**Correspondence Management Policy**

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# Introduction

## Policy statement

This policy will illustrate the commitment of Sheerwater Health Centre to an advanced approach to managing the spectrum of all types of communications. The relevant administrative staff can support clinicians by processing all incoming correspondence and strive to manage a significant proportion of this to substantially reduce the administrative tasks of the clinical team. This will allow clinicians to redirect this time in support of the organisation’s patient population.

It is the responsibility of the administration team to process all incoming correspondence. Effective correspondence management will improve appointment availability, increase service delivery and enhance job satisfaction at all levels within the organisation.

Patients can access advice, support and treatment digitally via the NHS App which is now used by millions of patients. A list of benefits to both patients and the organisation, the risks and issues and security and data protection coupled with other related digital guidance can be found at the NHS England webpage titled [NHS App](https://www.england.nhs.uk/long-read/nhs-app/). Furthermore, there is guidance to support online patient facing services titled Digital Primary Care: [The Good Practice Guidelines for GP electronic patient records (GPGv5)](https://www.england.nhs.uk/digital-gp-good-practice-guidance/all-guidelines/#online-patient-facing-services).

In addition, other forms of digital access that manage communication workflow into the organisation can be via IT systems such as Docman or by utilising online consultations such as eConsult. It should be noted that this policy does not provide guidance on any specific process for these IT systems. Detailed guidance and information are available from the respective provider and, in particular, how this links into the clinical system.

This policy should be read in conjunction with the following:

* [NHS E Records Management Code of Practice 2023](https://transform.england.nhs.uk/media/documents/NHSE_Records_Management_CoP_2023_V5.pdf)
* [CQC GP Mythbuster 46: Managing test results and clinical correspondence](https://www.cqc.org.uk/guidance-providers/gps/gp-mythbuster-46-managing-test-results-clinical-correspondence)
* [Communication Policy](https://practiceindex.co.uk/gp/forum/threads/communication-policy.6896/)
* [Managing Incoming Pathology Results](https://practiceindex.co.uk/gp/forum/resources/managing-incoming-pathology-results.722/)
* [Access to Medical Records Policy](https://practiceindex.co.uk/gp/forum/threads/access-to-medical-records-policy.15689/)
* [Confidentiality and Data Protection Handbook](https://practiceindex.co.uk/gp/forum/threads/confidentiality-and-data-protection-handbook-pdf-version.19006/)

The following eLearning courses are available on the e-learning platform Blue Stream Academy.

* Caldicott and Confidentiality
* Information Governance and Data Security

## Status

The organisation aims to design and implement policies and procedures that meet the diverse needs of our service and workforce, ensuring that none are placed at a disadvantage over others, in accordance with the [Equality Act 2010](https://www.legislation.gov.uk/ukpga/2010/15/contents). Consideration has been given to the impact this policy might have regarding the individual protected characteristics of those to whom it applies.

This document and any procedures contained within it are non-contractual and may be modified or withdrawn at any time. For the avoidance of doubt, it does not form part of your contract of employment. Furthermore, this document applies to all employees of the organisation and other individuals performing functions in relation to the organisation such as agency workers, locums and contractors.

# Managing correspondence in general practice

## Background

Correspondence management enables administrators and other trained staff to read, code and effectively distribute incoming clinical correspondence to the appropriate clinician, working in line with detailed guidance.

## Training

Ordinarily, staff who are expected to conduct correspondence management and clinical coding will be appropriately trained as this ensures that individuals understand their additional responsibilities and the requirement to adhere to guidance and protocol.

In some instances, non-clinical trained staff may change clinical codes on a patient’s clinical record. Refer to [Section 2.5](#_Managing_other_clinical) for further details.

## Workflow process

While correspondence is still often received by post, it is becoming increasingly common for tests results and correspondence to be received directly into the patient clinical record, or for correspondence to be received via email or electronic consultation requests from the patient.

It is therefore important that documented processes reflect all mechanisms of information exchange and the need for careful review to ensure there is no duplication as documents can often be sent by post and electronic means.

The process for correspondence management is shown at [Annex A](#_Annex_A_–) and as detailed within the [Communication Policy](https://practiceindex.co.uk/gp/forum/threads/communication-policy.6896/).

## Test results

Managing test results in general practice can be complex and as detailed within [CQC GP Mythbuster 46: Managing test results and clinical correspondence](https://www.cqc.org.uk/guidance-providers/gps/gp-mythbuster-46-managing-test-results-clinical-correspondence). Further to this guidance, detailed information can be found within the [Managing Incoming Pathology Results](https://practiceindex.co.uk/gp/forum/resources/managing-incoming-pathology-results.722/) document.

