St Helens and Knowsley Teaching Hospitals NHS Trust

Copy Letters to Patients Policy

Version No: 6

Document Summary:

The purpose of this policy is to ensure that all adult patients requesting access to correspondence relating to their outpatient attendance receive a copy of the letter sent to their General Practitioner (GP) by the Consultant or their team. This policy defines those roles and responsibilities and establishes good practice guidelines to assist staff with the effective management of requests for copy letters from patients.

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Version Control

Version	Date Approved	Brief Summary of Changes	Author (title)
7	July 2018	• Applied to the new policy format • Review of related policy and references	Patricia Keeley Assistant Director of Operations
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Document Control

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- New policy template applied

Does the document follow the Trust agreed format?	Y
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Does the document outline clearly the monitoring compliance and performance management?	Y
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Approved after minor amendments? *Any amendments to be submitted to Approving Body Chair for final sign off*	
Not Approved?	

Policy Author Signature:		Patricia Keeley	**Date: 04.11.2018**
Chair of Approving Body	**Name / Title:**	Anne Rosbotham-Williams Assistant Director of Governance	**Date: 07.11.2018**
	Signature:		
		Review Date:	**31.10.2021**

Withdrawal of Document

To be completed if a document has been superseded or no longer required

Date Document Withdrawn:	**Reason:**	
Policy Author Signature:		**Date:**
Lead Executive Director Signature:		**Date:**

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1. Scope

This policy applies to staff working in outpatient settings who are part of the process for ensuring adult patients are aware of the procedures for requesting copies of correspondence and for complying with requests.

2. Introduction

As part of the NHS Plan (2000) the Government has instructed NHS trusts to ensure that patients have the right to receive the clinical information that is communicated between healthcare professionals, if the patient so wishes. The purpose is to permit patients access to the same information that healthcare professionals use and allow the patient to have access to ethical autonomous decision making. It is therefore the duty of St Helens and Knowsley Teaching Hospitals NHS Trust and its clinical employees to serve those patients who wish to have access to clinical information involving the patient.

The position of St Helens and Knowsley Teaching Hospitals NHS Trust is that this policy and protocol (hereafter referred to as "the policy" – the copying of clinical letters to patients) will apply to adult patients only. The **default** position for patients will be that patients will be **opted out** unless the patient indicates that they wish to opt in to the process of receiving copies of clinical letters. There should be no burden upon clinicians providing copy letters. The communication provided in a clinical letter should not differ from any communication that has occurred in a clinical setting between the clinician and the patient.

Genito-Urinary Medicine patients are also automatically opted out.

3. Statement of Intent

The purpose of this policy is to ensure that all adult patients requesting access to correspondence relating to their outpatient attendance receive a copy of the letter sent to their General Practitioner (GP) by the Consultant or their team. This policy defines those roles and responsibilities and establishes good practice guidelines to assist staff with the effective management of requests for copy letters from patients.

4. Definitions

None

5. Duties, Accountabilities and Responsibilities

5.1 Trust Board

Overall responsibility for ensuring the Trust has appropriate policies and procedural documents in place that are legally compliant and effective in supporting achievement of the Trust's vision and objectives.

5.2 Director of Operations and Performance

The Director of Operations and Performance is accountable to the Trust Board for ensuring compliance with this policy and for ensuring that the policy is reviewed and updated by the specified review dates.

5.3 Assistant Director of Operations (ADO), St Helens

The ADO is responsible for reviewing and updating the policy within the specified review timeframe and for disseminating the policy to relevant departments and staff.

5.4 Staff working in Outpatient Departments

Staff are responsible for ensuring that patients are aware of the process for requesting copies of clinical letters and for complying with the requirements within this policy.

6. Standards and Practice

6.1 Advising Patients

The following phrase will be appended to all letters sent to patients inviting them to attend for a consultation: **"should you wish correspondence relating to this period of care to be sent to you, then please directly inform your consultant or the senior nurse or doctor whom you see."**

This expression is to be inserted on all letters of invitation to attend for consultation and the Health Records Department of the Trust will administer the insertion of this phrase.

A paper token is available at reception to give to staff members as a reminder aid

6.2 Paediatrics

The view of St Helens and Knowsley Teaching Hospitals NHS Trust is that this policy should apply to adults. It would be a logistical difficulty to always provide clinical letters to paediatric patients or their parents and then convert such letters at the age of majority (18). However, notwithstanding this statement, the participation of parents with parental rights to the clinical care of children is recognised as fundamentally important and, as such, specific arrangements between paediatric clinicians and the parents of a child to receive copy letters of clinical correspondence may be made as an individual arrangement.

