



An audit of the standard of response letters sent by hospital specialists to general dental practitioners following a referred patient's first appointment

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ABSTRACT

INTRODUCTION To assess the standard of response letters issued by dental hospital departments according to the requirements of the recipient dentists.

PATIENTS AND METHODS A cross-sectional survey from a UK dental hospital. All response letters issued from hospital departments between 1 January and 1 March 2003 were copied. Fifteen letters were selected for each department on a chronological sampling frame. The hospital response letters were compared to dentists' requirements, as determined in a previous study.

RESULTS Almost all departments achieved a minimum total score of 80%. The scores across all of the departments together achieved over 90% for all items of information except those relating to time. The samples of the three departments to score over 90% were the only ones to include SHO letters. The sample of the department with the highest score contained the most SHO letters and no consultant letters.

CONCLUSIONS The content standard of response letters was consistently high, particularly those letters written by SHOs, and most were written within 18 days of the patient's appointment. The use of a previously conducted questionnaire survey of dentists' opinions provided a valid means of assessing the quality of the response letters from hospital specialists.

KEYWORDS

Dental audit – Correspondence – Dental school

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Several studies have been conducted to assess the content and quality of hospital specialist response letters, but they have been restricted to the work of a single specialty.^{1–3} Ricketts *et al.*⁴ conducted a peer review of response letters, where seven restorative consultants each supplied five letters and assessed them. However, the aim of this audit is to assess consultant letters from all dental hospital departments according to the requirements of the dentists to whom they are addressed. Audit plays an essential role in quality assurance and demonstrates the desire to both identify weaknesses in existing communication pathways and a willingness to improve the service.

Methods

For the purposes of the audit, a copy was taken of every response letter issued between 1 January and 1 March 2003, following a patient's first appointment at University Dental

Hospital, Cardiff. The sample comprised 15 letters per department. For each department, the total number of response letters was divided by 15 to give a figure *n* and every *n*th letter was selected on a chronological sampling frame.

An assessment tool for the audit was developed using the results of a previously conducted survey to discover general dental practitioners' requirements of a hospital specialist's response letter. In that survey, a questionnaire was issued to all dentists who were sent a response letter between 1 January and 1 March 2003, following their referred patient's first appointment.

The questionnaire aimed to discover:

1. The timescale acceptable to dentists for the arrival of the letter following the referred patient's first appointment and whether the letters currently arrived within that time.
2. The items of information required by general dental practitioners following the referred patient's first appointment.

Table 1 Information required by general dental practitioners in a response letter following a patient's first appointment

Information required	Allocated mark
The patient's details	1
The diagnosis	1
The treatment proposed for the patient	1
Which department the patient was seen by	1
An indication of the severity of the condition	1
Whether or not the patient has been accepted for treatment at the hospital	1
Patient seen by whom (consultant, registrar, SHO)	1
The prognosis	1
The date of the patient's appointment	0.5
The timescale envisaged for treatment	0.5
The letter was dated within 18 days of the patient's appointment	1
Total marks available per letter	10

3. Whether or not general dental practitioners required more information in the response letters they were receiving.

For each of the eight items of information that dentists considered to be essential and which was present in a response letter, one point was awarded. For each of the two items of information that dentists considered desirable, half of one point was awarded. A further point was awarded if

the date of the letter was within 18 days of the patient's appointment (theoretically allowing the letter to arrive with the referring dentist within the 3 weeks that the questionnaire respondents had specified). This brought the total available mark to ten points per letter, or 150 points per department (see Table 1).

The assessment was carried out by a single operator (PT).

Results

Almost all departments achieved a total score of at least 80% (Table 2) and a mean overall score of 89%. The scores across all of the departments together achieved over 90% for all items of information except those relating to time; timeliness of write-up, date of patient appointment and timescale of proposed treatment. Few letters exceeded the time limit (2.5%) but varying proportions of hospital specialists did not include the appointment date, giving an unknown time-lapse in 41% of letters (Table 3). The grade of staff responsible for writing the letters in each sample is shown by department in Table 4.

Discussion

If it is assumed that the letters without clinic dates were written no later than those with clinic dates, then the proportion of response letters that could arrive with the dentist more than 3 weeks after their patient's appointment was 5.5%.