The above Mythbuster details that communicating effectively is a crucial part of the system and details the considerations to be taken. During any inspection, the CQC will wish to be satisfied that [Regulation 12](https://www.cqc.org.uk/guidance-providers/regulations-enforcement/regulation-12-safe-care-treatment) and [Regulation 17](https://www.cqc.org.uk/guidance-providers/regulations-enforcement/regulation-17-good-governance) are being satisfactorily maintained.

Further reading to support communication can be sought from [The Governance Handbook](https://practiceindex.co.uk/gp/forum/resources/the-governance-handbook-ms-word-version.1872/).

## Managing other clinical correspondence

Safeguards need to be in place to manage clinical correspondence including changes required to a patient’s medication.

While a clinician is responsible for making sure that actions are taken when appropriate, non-clinicians can do some tasks if there are appropriate safeguards in place. An example could be to identify when a change of medicine is required and then pass this to a prescriber to obtain approval and a prescription. When non-clinical staff are used, there is to be training and established protocols.

## Communicating changes to a patient’s medication

As for communicating results, patients are to be informed of any change to their medication should this have been altered outside of any consultation and without the prior knowledge of the patient.

Should this occur, then the patient should be contacted and advised of the reasons, be it consultant opinion, a commissioning requirement or best practice. Whatever the reason for the change, the patient is to confirm their identity and only once the caller is satisfied that the person who is being spoken to is the correct patient can the information be relayed.

Should an answerphone message need to be left then, as for leaving a message in relation to a test result, staff are to state that they are calling from this organisation and request that the patient calls back.

## Communicating via online access

NHS England has published a number of [guides and leaflets](https://www.england.nhs.uk/gp-online-services/support/supporting-material/patient-information-guides/) that provide further detailed information about how patients can access their health record online.

Patients who wish to register for online services, including viewing any clinical correspondence, are to complete the registration form at Annex A to the [Access to Medical Records Policy](https://practiceindex.co.uk/gp/forum/threads/access-to-medical-records-policy.15689/). Patients must provide two forms of ID for verification purposes to ensure that online access is granted only to the patient or their authorised representative(s). Further information can be found in the above policy and also in the NHS England [Good Practice Guidance on Identity Verification](https://www.england.nhs.uk/wp-content/uploads/2015/03/identity-verification.pdf).

## Clinical coding

The purpose of clinical coding, using [SNOMED CT](https://termbrowser.nhs.uk/), is to ensure that all information in the patient’s health record is given a concept ID (historically a Read code). Using SNOMED CT enables consistent, processable representation of clinical content in health records. This process is conducted by administrative and secretarial staff at this organisation using terminology from the NHS Digital SNOMED CT Browser.

When searching for the concept ID, there is the option to search using a term, a SNOMED concept ID, a Read code or an ICD-10 code.

Staff will be expected to code the following types of correspondence, although it should be noted that this list is not exhaustive:

* Discharge summaries
* Clinical letters
* Test results
* Imaging results

It is essential that all types of correspondence are coded accurately. For example, if a letter is received from a patient’s consultant at the local hospital, this could be given the concept ID 275693003– *Letter from consultant* and then tasked to the patient’s GP to review if there are actions within the letter, i.e., change of medication, requires weekly dressing changes etc.

## Processing and records storage

The administrative team is responsible for ensuring that the correct procedures are adhered to when processing original documents thereby ensuring that the copy is a true representation of the original document and the process complies with the guidance detailed in the [NHS England Records Management Code of Practice 2023](https://transform.england.nhs.uk/media/documents/NHSE_Records_Management_CoP_2023_V5.pdf) and the Record Retention Schedule.

Any document must be able to perform the same function as the original document while also retaining its authenticity, integrity and usability as a record.

## Legal admissibility of scanned records

The legal admissibility of scanned records, as with any digital information, is determined by how it can be shown that it is an authentic record, including the need to scan blank pages within a document, evidencing consecutive page numbers. If there is a requirement to retain a hard copy, this will be classed as the ‘best available evidence’ for legal purposes.

## Audit

Systems should be audited regularly to ensure that they are functioning effectively. This will help to identify any changes or improvements that need to be made. Consideration may be given to non-clinicians undertaking certain tasks safely, e.g., reviewing normal test results with appropriate safeguards in place.

**Annex B**

**Docman Process**

**To Scan Documents**

Place documents on scanner, open Docman, click on **Filing** in top left hand corner. Then select **Scan** on the right hand side. Then **capture from scanner**, tick in the box if two sided documents. Then select all pages and **Save.** You can also use the capture feature to drag and drop documents that have been saved to the computer.

**To File Documents**

Select **File** on top left hand side.

Select the letter on the left hand side, this opens the document, then click the green **File** **Document** icon on the right.

