

The Newcastle upon Tyne Hospitals NHS Foundation Trust

Sharing Letters with Patients Policy

Effective: January 2011

Review: January 2013

1. Policy Statement

- 1.1. The Trust is committed to sharing all available information with patients and this will include complying with the sharing letters with patient's policy.

2. Purpose

- 2.1 The purpose of this policy is to:

- enable patients to access information about their care and treatment should they wish to do so.
- ensure consistency of approach across the Trust wherever practical to the process of sharing letters with patients.
- provide a framework for monitoring the status of guidance implementation across the organization.
- ensure mechanisms are in place to audit compliance as part of clinical governance.

3. Background

- 3.1. The initiative to copy clinicians' letters to patients is part of the government's policy to increase patients' involvement in their care and treatment. Both the NHS Plan, July 2000 (paragraph 10.3) and the Kennedy Report 2001, of the Public Inquiry into children's heart surgery at the Bristol Royal Infirmary (Recommendation 17) refer to copying to the patient letters that are written between clinicians about them. There is wide-spread support that the partnership between doctors and their patients should be improved and strengthened, and that providing better and timely information to patients is an essential element of a modern and effective health service. It is one strand in the many different ways to improve and enhance communications between patients and professionals in the NHS.
- 3.2. The NHS Plan made a commitment that patients should be able to receive copies of clinical letters written about them from 1st April 2004.
- 3.3. There are many issues to consider concerning copying letters to patients.
- Writing style and terminology
 - The need to ensure understandable information
 - Confidentiality and sensitive information
 - Access for specific groups such those with visual impairments, learning disabilities, language/reading difficulties
 - Information to Carers on an authorised basis.
 - Workload and financial costs
 - Increasing patient anxiety

- 3.4. There is considerable evidence and experience to suggest that patients receive good quality letters very positively and with the outcome of improved satisfaction and reduction of anxiety. However, the most pressing implication of the policy relates to those sending the letters if they do not prepare properly and patients receive inappropriate or unsuitable letters, which might cause unnecessary distress or concern.

4. The Consent Process for Sharing Letters with Patients

- 4.1. All patients should be asked by the reception clerk or author of the letter, at each clinical episode (**whether inpatient or outpatient**) whether or not they wish to receive a copy of any letters that may be written about them to other health care professionals.
- 4.2. The patient's consent to receiving any letters should be documented at every clinical episode on the appropriate R4B (clinical record sheet) in the patient's health record folder relevant to that attendance.
- 4.3. If the health professional or discipline providing the service does not have access to the patient's health record, then a robust system within the appropriate department/ward must be set up to ensure that patients are asked and where consent is gained it is documented appropriately on the R4B for relevant action.

5. Practical considerations

- 5.1. The format of the letter is subject to the individual health professional. The original NHS Plan policy mainly referred to copying letters written between health professionals to the patient. However, it was clear this does not prevent writing to the patient and copying that letter to the health professionals. Indeed, this is now advocated as a more patient-centred approach to be encouraged.

6. When should a letter not be copied?

- 6.1. There may be reasons why the general policy of copying letters to patients should not be followed. These include:
- where the patient does not want a copy
 - where the clinician feels that it may cause harm to the patient (or for other reasons)
 - where the letter includes information about a third party who has not given consent
 - where special safeguards for confidentiality may be needed, e.g. Child Protection Cases

If you have not shared the letter with the patient, where it has been requested, the reason why should be justified and clearly documented in the patient's health record.

- 6.2. Giving of "bad news" is not in itself enough to justify not copying a letter. However, good practice would suggest that issues not discussed in the consultation should not be included in the letter.

7. Special considerations

- 7.1 Patient groups with specific needs

7.1.1. Some patient groups, such as those with difficulties in understanding written information given to them, will have specific issues and needs. Health professionals will need to be confident that appropriate consent has been gained prior to copying letters and where necessary letters to be copied to a carer or guardian should be clearly recorded within the patients' case notes.

