more widely available.

The patient

We can increasingly expect more of the clinical record to become freely available to the patient.

Since 2004, trusts have been obliged to copy patients into clinical correspondence unless the patient opts out of this. A number of studies¹ have shown that patients generally feel this practice makes their consultations more meaningful though there is concern from health professionals that they are of limited benefit and are a drain on resources. With the DH policy "The Power of Information"², we can increasingly expect more of the clinical record to become freely available to the patient.

The obvious clinical safety benefits of timely letter production and availability are multiplied as patients with complex conditions are more commonly managed in the community with multiple clinicians caring for them.

The secretary

The secretary's role in the creation of clinical documentation such as clinic letters is pivotal. Over time, the demands on secretarial staff have increased whilst the numbers available are falling resulting in more and more being replaced by temporary staff.³ Consequently, backlogs in transcription have become common and this perpetuates the staff retention issues many trusts suffer. As trusts are looking for new ways to improve efficiency as part of the QIPP agenda, more pressure is being exerted on secretarial staff to turn over transcription promptly. Some trusts have turned to outsourcing much of their transcription to external agencies leaving their staff a more editorial role checking demographics and proof reading prior to final review by clinicians.

The full patient record

Clinic letters are generally filed in patient records either in hard copy format or electronically and often both, since most trusts are at varying points on the journey to becoming paper-lite. They provide evidence of the visit which is likely to be easier to find and read than any handwritten note of the clinical consultation. Consequently, clinicians rely on them as a source of information which can be located efficiently whilst collectively providing an holistic view of the patient and so minimise clinical risk.

Hidden stakeholders

Commissioners are beginning to apply quality and timeliness criteria to clinic letters - so there is financial incentive to send a quality document out quickly.

As commissioners are able to reward service providers for excellence through the CQUIN framework⁴, they are looking for novel and measurable ways to compensate best practice. As a result, we are seeing more commissioners begin to apply quality and timeliness criteria to clinic letters so there is financial incentive to send a quality document out quickly. In Leicestershire (see figure 2), their CQUIN covers both the content of the letter and the time taken to reach GPs. In Blackpool, a CQUIN target has been set for 95% outpatient letters to reach GPs within 14 working days.⁵

Consequently, trusts are beginning to examine their processes for letter production and learn from the improvements they have made in generating discharge summaries.

LOCAL CQUIN	<p>Outpatient letter to contain minimum dataset to ensure consistent completion</p> <ul style="list-style-type: none"> • Outpatient letter – %tbc compliance with content bundles • Patient information • Date of attendance • Diagnosis and Treatment • Investigations and Results • Medication Changes and medication on discharge • Actions and future plans 	4.3%
LOCAL CQUIN	<p>Outpatient letter to be completed and issued to patients GP within x days</p> <ul style="list-style-type: none"> • Outpatient letter to be completed and issued to patients GP within x days of appointment 	4.3%

Figure 2 - Extract from CQUIN Targets - Leicestershire

Clinical coders are responsible for coding clinical notes at the end of an episode of care. Most commonly, they only code inpatient spells. They review patient records to collate the relevant details to ensure the trust is compensated for the care that has been delivered. The most important document to gather this data from is the discharge summary. However, often previous clinic letters together with the inpatient handwritten entries are also viewed as they may alert the coder to co-morbidities which may potentially raise the HRG (and hence trust remuneration) for the care given since the patient is deemed to be a more complex case.

So what should a clinic letter look like?

Unlike discharge summaries that now have approved guidelines⁶, it is less clear what should be included in a clinic letter. As with all clinical documentation there are hugely varying opinions. The majority of hospital doctors⁷ and GPs⁸ agree that a structured letter is preferable to pure narrative; diagnoses, drug history and management plan are cited as being the most valuable content.