6.2.1 Transfer from Paediatric to Adult Services

Under such circumstances any previous paediatric individual arrangement is null and void, and the now adult patient will have to apply as an adult to opt in. Paediatric staff must inform transferring patients of this.

6.3 Patients with additional communication needs

6.3.1 Patients whose first language is not English

Letters can be translated into alternative languages for patients whose first language is not English on request. Before making a request for information to be translated into an alternative language or format, permission must be sought from the budget holder in the area requesting the translation, as the area requesting the translation will be responsible for any costs incurred.

Once the translation has been approved, a purchase order must be raised to meet the costs of the translation. If you require a quote for the information you need translating prior to ordering it, please forward the information to patientexperienceteam@sthk.nhs.uk who will request a quote from the current provider of interpreting services.

Complete the intranet booking form and submit to Interpreter.bookings@sthk.nhs.uk, stating which language or format you need your information translating into, and attach the information to be translated and details of the purchase order. The translated information will be returned both in Word and PDF format, usually within 5 working days of the date of the request.

6.3.2 Patients who have additional communication needs due to a disability

Letters can be translated into alternative formats for patients who have additional needs due to a disability, for example Braille, easy read etc. For advice on how to proceed with ordering this type of translation please contact the Patient Inclusion and Experience Lead via email at patientexperienceteam@sthk.nhs.uk

6.4 Terminology

It is recognised that the clinical terminology used by clinicians in communication with other clinicians or healthcare workers may not be understood clearly by people and patients without such clinical knowledge. It would be unreasonable to explain in a letter every detailed clinical term that may be misunderstood. However, it is possible to draw up a list of commonly used clinical expressions to append to any copy letter. Preferably, difficult to understand terminology should be avoided or clearly explained.

Abbreviations may be used **provided that** at the initial use of the abbreviation there is a clear definition of what the abbreviation stands for and what it means.

6.5 Confidentiality

All correspondence remains confidential. Letters to patients will need to have the phrase **"Private & confidential: to be read by addressee only"** appended clearly at the heading. Envelopes must be marked **"To be opened by addressee only"**. None of the above circumvents any legislation relating to data protection legislation.

6.6 Who is included and excluded in receipt of correspondence

As stated above, the default position of the Trust is that patients will need to actively opt in by request. The paediatric position is outlined above.

6.7 Carers of Adult Patients Who Lack Capacity

Patients who lack capacity (decision-making ability) and who have nominated a carer to supervise their care may be unable to communicate their intentions. Under such circumstances all attempts should be made to communicate with the patient about their desire regarding opting in or opting out. If informed agreement can be reached with the patient, then subject to an agreement between the nominated carer and the Trust, the carer will be the recipient of any copy communications. Under such circumstances the copy letter should be addressed to **"the carer of ……"**. This subsection will be reviewed and may be amended in light of future legislation concerning Mental Capacity or Incapacity. Carers who achieve rights under any clinical advocacy legislation will be subject to 'Responsibilities of Patients' and 'Change in Circumstances' as detailed below. If the patient cannot communicate then the carer has no right to receive a copy letter unless an individual agreement is reached between the carer and the Trust.

6.8 Carers of Adult Patients who have Capacity

Under such circumstances all letters should be addressed to the patient in the usual way as outlined in this policy. Letters that are copy letters **must not** be addressed to the carer.

6.9 Identification of patients who have opted in

This will be on a paper token (as above) or on a verbal basis. The usual position will be that patients will give the token to the clinician at the beginning of the consultation/procedure. The token will then be appended at the date entry in the case record of the consultation.

Signage advising patients of how to opt in will be posted in all clinical areas with instructions to advise staff if they are opted in patients.

6.10 Standardisation of letter contents

It is common that clinical letters are used as a form of chronological description of events in a style of prose of the author. There is not often a standardisation of letter contents. Letters should not become over-long detailing events and issues that are not clinically relevant.

6.11 What is included and what is excluded in letter contents

The contents for inclusion are outlined below. **In all circumstances the Trust case record must be seen as the main repository or archive of clinical information**.

Letters should be **brief, concise** and **precise**.

As a **suggestion**, for practical purposes the following order may be followed:

- What did the patient present with
- What were the **important** symptoms
- What were the **important** findings on examination
- What were the **important** positive and negative examination results
- What is the proposed clinical management plan
- ❖ It is reasonable to write down any changes in medication as opposed to a list of what the patient was prescribed and what they are prescribed now
- ❖ However, any changes or specific instructions about medication must be very clearly outlined
- Communicate important messages such as new, or unrecognised, or untoward clinical issues or events (eg developed allergies, drug reactions, change of or additional diagnosis/diagnoses, untoward incidents etc) or patient concerns or patient caveats to the clinical management programme (eg living wills, do not resuscitate instructions), refusal of treatment/investigation, on-going referral (who will be referring)
- What are the contact arrangements
- What has been communicated to the patient, verbally and in writing including pertinent risks, complications and side effects
- What are the follow up arrangements

It should be possible, as a generality, to limit a letter to a one side of A4 paper including headers and footers by being concise and precise. However, this statement is not prescriptive and individual circumstances may create a letter beyond one A4 page. Nevertheless, aiming to be concise, precise and expressing issues in plain English should be the goal of letter writing. Letters that are more than one page should be stapled together to reduce the risk of the pages coming apart. Long letters do not necessarily mean good communication.