7.1.2. There is no formal legal provision underpinning such arrangements, and health professionals must fall back on the considerations of their clinical team, advice from their Trust internal legal advisers, or their professional bodies and the "Good Practice in consent Implementation Guide" to ensure that arrangements are in the best interests of patients.

7.2. Children and Young People

"Children, young people and parents can only participate fully as partners in care if they have access to accurate information that is valid, relevant, up-to-date, timely, understandable and developmentally, ethically and culturally appropriate."
(DoH, April 2003, *Children's NSF Standard for Hospital Service*)

7.2.1 Copying or sharing letters with children and parents will enable a child and their family to exercise choice. A range of communication methods may need to be used and consideration should be given to different ways of giving information. Ideally, health professionals should write direct to parents/guardian. They must ensure when writing to the child this is done in a way in which they can understand, taking account of age and competence to understand the implications.

7.2.2 Care must be taken when dealing with parents who may be separated or who were not married at the time of the child or young persons birth to ensure that appropriate sharing of information is valid to their status.

7.2.3 Advice on these issues can be obtained from their Clinical Director or Outpatients and Medical Records Manager or deputy.

7.3. Accessibility – issues of equality and diversity

7.3.1 Patients who choose to do so should be able to receive letters in a format they can understand and use. This is in accordance with the equal opportunities legislation, including the provisions of the Equality Act 2010, the Disability Discrimination Act 1995, the Race Relations (Amendment) Act 2000 and the Human Rights Act 1998.

7.3.2 Thought should be given to whether or not the patient needs the letter sent to them in a different format, particularly for those with visual impairments, learning disabilities and different languages. This should be highlighted as part of the Alert Process in the Patient's Health Record.

This includes specific needs for:

- Larger print
- Braille
- Tape
- Learning Disabilities
- Requirements for Interpreting/Translation

Advice can be obtained on these issues from the Patient Carer and Public Involvement Co-ordinator or the PAL's officer.

7.4. Documenting communication/ Defensible documentation

7.4.1. Consideration will be required in relation to all letters, especially discharge letters, where it may not be clear from the patient's health record what has been said to the patient during the inpatient stay. The need for good record keeping is paramount to identify details discussed.

7.4.2. All communication with the patient should be clearly documented within the patients case notes. With regard to sending the discharge letter to the patient, caution should be exercised to ensure that sensitive or unconfirmed information is not divulged through the letter that has not already been discussed with the patient.

8. Monitoring

8.1. The Outpatient User Group (chaired by the Head of Patient Services) in association with Directorate Management teams will monitor compliance with this policy.

The Outpatient user group will ensure compliance audits are undertaken within all Outpatient areas within the Trust. The directorate management teams will have the same responsibility for inpatient letters. The Head of Patient Services will determine the regularity of the audits following the review of individual directorate results at the Outpatient user Group meeting.

8.2. Directorate Managers and Clinical Directors

Directorate Managers and Clinical Directors are responsible for ensuring that this policy is implemented and that recommended guidance is adhered throughout the service in accordance with this policy.

Author: Medical Records Manager

Medical Records General Procedure 15 Sharing Letters with Patients

The NHS Plan says:

“Patients will...have the option of having much greater information about the treatment that is being planned for them. Patients have the right to see their medical records though in practice much communication between professionals is not available to the patient concerned. Patients often do not know why they are being referred, or what is being said about them. In future, as a result of the NHS Plan:

“Letters between clinicians about an individual patient’s care will be copied to the patient as of right”

The Kennedy Report stressed both the importance of culture change in the NHS and the need to improve communications between patients and clinicians. Recommendation 17 supported the government’s policy of copying letters to patients.

Compliance with this policy is part of the Trust’s Clinical Governance Development Plan and will be monitored accordingly.

In order to comply with these requirements certain administrative processes need to be put in place e.g. obtaining and recording consent of patients. To facilitate this, the following procedure has been developed.