With the growing number of stakeholders affected by these documents, an element of standardisation would encourage clear, comprehensible recording of pertinent data for rapid assimilation of facts by the reader. This needs to be carefully balanced to ensure the document remains meaningful to all readers. Some clinicians argue that although patients are copied in, the letter is not aimed at the patient but at fellow clinicians. One consultant said that if he is keen for a particular message to be conveyed to the patient, he writes a separate letter addressed to the patient at a level of detail the patient can understand. (He went on to comment that there is a subset of patients, often with rarer chronic diseases, who have often become experts and may know more about their condition than their GP.)

Catalyst for change

Trusts are looking for efficiencies at many levels, be it reduction in paper, reducing administrative steps as well as looking to increase the time clinicians have available to spend with patients.

Historical anecdotes of discharge summaries arriving years after a patient left hospital are a thing of the past and the shake-up in their production is now filtering through to their clinic equivalent. As funding becomes attached to clinic letters in the form of CQUIN payments, their importance is now coming to the attention of trust directors. The growing number of stakeholders awaiting their content and in particular, the financial consequences of the letter has fuelled the need for these documents to be drafted, processed, filed and sent to the recipients more efficiently. In parallel, trusts are looking for efficiencies at many levels, be it reduction in paper, reducing administrative steps as well as looking to increase the time clinicians have available to spend with patients.

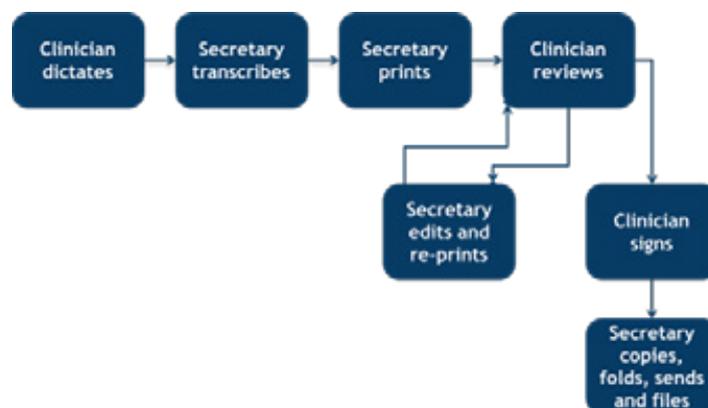


Figure 3 - Historical clinic letter production

Old production methods (see figure 3) have already begun to improve with the advent of various technologies:

- Improved digital dictation
- Off site out-sourced transcription
- Workflow enhanced processes
- Electronic signature
- Back-end speech recognition
- Front-end speech recognition
- Attachment to co-existing electronic patient records
- Creation from within electronic patient records

In spite of investment in these technologies, not all trusts are seeing the improvements they were expecting. For example, although dictation may be transcribed faster using outsourced services, in many cases this has failed to provide financial benefit to the trust. The replacement of traditional dictation and transcription is not embedded within the wider context of process enhancement and technology deployment in the organisation.

Getting Clinic letters into shape

Over the past few years, we have read a lot about clinical IT Programmes that have failed to deliver anticipated benefits. It is easy to generalise as to why this might be but there are a few common themes in programmes that fail to deliver:

- Lack of senior management engagement
- Lack of continued clinical input
- Lack of change management support
- Making changes with no obvious initial benefits for those most affected (often clinical benefits are far downstream)

Integrating clinical solutions is never simple and may result in erosion of benefits due to e.g. double data entry. There is a balance to be had in configuring a single solution for each sub-specialty or integrating multiple departmental solutions. No option will be ideal for all users and adopting an 80:20 approach to tailoring a product is likely to benefit the widest range of users and to secure clinician adoption.

Senior management & clinical engagement are key success factors when implementing new technology. Particularly during the early stages of deployment when new processes always take longer than the ones they have been designed to improve.

Clinical engagement is key to harnessing the benefits of technology. Natural Champion Users invariably self-select and are valuable assets to be exploited particularly during the early stages of deployment when new processes always take longer than the ones they have been designed to improve.