The letter should always identify the consultant in charge and a contact telephone number.

A letter may terminate with the end of the important messages (see above) pending the results of investigations or on-going referral.

Many clinicians use the clinic or discharge letter as a reference communication should the clinical notes not be available. This is understandable, however, this does not mean that such letters require to be long with unnecessary information. They should contain all the pertinent information, rather than a complete list of irrelevant information which adds nothing to the communication.

Should a clinician wish to record a detailed chronological episode then this should be expressly annotated as such rather than as a letter of communication and be considered and labelled as a **Record of Events** as opposed to a letter of communication. Such a **Record of Events** document would not be a communication yet will be subject to the provisions of the Data Protection Acts and as such would always be amenable for access by patients in the usual way.

Good clear concise and precise communication may ease any misunderstandings and obviate follow up telephone calls that seek explanation(s) both in primary and secondary care. The ability to inadvertently confuse a patient in communications with medical parlance or expressions does nothing to foster cooperative working between healthcare professionals and patients.

6.12 Patient Booklets and Information

The patient booklet should include reference to the receiving or not of copy clinical letters.

6.13 Future developments

The Trust will actively develop IT solutions to provide electronic correspondence with all GP practices within and outside our local Clinical Commissioning Groups (CCGs) at which point paper correspondence will cease. In addition, the Trust will capture patient email details and at a time when there is a suitable IT solution to support will cease paper correspondence to those with access to email continuing with paper to those patients who do not have access to email. At this point when IT solutions are in place this policy will be revised and patients will automatically be provided with copies of all correspondence with the option to 'opt out' of the scheme.

7. Training

Relevant staff will be made aware of this policy and the process outlined above. No additional training is required.

8. Monitoring Compliance

8.1 Key performance Indicators of the Policy

Describe Key Performance Indicators (KPIs)	Frequency of Review	Lead
Compliance with providing copy letter to patients who request	Annual	Heads of Nursing and Quality

8.2 Performance Management of the Policy

Aspect of compliance or effectiveness being monitored	Monitoring method	Individual responsible for the monitoring	Frequency of the monitoring activity	Group / committee which will receive the findings / monitoring report	Group / committee / individual responsible for ensuring that the actions are completed
Patients receiving copy letter when requested	Monitoring of patient complaints / concerns for non-compliance in the supply of a copy letter if requested	Heads of Nursing and Quality	Annually	Patient Safety Council	Patient Safety Council

9. References/Bibliography

Copying letters to Patients, Department of Health. April 2003 (Archived)

Data Protection Act, 2018

10. Related Trust Documents

All policies are available on the Trust Intranet Policy pages

No	Policy
1	Policy: Subject Access
2	Policy: Safeguarding Children & Young Adults
3	Policy: Safeguarding
4	Policy: Confidentiality Code of Conduct
5	Policy: To meet the communication needs of patients

11. Equality Analysis Form

The screening assessment must be carried out on all policies, procedures, organisational changes, service changes, cost improvement programmes and transformation projects at the earliest stage in the planning process to ascertain whether a full equality analysis is required. This assessment must be attached to all procedural documents prior to their submission to the appropriate approving body. A separate copy of the assessment must be forwarded to the Patient Inclusion and Experience Lead for monitoring purposes. Cheryl.farmer@sthk.nhs.uk. If this screening assessment indicates that discrimination could potentially be introduced then seek advice from the Patient Inclusion and Experience Lead. A full equality analysis must be considered on any cost improvement schemes, organisational changes or service changes which could have an impact on patients or staff.