- 1) All patients for outpatient attendances and admissions are entitled to receive a copy of a letter about them produced between care providers.
- 2) When the patient attends the outpatients or ward environment a member of staff will ask if they wish to receive a copy of a letters about their treatment. This could be a clerk, nurse or the medic who is the author of the letter.
- 3) The member of staff will be responsible for documenting this requirement on the reverse of the ‘Patient Alert Form’ or on the appropriate R4B within the patient’s casenotes as soon as possible following discussion.
- 4) If the notes are not available at clinic or on the ward an alerts form must be completed and held with the other patient’s documentation until the casenotes are located and received.
- 5) If the patient changes his/her mind after the consultation/discharge the alerts form must be updated in the case notes at the earliest opportunity.
- 6) The secretaries will use the information on the alerts form/R4B to determine if the patient wishes to receive a letter therefore it is critical all information, both on PAS and on the front sheet in the notes, is correct and up to date.
- 7) The secretaries will enter on the letter that a copy has been sent to the patient.

Copying letter to Patients...

Copying letters to patients

A few keys steps to successfully writing letters that can be copied to patients:

1. Consider only offering one or two copy letters per clinic initially. Choose more straightforward consultations and see what difficulties arise in practice.
2. Ensure the patient has consented to having a copy letter and this is recorded within their casenotes.
3. Broadly plan what you wish to include in the letter and how it is going to be structured. This should help keep the letter concise.
4. Use plain English. Try to write a letter that the patient will understand.
5. Consider using a standard opening statement including the reason the patient attended clinic (i.e. "I reviewed Mrs Smith in the Endocrine clinic today, she came for a review of the treatment of her thyrotoxicosis"). Avoid subjective comments like "this delightful 64 year old woman".
6. Avoid the use of complex medical terminology where possible or include brief explanatory statements in brackets (i.e. "(overactive thyroid gland)" could be added to the example above).
7. Short sentences and paragraphs make the letter easier to read and understand. Subheadings in bold or bullet points may also improve readability.
8. Consider the use of standard letters or templates, which may help workload issues and aid understanding.
9. The letters should be a clear and accurate reflection of the consultation. As far as possible do not include any new information that was not discussed with the patient.
10. Aim to set out the facts clearly and avoid unnecessary speculation. If there is a need to relay information not directly related to the patient consider writing this in a separate letter.
11. Proof read and correct the letter thoroughly making sure the letter makes sense and there are no dictation or typing errors.
12. Mistakes and incorrect information will inevitably occur and rectification of these is an aim of this process. Ensure that the letter has enough information to enable the patient to contact you or your secretary to do this.
13. A good letter may well improve decision-making and compliance with the management plan. Write your letter with this aim in mind.

Copying letter to Patients...

Writing letters directly to patients

In certain circumstances you may feel it is better to write a letter directly to the patient with a copy to the General Practitioner. This letter-writing process is slightly different:

1. Once again, it is important to plan what you wish to include in the letter and how it is going to be structured.
2. Writing a letter directly to the patient can allow them to have some personal responsibility for the management of their condition. It is therefore imperative that the information is clear and concise.
3. Find out from the patient how they wish to be addressed (e.g. Mrs Brown, Ms Brown or Edith).
4. A consistent opening statement is important to help set the tone of the letter (e.g. "I write regarding the consultation we had today, as I said I would"). Include a sentence to explain why they attended the clinic.
5. The language and phraseology used will reflect the fact that it is being written to the patient (e.g. "You told me that you had had chest pains for 6 months" or "You have been feeling life is stressful recently").
6. It is again important to avoid complicated terminology. However, you may choose to include the medical terminology in brackets for the GP in these letters (e.g. "I explained you have a leaky heart valve (mitral regurgitation)").
7. Use terms and language that reflect the consultation and what was said. Do not include new information in the letter.
8. Use of plain English, short sentences and paragraphs, subheading and structure remains important.
9. Include a carefully worded management plan to clarify what the patient is to do (e.g. "We agreed you would arrange to see the practice nurse to keep an eye on your blood pressure. You would see your GP about starting blood pressure tablets if it was persistently over the target level of 140/80").
10. Finish with a clear summary statement. Include contact details in case the patient wishes to discuss or clarify any of the information in the letter. Mistakes and incorrect information will inevitably occur and rectification of these is an aim of this process.
11. When proof-reading ensure the letter makes sense. Don't be afraid to make changes to improve clarity and understanding.