In parallel, understanding the bottle-necks in current letter production is paramount to prevent perpetuation of these issues when new technology is introduced. It is not uncommon to uncover multiple parallel processes within a single department and the processes may vary from one clinic to another. For example, some clinicians may wait for investigation results before completing dictation or final editing as results may impact on the diagnosis or management plan. This alone may delay the dispatch of letters since the turnaround time for the investigation may be a week or longer.

The timeliness of clinic letters requires robust technology that does not allow a pile of dictation to get lost in a queue or allow letters that have been typed and prepared, to remain unsigned whilst a clinician is on extended leave.

In parallel, it is essential to be clear on the trust's overall strategy for clinical documentation, whether it is to be paperless with a single electronic record or to integrate a number of solutions. This will provide the foundation to overlay other technology solutions.

The ideal components for professional clinic letter production

There are many technologies that will facilitate a trust in improving clinic letter production. It is possible to deliver them using a phased approach but the benefits usually multiply when employed concurrently.

Digital dictation and workflow management

Digital dictation has been widely adopted by many trusts and has notably improved the issues linked to damaged and lost tapes. When implemented with even a simple transcription queuing system, disputed priority issues diminish.

Some systems allow the digital voice file to be available to others using the system before the letter is transcribed. This has particular clinical safety benefits if the patient attends the hospital as an emergency the day after a clinic attendance or even if they are seen routinely the following week. More complex workflow systems speed up the editing and approval stages of letter production. One secretary explained that the workflow has transformed her life since she is located a long way from the doctors she works for and catching them to review and sign a batch of letters was highly time consuming. As soon as letters are typed, they are available for clinicians to review electronically. In some cases, they may be signed electronically by the clinician whilst still in the clinic session in which the letter was dictated. This allows the clinician to review patient letters whilst there is clinic downtime and the patient is still fresh in his/her memory.

On-screen editing by clinicians is favoured by many for speed and accuracy. As one consultant said: "I can do it faster myself than trying to explain it to my secretary and consequently, it saves us both time." On-screen editing allows clinicians to add in results that have become available since they dictated the letter. In addition, on screen editing reduces the amount of printing of draft copies hence reducing paper and printing overheads in line with trust efficiency policies.

Management Intelligence Tools

The implementation of advanced workflow management software such as Winscribe also provides management intelligence. These analytic tools provide an overview of the entire production process allowing managers to identify and analyse peaks and troughs and manage workloads effectively or even add in outsourced capacity as required. It also allows internal benchmarking and comparison with external data to encourage continuous improvement.

Integration with PAS and electronic patient records

The integration of the trust Patient Administration System (PAS) is key to optimising the benefits of these tools since it minimises the risk of patient mis-identification and also quickly identifies patients with missing letters. Structured templates can be pre-populated with patient demographics and can use pre-prepared word expansion for frequently used phrases. Gender specific, auto-text and clone letter features further streamline accurate production. This leads to consistent, efficient letter production with minimal manual transcription required saving time and increasing accuracy.

This can be coupled with Integration to electronic patient record solutions to exploit further benefits. This could include the ability to pre-populate some clinical details from the record or more importantly, automatically store the letter as a document within the context of the episode of care.

Electronic storage of these letters as they are produced in a central rather than departmental repository means that they are available to all eligible trust employees and are immediately part of the clinical record. Depending on the solution, they can be fully indexed to allow text searching. In addition structured documents can be linked to clinical coding taxonomies.

Electronic distribution

The stringent Information Governance requirements of Connecting for Health (CfH) have in the past stalled the ability of clinicians to communicate across trust boundaries using email. This has been partially overcome with the use of NHS.net email. Ultimately this has meant that the rate-limiting step for some trusts in delivering clinical correspondence to the recipients has been the need to rely on Royal Mail. In order to meet the requirements to deliver discharge summaries within 24 hours, some trusts have developed portals to allow GPs to access this correspondence. These portals tend to require the recipient to remember to “pull” the information rather than it being fed through a “push” mechanism as it becomes available.

