

COPYING LETTERS TO PATIENTS PROCEDURE

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| Copyright | 2018 |
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| The Trust monitors the implementation of and compliance with this procedure in the following ways | |
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| Services | Applicable | Comments |
|-------------------------------------|-------------------|-----------------|
| Trustwide Essex MH and LD CHS | ✓ | |

**The Director responsible for monitoring and reviewing this procedure is
Executive Medical Director**

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PROCEDURE FOR COPYING LETTERS TO PATIENTS

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Assurance Risk Statement

This procedure sets out clear guidelines for the implementation of Copying Letters to Patients within all Trust Services.

This procedure will ensure that all healthcare professionals are aware of the broad legal and ethical issues related to copying letters to patients and will ensure that risks (legal or otherwise) associated with the policy are minimised.

1.0 INTRODUCTION

1.1 This document details the procedure to be followed to allow service users to be copied into correspondence to which the associated policy (CPG XX) applies.

2.0 WHAT LETTERS SHOULD BE COPIED?

2.1 A 'letter' includes communication between different health professionals, for instance those from and to GPs, hospital doctors, nurses, therapists and other healthcare professionals. Types of letter include referral letters (including hand written copies), letters from clinicians to other agencies (like social services or housing, employers or insurance companies). In some cases clinicians prefer to write to the service user and copy the letter to the other professional, and that remains an option here. It is for the service user and the relevant clinician to agree between themselves how the policy will apply to their relationship. The agreement will then be valid for all future interactions with clinicians from that service until a review of the service user's wishes takes place.

2.2 Department of Health Good Practice Guidelines 2002 say that "Raw' data, such as single test results, should not normally be sent directly to patients. Such data could include, for instance, an x-ray and its accompanying report, or the results of blood tests taken as part of a wider investigation of symptoms. In due course, the outcome of such tests should be included in a letter that is copied to the patient. Where no such letter is needed (for instance where a general practitioner has commissioned a range of tests), some other means of communicating the results to patients will be necessary."

3.0 DISCUSSION WITH SERVICE USER

3.1 At the first consultation, or as soon as practicable after that, the relevant clinicians will discuss with that service user about whether they want to receive copies of correspondence from that service. The default decision is that letters are copied to the patient- however the patient has the choice not to receive them. Whilst the Trust believes there are advantages to receiving

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copies of letters, the Trust recognises that it is a personal choice and that some people will not want to receive copies of letters and that choice must be respected.

- 3.2 A consent form is attached as Appendix 1, which provides prompts for the clinician and the opportunity for the service user to say if they do not want to receive copies and how they want to receive them. They can also indicate whether someone else, like a carer, can receive copies.
- 3.3 Service users should be told about the Trust's policies of 'no surprises' and what the advantages of sharing letters are. The clinician should also explain under what circumstances letters might be withheld in the judgement of the clinician.
- 3.4 The consent form and wishes should be kept in the patient's record and periodically reviewed by the doctor with the service user or at the request of the service user.
- 3.5 The relevant doctor's medical secretary and/or team administrator shall be responsible for retaining the signed forms from service users on their records. The Medical Secretary shall send a copy of the form to the Head of the Trust's Appointments Office (who shall record on the patient's electronic record, in the comments box, that a valid instruction and consent form is in existence for that patient. An electronic version of that form shall be included in the electronic record).
- 3.6 The Medical Secretary/team administrator (TA) shall be responsible for keeping a record of what letters are copied to the patient (or whoever, as contained in the signed consent form). This information shall be audited by the Trust's Clinical Audit Department once a year. If a Medical Secretary/TA is in any doubt about what should be copied the Doctor shall make a decision with reasons recorded in the patients' notes. (See sections 6 and 7).
- 3.7 The Medical Secretary or administrator shall also send a copy of the signed form to the service user (complying with any instructions contained within it). Service users should be reminded that if they wish to amend the form they must do so in writing to their doctor.

4.0 NO SURPRISES

- 4.1 Department of Health Guidelines state, "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. As a general rule the contents of 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."

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5.0 CAPACITY

- 5.1 It is for the clinician to judge whether the service user has capacity, though there may be a pre-existing Advance Decision where the request is recorded, which the clinician must take account of (see CLP 6 Advance Directives)
- 5.2 It is good practice to involve carers where the patient does not have capacity but it is for the clinician to decide whether to copy carers into letters. Some carers' and family rights are governed by statute law, for example when dealing with children (covered by the Children Act, 1989).
- 5.3 For patients under the care of CAMHS, permission should be sought from the legal guardian if the patient is under 16 and considered not Gillick competent.
- 5.4 If there is any doubt you should seek legal advice from the Trust's legal adviser.

6.0 WITHHOLDING LETTERS

Letters can be withheld if:

- The patient doesn't want to receive them
- In the opinion of the clinician, there is a serious risk of the information causing harm to that person or others
- The letter contains confidential information about a third party where the third party has not given consent. Consent should be sought where this is so.
- Decisions clinicians make should be recorded in the notes with an explanation given.

7.0 PLAIN ENGLISH

- 7.1 Letters should be written clearly in plain English (with translations if required), although they may contain medical technical expressions. If the service user should have difficulties understanding parts of the letter, they should be advised to request either the person who wrote the letter (e.g. the psychiatrist) or the person to whom the letter was addressed (e.g. the GP) to provide clarification.
- 7.2 Copies to patients should be accompanied by a covering letter, advising them to request the sender or the recipient of the letter to provide clarification, should they have difficulty understanding any of its contents.
- 7.3 The clinician needs to be sensitive to the needs of the patients and should make arrangements for letters to be sent in the appropriate form (e.g. large print, assisted communication for people with a learning difficulty). It may also be necessary to have letters translated into appropriate languages, in which case the Trust's Interpretation and Translation service should be used.

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8.0 MECHANICS

- 8.1 It is the responsibility of the relevant clinician to make arrangements for letters to be copied as directed by the patient with a note kept on file of what was sent and to whom. (See also Section 3, para 3.5 and 3.6)

9.0 FURTHER GUIDANCE

This policy shall be read in conjunction with Trust policies

- CP9 - Record Management
- CP2 - Complaints Policy
- CLP6 - Advance Directives
- CG16 – Consent

END