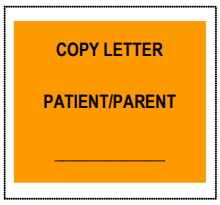
Equality Analysis				
Title of Document/proposal /service/cost improvement plan etc:	Copy Letters to Patients Policy			
Date of Assessment	15 June 2018	**Name of Person completing assessment /job title:**	Patricia Keeley	
Lead Executive Director	Rob Cooper		Assistant Director of Operations	
Does the proposal, service or document affect one group more or less favourably than other group(s) on the basis of their:		**Yes / No**	**Justification/evidence and data source**	
1	Age	Yes	As per 6.2	
2	Disability (including learning disability, physical, sensory or mental impairment)	Yes	As per 6.6	
3	Gender reassignment	No		
4	Marriage or civil partnership	No		
5	Pregnancy or maternity	No		
6	Race	No		
7	Religion or belief	No		
8	Sex	No		
9	Sexual Orientation	No		
Human Rights – are there any issues which might affect a person's human rights?		**Yes / No**	**Justification/evidence and data source**	
1	Right to life	No		
2	Right to freedom from degrading or humiliating treatment	No		
3	Right to privacy or family life	No		
4	Any other of the human rights?	No		
Lead of Service Review & Approval				
Service Manager completing review & approval Job Title:		Pat Keeley		
		Assistant Director of Operations		

12. Appendix

Appendix 1 – Reception Notice

If you are a patient, do you wish to receive a copy of any clinical letter that will be sent out from the doctor or senior nurse?

[redacted]



If so, please ask the receptionist for, or take, an orange paper token *(as shown)* and give the token to the doctor or senior nurse who will be seeing you at your consultation.

[redacted]

<u>Children as patients:</u> the parent, or person with parental responsibility, can request a copy letter; however, please advise the doctor or senior nurse of the correct name and address to which the copy can be legally sent.

[redacted]

The trust requests that you if you wish a copy of a letter every time, you must <u>repeat the request</u> with an orange token for a copy letter at <u>each</u> consultation.

[redacted]

Please note: if you wish a copy of a result from an investigation, this will be in the form of a letter from the clinician who requested the investigation, not the department that performs the investigation.

[redacted]

Further note: it will take some time for a letter to be dictated, typed, checked, signed, posted internally and then posted externally; so you will not receive a copy in the post for several working days.

Please help us by ensuring that <u>your name</u>, <u>your address</u> and <u>your date of birth are correct</u> at each visit.

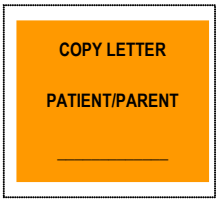
Appendix 2 – Advice to Clinicians

The system described applies to **all** clinicians who dictate clinical letters, that is, doctors (consultants, associate specialists, staff grades, foundation year doctors, speciality trainees and registrars, clinical fellows etc), nurses (in autonomous or delegated clinical practice) and Therapists (in autonomous or delegated clinical practice). Patients have a right to request copies of clinical letters.

System in general

1. Patients will be advised by notice at clinical reception areas that they can request a copy letter.

2. Patients who wish to avail themselves of this service must take an orange paper token as shown. The patient gives this to the senior clinician doctor (or nurse) who is undertaking the consultation. This physical process serves as a gesture that can be recalled. Some clinicians already copy clinical letters to their patients, usually on a completely opted in basis. However, this can lead to confusion and unnecessary stationery and postage costs if the patient does not wish to receive every letter. Those clinicians who undertake this form of system are required to adhere to the new system which allows for choice at each consultation. A patient who wishes a copy letter every time **must** hand over a token each time.



3. On receipt of the token the clinician must stick the token in the case record at the consultation entry date mark. (The token serves as a reminder that a copy letter must be sent and also provides an audit trail should there be a complaint of non-receipt of the copy letter).

4. The consultation proceeds as usual.

5. A clinical letter is dictated either a) in front of the patient; b) after the patient has left the consultation; or c) at the end of the clinic. In any of these circumstances the token will serve as a reminder to dictate a copy letter and this fact must be annotated on the dictation.

6. On completion of the letter at the secretarial office, the clinician or the secretary, or whoever is signing the letter, **should sign and date the token if they wish** (establishing a record of copy and posting). A case record return-to-circulation should not be delayed.

Specific circumstances & qualifications:

a) **Children:** the copy letter is best addressed to the parent or person with parental responsibility rather than the child, unless the child and/or parent or person with parental responsibility specifically requests the copy letter is addressed to the child.

b) **Children who then become adults:** the child is then the patient, unless they lack capacity and have a carer, and so the letter is best addressed to the patient, unless it is determined differently.

Investigation results: it is the duty of the **requesting clinician** to send a copy letter, and not that of the department that performs the investigation. Unqualified investigation results

must **not** be sent to the patient, a letter is the appropriate form of communication.

c) **Non-outpatient consultations/situations:** there will be occasions when a clinician-to-clinician letter arises outside the usual outpatient consultation. For example, an anaesthetist may uncover a significant fact of future relevance and dictate a clinical letter. The patient should be afforded the same right to see a copy of this letter. This can also apply in the Emergency Department.

d) **Data Protection Act 2018:** this act applies at all times.