Check that the patient’s name, DOB and address details that appear in the blue banner are for the same patient that the letter relates to.

Read the letter and then fill in the following -

**Event date** - will auto populate but check this is the date of the letter or the clinic date, this is really important as this is the date EMIS uses to file the document, if it’s wrong it takes time to locate the document in EMIS.

**Description** – i.e. clinical letter/admin letter/result.

**Organisation** – i.e. hospital name/diagnostic world. If the letter is from a patient use Sheerwater Health Centre.

**Department** – i.e. gastro/x-ray/cardiology.

**Folder** - does not need to be filled.

**Clinical code** - use pick from browser and search for relevant such as seen in gastro/A&E/discharge summary/did not attend.

Then click on **Confirm** and then **Save.**

(The document will now move from the filing list into the tasks list.The document is also now saved in EMIS and can also be viewed there as well as in Docman tasks.)

**To Workflow Documents**

Choose tasks top left.

Click on the first letter.

Select **View in EMIS** on right, this selects the correct patient in EMIS, go to the consultation page in EMIS and find the relevant document. Right click on it to edit.

Click on **Date/Consulter/Place** box and change the consulter from Docman to your own name. Click **OK**.

Next read the whole letter, then click on **Run Templates** and select the **Workflow Template**.

Select a **letter type** – i.e. seen in gastro/radiology etc.

Check the **date letter received** box is correct.

**Letter action** - you will need to choose one of the top three options only -

1.**Mail admin procedure**, this is for any letters that the GP does not need to see.

2. **Incoming mail: forwarded to GP (action required)**. Choose this for any letter the GP needs to take action on such as changing a prescription or following up or referring a patient onwards.

3 **Incoming mail: forwarded to GP (no action required)** Choose this option for results or to alert a GP about child protection/vulnerable adult information that they may need to know about.

Add any information from the letter such as BP/temperature readings from A&E letters in **Common Numerics**.

Click on **Save** top left to save template.

Click on **Comments** section and type in a brief summary of what the letter is about.

Click on **Problems** and code any new diagnosis from the letter. Then **Save** the consultation.

Back in Docman -

If you are forwarding the letter to the duty doctor you can use the **Annotate** function to highlight the info that the doctor needs to see in the letter.

Then you either need to choose **Complete** and then **Finish** (to finish processing the document) or, if you need to send the letter to the doctor, select **More Actions**, then **Forward**, choose the duty GP, then add the reason for sending (for meds change/info etc) and then **Complete** and **Finish**.

**Annex C**

**PROCEDURE FOR TRANSFERRING AND ACTING ON INFORMATION ABOUT PATIENTS SEEN BY OTHER DOCTORS OUT-OF-HOURS**

**Introduction**

The practice has a system for transferring and acting on information about patients seen by other doctors out of hours. The system covers

• transferring information to the practice

• transferring that information into the clinical record

• identifying and actioning any required follow-up.

**Document transfer process**

NHS 111 reports are transferred electronically to practice Docman server. These reports are checked each morning by receptionist and then transferred to the consultation records electronically to relevant patient records on the EMIS web clinical system.

* The morning receptionist is responsible for transferring the messages sent by out-of-hours service into patients’ records on EMIS clinical system.
* The messages are transferred into patients’ records every day.
* Process to send out of hours reports to GPs on duty is described below
* Open Docman screen homepage
* Click on file documents
* From todays’ date, click on any entry “EDT Image”. Only continue if showing NHS Confidential – Personal data

Out of hours location or 111 call

* Other post does not need to be actioned
* Ensure report is for a patient on our list
* Highlight all pages of the report and click “File documents”
* Search patient data – name or date of birth
* Press select to identify correct patient
* Highlight date of case and click
* Tick box “Workflow the documents” at bottom corner
* Click “File Documents” again
* Highlight name of GP on duty that day and select
* Next screen click “Send”
* If there are too many reports for one GP then split some for GP next day if not urgent

IF ANY CONDITIONS ARE SERIOUS / MAJOR ADVISE GP AS SOON AS POSSIBLE

# Annex A – Incoming correspondence process

**Medication**

**e.**

**Correspondence received**

Tasked to admin to arrange review, etc.

Tasked to admin to arrange appointment

Tasked to admin to arrange repeat test or appointment

Tasked to originator if action required

Tasked to originator if action required

Tasked to originator if action required

Scanned & coded

Processed by administrative team

Filed if no follow-up action required

Processed by administrative team

Filed if no follow-up action required

Filed if no follow-up action required

Scanned & coded

Scanned & filed

Scanned & coded

Scanned & coded

Date stamped

Date stamped

Date stamped

Date stamped

Date stamped

**Hospital discharge**

**Administrative**

**Test results**

**Clinical letter**