

The Newcastle upon Tyne Hospitals NHS Foundation Trust

Sharing Letters with Patients Policy

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Date Ratified	18 December 2018
Ratified By	Clinical Policy Group

1 Introduction

- 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.
- 1.2 This policy sets out how The Newcastle Hospitals NHS Foundation Trust will meet the Department of Health's policy to copy letters to patients, which came into effect in April 2004.
- 1.3 The principles are consistent with established good professional practice already required within health services. This includes good communication, obtaining consent, record keeping and handling, confidentiality, data protection and the provision to meet legal requirements to prevent discrimination. The Statutory Accessible Information Standard requires the Trust to provide information in formats that meet the needs of disabled and Deaf people.
- 1.4 Staff are required to read this policy in conjunction with the Department of Health (Archived) **Copying Letters to Patients Good Practice Guidelines** (2004).
- 1.5 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.

2 Scope

- 2.1 The policy is intended to be used by:
 - Healthcare professionals
 - Health records and information staff, including those responsible for commissioning new systems
 - Medical secretaries and administrative staff
 - Non NHS staff working into health teams where records are integrated

3 Aims

The aim of this policy is to ensure that individuals and their carers attending the Trust have access to the information that is being shared with their GP or other care providers. The general principle is that all letters that help a service user's understanding of their health and the care they are receiving should be copied to them as of a right.

4 Duties (Roles and responsibilities)

4.1 Directorate/Departmental Manager

Each departmental/directorate manager has responsibility for the local implementation of this policy. This is to ensure that all staff within the directorate/department are aware of the Trust's obligations in relation to Sharing Letters with patients.

4.2 Outpatient Managers/ Local Administrative Managers

Outpatient and secretarial managers are responsible for ensuring there are systems and processes in place that will allow individuals to receive copies of their documentation when it has been requested.

4.3 Outpatient User Group

The Outpatient User Group is responsible for ensuring that this policy is implemented and that the requirements for monitoring this policy are developed, co-ordinated and monitored.

4.4 All Staff

All Trust staff, whether clinical, administrative or supportive, should be provided with appropriate training on induction and beyond to ensure that they are aware of their personal responsibilities in respect of supply copy information to patients and their carer's.

5 What Constitutes a Letter

A letter includes communications between different health care professionals. Different types of letters include:

5.1 Letters of communication between different health professionals, for instance those from and to GP's, hospital doctors; nurses; therapists and other health professionals.

5.2 Letters or forms of referral, letters following discharge from hospital or episode of treatment, and letters following outpatient consultations.

5.3 Letters from NHS health professionals to other agencies such as social services, housing.

6 What Does Not Constitute a Letter

Other documents, for example, single test results or Mental Health Act reports should not normally be sent to service users. In due course the outcome of such tests should be included in a letter that is shared with the service user.

- 6.1 Reports written to Mental Health Review Tribunals and Manager's Hearings should adhere to the guidance set out in the Mental Health Act.
- 6.2 For the purpose of this policy 'letters' do not include multidisciplinary team meeting minutes, assessment tool reports and rating scales. Clinicians should have measures in place to communicate this information to service users.

7 Capacity to Consent to Receiving Letters

The MCA's starting point is to confirm in legislation that it must be assumed that an adult (aged 16 or over) has full legal capacity to make decisions for themselves unless it can be shown that they lack capacity to make a decision at the time the decision needs to be made.

- 7.1 If there is concern regarding Capacity the Trusts Policy on the Mental Capacity Act 2005 should be followed:
[\(Mental Capacity Act \(2005\) Policy and Procedure\)](#)

8 The Consent Process for Sharing Letters with Patients

- 8.1 All patients should be asked by the reception clerk or author of the letter, at the beginning of 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 and if they need a specific format for the letter - Where the clinical episode expands beyond 12 months this should be reviewed.
- 8.2 The patient's consent to receiving any letters should be documented at the beginning of the clinical episode on the appropriate R4B (clinical record sheet) in the patient's health record folder relevant to that attendance and flag any format needs.
- 8.3 The patient should be reminded each time a letter is to be copied, that they have consented to receive letters and therefore will receive them.
- 8.4 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.
- 8.5 The service user may decide to opt out of receiving copies of letters, which can be done at any time.

9 Practical considerations

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.

10 When should a letter not be copied?

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.

10.1 "No Surprises" where the letter contains abnormal results or significant information that has not been discussed with the patient, it will be important for arrangements to be made to give the patient a copy of the letter after its contents have been discussed in a consultation with the receiving professional.

10.2 As a general rule the contents of the copied letters should reflect the discussion in the consultation with the sending healthcare professional, and there should be no new information in the letter that might surprise or distress the patient.

11 Copying letters to Carers

11.1 Some patients have carers, for example partners, friends or family members, who are actively involved in their care. Carers may need information and support from professionals supporting the person they care for.

11.2 If the patient wants to have information shared with their carer's, a copy of letters can be sent to their carers providing that the service user has given written consent. This should be recorded in the patients' record.

12 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*)

- 12.1 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.
- 12.2 Care must be taken to ensure that the appropriate parent/guardian is identified and the name updated if required. This will be particularly important within changing family dynamics, to ensure that appropriate sharing of information is valid to their status.
- 12.3 Advice on these issues can be obtained from their Clinical Director or Outpatients and Medical Records Manager or deputy.

13 Accessibility – issues of equality and diversity

- 13.1 There is a requirement under the Accessible Information Standard 2015, the Equality Act 2010, the Care Act 2014 and the NHS Constitution that information is supplied to people who have a disability or impairment in a format that is accessible to them.
The aim of the standard is to make sure that adults can access the health and social care services they need and have the information in a format that means they can make their own decisions about their treatment.
The accessible information standard has five basic steps which we **MUST** comply with, further guidance regarding the standard can be found on the trusts intranet page: <http://nuth-vintranet1:8080/cms/SupportServices/EqualityDiversityHumanRights/CommunicationSupport.aspx>
- 13.2 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. If Easy Read format is requested a written English letter should also be included as it may not be possible to convey the full meaning of the information.
- Requirements for Interpreting/Translation

- Email. If patient's request email they must be made aware that we can not guarantee data security and consent to this format should be documented in the patient's record.
- Other formats the patient requests

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

13.3 Care must be taken to ensure the letter refers to the patient in their current gender.

For example not referring to a Trans Woman as a gentleman

14 Equality and Diversity

The Trust is committed to ensuring that, as far as is reasonably practicable, the way services to the public and the way the Trust treats its staff reflects their individual needs and does not discriminate against individuals or groups on any grounds. This document has been appropriately assessed.

15 Monitoring

Standard	Monitoring and audit			
	Method	By	Committee	Frequency
To provide assurance of compliance	Audits to be undertaken within all Outpatient areas.	Directorate Management Teams	Outpatient User Group	Yearly
To provide assurance of compliance	Audits to be undertaken on all Inpatient wards.	Directorate Management Teams	Outpatient User Group	Yearly

16 Consultation and review

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.

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Sharing Letters With Patients

Medical Records

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:

- You are aware of your right to receive or refuse copies of letters.
- You are asked if you would like a copy of any letter written about you.
- 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 your first appointment related to your referral or treatment episode 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.