However, according to the results of the dentists' questionnaire, 58% of letters arrive late, although this was not an exact measurement but an approximation based on

Table 2 Marks (percentage in parentheses) awarded to each department by item of required information

Item + proportion of overall score	A	B	C	D	E	F	G	H	Total
Patient details (10%)	14 (100)	15 (100)	15 (100)	15 (100)	15 (100)	15 (100)	14.5 (97)	15 (100)	118.5 (100)
Diagnosis (10%)	13 (93)	13 (87)	13 (87)	15 (100)	12.5 (83)	11 (73)	15 (100)	15 (100)	107.5 (90)
Proposed treatment (10%)	12 (86)	15 (100)	15 (100)	15 (100)	14.5 (97)	14 (93)	15 (100)	15 (100)	115.5 (97)
Department (10%)	14 (100)	15 (100)	15 (100)	15 (100)	15 (100)	12 (80)	15 (100)	14 (93)	115 (97)
Severity (10%)	13 (93)	14 (93)	14 (93)	15 (100)	13 (87)	12 (80)	15 (100)	15 (100)	111 (93)
Acceptance (10%)	14 (100)	15 (100)	15 (100)	14 (93)	15 (100)	15 (100)	15 (100)	15 (100)	118 (99)
Prognosis (10%)	13 (93)	12 (80)	14 (93)	15 (100)	14 (93)	13 (87)	15 (100)	15 (100)	111 (93)
Seen by (10%)	13 (93)	15 (100)	15 (100)	15 (100)	15 (100)	13 (87)	15 (100)	15 (100)	116 (97)
Date of appointment (5%)	3 (21)	7.5 (50)	5 (30)	7.5 (50)	7.5 (50)	0 (0)	0 (0)	2.5 (17)	33 (28)
Timescale (5%)	1.5 (11)	7.5 (50)	6 (40)	4.5 (33)	7.5 (50)	6 (40)	7.5 (50)	5 (30)	45.5 (38)
In time limit (10%)	6 (43)	14 (93)	9 (60)	13 (87)	15 (100)	0 (0)	0 (0)	5 (33)	62 (52)
Total (100%)	116.5 (83)	143 (95)	136 (90)	144 (96)	144 (96)	111 (74)	127 (85)	131.5 (88)	1053 (89)

Table 3 Numbers (percentage in parentheses) for the timeliness of dictation by department

	A	B	C	D	E	F	G	H	Total
Dictation within time limit	6 (43)	14 (93)	9 (60)	13 (87)	15 (100)	0 (0)	0 (0)	5 (33)	62 (52)
Dictation exceeds time limit	0 (0)	1 (7)	0 (0)	2 (13)	0 (0)	0 (0)	0 (0)	0 (0)	3 (3)
Unknown time lapse prior to dictation	8 (57)	0 (0)	6 (40)	0 (0)	0 (0)	15 (100)	15 (100)	10 (67)	54 (45)

Table 4 Numbers of each grade of staff responsible for dictating the sample letters

	A	B	C	D	E	F	G	H	Total
Consultant/ senior lecturer	14	0	9	5	14	15	15	15	87
SpR/lecturer	0	4	6	0	0	0	0	0	10
SHO	0	11	0	10	1	0	0	0	22

recall. It may be difficult for dentists to assess the time lapse since the patient's appointment as it may be months after their referral that they receive a response letter, of which 41% do not contain the date of the patient's appointment. Lamey *et al.*¹ found that dentists were unhappy about the timeliness of arrival of response letters, even though the waiting time for an appointment from the time of referral was only 6 weeks. This suggests that it is the element of uncertainty about the arrival of the referral letter that concerns dentists, and this could be prevented by the acknowledgement of receipt of the referral.

However, if the dentists were correct, this suggests that delays must occur at any or all of the following stages: (i) at the writing-up stage; (ii) waiting for the letter to be signed; (iii) postal arrangements within the dental school; and (iv) postal arrangements within the Royal Mail.

Bowie *et al.*⁵ found the greatest delays in their letter audit were at the dictation and write-up stages and allowed 3 days for each, but did not follow-up the letters once they were mailed. However, the aim of their hospital was for the general medical practitioners to receive a letter within 7–14 days of the patient's appointment. The cut-off time of 18 days for dictation used in this study may be too long to allow the letter to arrive within 3 weeks of the patient's appointment. If this was adjusted, then the number of letters arriving outside of the time limit would exceed 5.5%.