However a number of pilots with CfH endorsement are now allowing secure delivery of emailed clinical correspondence or are utilising other existing networks such as those used by acute trusts to deliver blood results to primary care.

Speech recognition

One solution that is delivering immediate benefits when coupled with other technologies is Speech Recognition. It has been successfully used for many years by Radiologists and Histopathologists in acute trusts. They tend to be able to dictate in quieter parts of the hospital, turning their speech directly into text. The software has been considerably improved over the years; accuracy and speed of acceptance have led to its increasing adoption amongst other specialists – even in noisy emergency departments across Australia. The numerous benefits include enhanced transcription speed, reduction in letter edit and review cycles and clinician satisfaction. Many doctors who have used the software to dictate clinical correspondence then chose to use it in other areas of their work such as in routine email correspondence.

A recent study at a Gastroenterology clinic found Speech Recognition technology reduced outpatient letter transcription time by 45%

There are some clinicians who are less willing adopters but even for them, the software can be used in the background (back-end speech recognition) so that the speech is transcribed by the time it reaches the medical secretary who then checks it by simultaneously reviewing the text with the voice file cutting transcription time by 45% ($p < 0.00002$)⁹ The feedback from those involved in trials of these solutions is very positive, particularly as for most users, the training is relatively short. In addition, in the study referenced above, the secretary involved in the pilot was reluctant to go back to her old ways of working when the study was complete. For secretaries who have been involved in wider scale roll outs of this software, this gives them an opportunity to not only become editors rather than typists but also train their colleagues – both secretarial and clinical in optimal use of the solution thus enhancing their role.

Reusable data, Reusable technology

One of the frustrations of deploying any clinical system is that to really reap the benefits, one has to fill it up with salient structured data. Clinicians have grappled with this dilemma for many years, particularly as many of them claim to be poor typists and do not have the time to input data accurately. The good news is that using the technologies described above, data will not only be available but will be reusable as templates for future documents or extractable for research and audit.

Bringing it all together

The true benefits of these solutions are multiplied when these solutions are deployed together as seen in this study of 1000 UK medical secretaries¹⁰:

Traditional Transcription	Digital Dictation	Template auto-population	Protected Typing Time	Speech Recognition	Average Time to transcribe 1 minute of dictation
✓	✓				20 minutes
	✓	✓			12 minutes
	✓	✓	✓		8 minutes
	✓	✓	✓		6 minutes
	✓	✓	✓	✓	3-4 minutes

Figure 4 - Average time to transcribe 1 minute of dictation by 1000 UK Medical Secretaries

These time savings together with more efficient use of clinician time, stationery are precisely what trusts require in order to deliver timely, high quality clinic letters. Trusts such as Leeds Teaching Hospital NHS Trust are expecting to see £2m worth of savings¹¹ through deployment of Digital Dictation, Clinical Correspondence and Speech Recognition. In parallel qualitative benefits include:

- Document production process optimisation designed around patient journey
- Solution fully integrated to their other hospital systems (both current and future).
- Improved process for clinicians and secretaries
- Enhanced clinical safety through document sharing and governance and through utilising workflow functionality to clearly identify outstanding tasks and actions
- Standardisation of templates which are pre-populated with demographic data
- Reporting tools and dashboards to enable the Trust to accurately measure performance metrics
- Provides the ability to manage secretarial resources to ensure optimum document production
- Improved trust green credentials through reduction in number and usage of e.g.: printers, paper, postage.

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About Winscribe

Winscribe is a world leading provider of digital dictation software. Winscribe supports healthcare organisations all over the globe with their requirements for digital dictation, digital transcription, speech recognition, clinical correspondence and workflow management.

Over 90 NHS Trusts use Winscribe to meet their CQUIN efficiency and document turnaround targets.

Winscribe is the largest supplier of digital dictation technology in the world with installations in 25 countries and more than 350,000 users globally. For more information please visit www.winscribe.co.uk

Endnotes

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- ¹⁰ Winscribe Data
- ¹¹ Deployment of Winscribe and Epro solutions to 2500 medical staff