Letters to Patients: Frequently Asked Questions

1. **Do I have to offer my patients copies of letters? Can I opt out?**

Since April 2004, patients can obtain copies of the letters written about them by right. This is an opt-in system for the patient and they do have to consent to copies being sent to them. Health professionals do not have an opt-out option. Thus, any letter you write about the patient after April 2004 could be copied to them unless there are very good reasons to not do this, which you would need to be able to justify.

Therefore, it is your responsibility to ensure that all letters that are written about patients are good enough and appropriate to be copied to that patient.

2. **How can I write a letter that a patient can understand but that is also adequately informative to a Consultant colleague or GP?**

Research has shown that patients do understand most of what is written in clinical letters. Keeping the language straightforward, with short clear sentences, does not diminish the professional nature of the communication between colleagues.

3. **What about complex medical terminology?**

Sometimes, lay terms such as heart attack can be used instead of the medical term without loss of meaning.

Most patients understand the need to use medical terminology and seem to be quite happy with letters that contain 'technical' terms with lay explanations. For instance, specific terms (e.g. mitral regurgitation) may need to be used with an explanatory phrase (e.g. leaky heart valve), which can be added in brackets.

4. **Surely getting a copy letter about the possibility of a serious illness (eg multiple sclerosis or cancer) will make patients very anxious, perhaps unnecessarily?**

Research has shown that patients are often more worried than the physician about the 'rare but serious' causes of their symptoms. They are made less rather than more anxious by seeing in a letter that the doctor shares their concerns and is taking them seriously, so long as this is discussed in the consultation.

A small group of patients do not want to see such information, which is why consent to receive the letter must be checked.

A simple but important rule is to not add any new information in the letter that wasn't discussed in the consultation.

5. **What about sensitive information such as alcohol/drug abuse, marital difficulties etc - can that still go into letters that the patient will see?**

Patients questioned on this topic generally were quite happy for such information to be included in a letter so long as it had some relevance to medical issue (e.g. alcohol abuse was seen as relevant to a referral for abdominal pain but probably not important in one for a new hearing aid).

Clinicians have a right to withhold from letters 'information that might be damaging to the patient' - although if challenged by a patient, the clinician would have to be able to justify their decision.

6. What if I make a mistake in the letter?

Part of the aim of this process is to improve the quality of medical records by correcting erroneous information in letters. Therefore, a patient contacting us to do this is a positive outcome and should be encouraged. Instructions on how to do this should be included in the letter.

7. Is this going to mean lots of extra work for me?

Experience to date has shown routinely copying referral and other letters to patients has shown that virtually no patients make appointments specifically to discuss the content of their copy letter. Occasionally they might mention the letter when consulting about the problem in the future, but usually just to say it was useful to know what was going on. Patients do use the letters to chase appointments and sometimes take the letters to the clinic appointment.

Pilot projects and experiences in secondary care have had similar results, reporting improvements in the therapeutic relationship and very few negative experiences.

8. Is this going to mean lots of extra work for administrative staff?

There is additional work for secretaries who must generate a second copy of the letter and a stamped envelope to send to the patient. In most pilot projects once the system is established this has not had a major impact on workload.

9. What about telephone calls from concerned patients wishing to clarify or discuss issues in the letters?

Again, this does not seem to be as much of a problem as people may anticipate. Correction of mistakes is a positive outcome and is time valuably used. Otherwise the experience is that staff are not inundated with calls. Letters sent to patients with inappropriate information or unsuitable wording may well cause anxiety and lead to distressed telephone calls or complaints.

10. This is going to lead to lots of complaints isn't it?

Complaints tend to stem from poor communication. Thus, provided the letters are appropriately written and communication therefore improved, complaints should not be more frequent. This is the experience from pilot projects where satisfaction is increased by receiving copy letters and more information.