Any letter signed by someone other than its author was clearly marked *per pro*. For some departments, one person dictated the whole sample and this affected the overall

mark for better or worse depending on the normal letter content of that individual. This had a major impact on the department's score for any items habitually excluded. Similarly, if a department's secretary always included the department and the clinic date, then that department would score consistently higher than another whose secretarial staff did not. In the study by Hammond *et al.*,⁵ the date of the patient's appointment was one of the pieces of information most highly valued by dentists.

In the same study, Hammond *et al.*⁵ also found that the sample of consultant letters yielded 'not a single typographical error' but this was based on only 13 letters, one provided (and selected) by each consultant. Understandably, there were some typographical errors found in this sample of 120 letters, mostly due to phonetic similarity such as reseed-ing/receding and except/accept, but others are more confusing, such as '...then refer him to oral surgery department to have extraction of 6 6 roots and 15 6 which are restorable' and '...a symptomatic root-filled upper right central lateral incisors'.

The department with the highest overall score was the only one which did not include a single consultant's letter in the sample, and which contained the greatest number of SHO letters. In fact, the three departments which scored over 95% were the only ones to include SHO letters in the audit sample. Consultants may assume greater knowledge on the part of the recipient than is actually the case, whereas the SHOs are so concerned about missing something important that they take a 'belt and braces' approach. Rawal *et al.*⁶ showed that the majority of general medical practitioners prefer a structured response letter and Lamey *et al.*¹ have suggested using headings to ensure the comprehensiveness of the response. Perhaps this could be adopted in a modified form, whereby the hospital specialist is concerned solely with clinical issues and the secretarial staff supply details such as clinic name and date.

Conclusions

The content standard of the response letters was consistently high and acknowledged as such by the majority of dentists who required no further information regarding their patients.

The apparent time lapse between the dictation of a letter and its arrival with the dentist merits investigation and improvements where possible. The use of a questionnaire survey of general dental practitioners' opinions provides a valid means of assessing the quality of the response letters from hospital specialists, as general dental practitioners constitute their target audience.

References

1. Lamey P-J, Samaranayake LP, Glass GWJ. Communication between a specialist dental hospital department and referring general dental practitioners: an attempt at clinical audit. *Community Dent Oral Epidemiol* 1987; **15**: 277–8.
2. Noble P. Audit in orthodontic practice: how well do we communicate with our referring practitioners? *Br J Orthodont* 1994; **21**: 321–6.
3. Hammond M, Evans DR, Rock WP. A study of letters between general dental practitioners and consultant orthodontists. *Br Dent J* 1996; **180**: 259–63.
4. Ricketts DNJ, Scott BJJ, Ali A, Chadwick RG, Murray CA, Radford JR *et al*. Peer review amongst restorative specialists on the quality of their communication with referring dental practitioners. *Br Dent J* 2003; **195**: 389–93.
5. Bowie P. Turnaround time of in-patient discharge letters: a simple system of audit. *Health Bull* 1996; **54**: 438–40.
6. Rawal J, Barnett P, Lloyd BW. Use of structured letters to improve communication between hospital doctors and general practitioners. *BMJ* 1993; **307**: 1044.

e-Letters – new additions

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Since the March issue of the Annals, the following letters have been published on our website
<<http://www.rcseng.ac.uk/services/publications/letters/>>:

- Artificial intelligence in medicine – 1 response
- 'One-stop' inguinal hernia surgery – day-case referral, diagnosis and treatment – 1 new response
- How to approach major surgery where patients refuse blood transfusion (including Jehovah's Witnesses) – 2 responses
- Logbook coding: How consistent are we? – 2 responses
- Reducing methicillin-resistant *Staphylococcus aureus* (MRSA) patient exposure by infection control measures – 3 responses
- Radioguided occult lesion localisation (ROLL) is available in the UK for impalpable breast lesions – 2 responses
- The value of postmortem examinations after surgery – 2 responses

Erratum

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USE OF AORTIC RESTRICTOR IN INTRA-MEDULLARY NAILING

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We apologise for the omission of Marion Mueller FRCS from the authorship of this Technical Tip. The authors should have been listed as given above. This was due to an editorial oversight.