11. What about patients with learning difficulties or those that can't read English?

The Human Rights Act 1998 and the Race Relations Act 2000 provide the legal basis to prevent discrimination against patients in these groups. In principle, advocacy and interpretation services should be accessible to all our patients. Patients should be encouraged to seek assistance where necessary.

12. What about third party information in letters?

The Data Protection Act excludes 3rd party information from copied correspondence - such information would need to be removed before a letter is copied

13. How do I know the letter will get to the right person at the right address?

Patients have a responsibility to let us know their correct address, especially if they are consenting to receive a copy letter. Our responsibility to keep up to date information is important for many other areas of practice. Households with two or more individuals with similar names need special care when the letter is addressed.

14. Should I be copying letters to patients or writing to them directly?

This is a matter of personal preference. The policy suggests copying letters but advocates writing direct if preferred. The Health Secretary, has stated that writing direct, with copies to the GP, as the ideal.

15. Where can I get further information?

The DoH website is very useful and includes reports from the pilot sites and good practice guidelines (www.doh.gov.uk/patientletters).

Appendix 6 – Patient Information Leaflet

As part of the NHS Plan, from April 1st 2004, you are able to receive a copy of any letters written by health professionals about you, if you wish to. This service is available at this hospital. Sharing letters in this way is part of increasing your involvement with your care and treatment.

We need to ensure that:

1. you are aware of your right to receive or refuse copies of letters.
2. you are asked if you would like a copy of any letter written about you.
3. you receive a copy of any letter about you if you wish to.

This means you will be asked by a member of the Trust staff at each visit if you would like to receive a copy of the letter about you. All you have to do is tell them whether you would like to receive the letter or not. If you say yes, a copy will be sent to you at the same time as the letter is sent to the health professional.

The choice is entirely yours and does not affect any part of the treatment or care you are receiving.

If you have any questions about the letter, you should contact the person/ team who wrote the letter, or your GP.

The Newcastle upon Tyne Hospitals NHS Foundation Trust

Sharing Letters With Patients

Medical Records

THE NEWCASTLE UPON TYNE HOSPITALS NHS FOUNDATION TRUST
IMPACT ASSESSMENT – SCREENING FORM A

This form must be completed and attached to any procedural document when submitted to the appropriate committee for consideration and approval.

Policy Title:	Sharing Letters with Patients	Policy Author:	Kathleen Jaques
		Yes/No?	You must provide evidence to support your response:
1.	Does the policy/guidance affect one group less or more favourably than another on the basis of the following: (* denotes protected characteristics under the Equality Act 2010)	No	This guideline is equally applicable to all with no discrimination between age, gender, race or sexual orientation.
	• Race *	No	
	• Ethnic origins (including gypsies and travellers)	No	
	• Nationality	No	
	• Gender *	No	
	• Culture	No	
	• Religion or belief *	No	
	• Sexual orientation including lesbian, gay and bisexual people *	No	
	• Age *	No	
	• Disability – learning difficulties, physical disability, sensory impairment and mental health problems *	No	
	• Gender reassignment *	No	
	• Marriage and civil partnership *	No	
2.	Is there any evidence that some groups are affected differently?	No	
3.	If you have identified potential discrimination which can include associative discrimination i.e. direct discrimination against someone because they associate with another person who possesses a protected characteristic, are any exceptions valid, legal and/or justifiable?	No	
4(a).	Is the impact of the policy/guidance likely to be negative? <i>(If “yes”, please answer sections 4(b) to 4(d)).</i>	No	
4(b).	If so can the impact be avoided?	No	
4(c).	What alternatives are there to achieving the policy/guidance without the impact?	No	
4(d).	Can we reduce the impact by taking different action?	No	

Comments:	Action Plan due (or Not Applicable):
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Name and Designation of Person responsible for completion of this form: Kathleen Jaques
Names & Designations of those involved in the impact assessment screening process: Trust Secretary

Date: 02nd February 2011

(If any reader of this procedural document identifies a potential discriminatory impact that has not been identified on this form, please refer to the Policy Author identified above, together with any suggestions for the actions required to avoid/reduce this impact.)