

**Copying Correspondence to  
Patients/Service Users Policy**

This Policy provides guidance on engaging patients/service users in their healthcare by receiving copies of correspondence between professionals involved in their care.

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Type of Policy	Clinical ✓	Non Clinical
Which Relevant CQC Fundamental Standards?	<ul style="list-style-type: none"> <li>• Care and treatment must be appropriate and reflect service users' needs and preferences.</li> <li>• Service users must be treated with dignity and respect.</li> <li>• Care and treatment must only be provided with consent.</li> </ul>	

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## Version Control and Summary of Changes

Version number	Date	Comments (description change and amendments)
2.0	August 2012	Harmonisation of policies as a result of the TCS process
2.1	August 2015	Review of Policy
3.0	May 2016	Amendments following comments and to reflect learning from serious incident

### For further information contact:

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### Equality Statement

Leicestershire Partnership NHS Trust (LPT) aims to design and implement policy documents that meet the diverse needs of our service, population and workforce, ensuring that none are placed at a disadvantage over others.

It takes into account the provisions of the Equality Act 2010 and promotes equal opportunities for all.

This document has been assessed to ensure that no one receives less favourable treatment on the protected characteristics of their age, disability, sex (gender), gender reassignment, sexual orientation, marriage and civil partnership, race, religion or belief, pregnancy and maternity.

In carrying out its functions, LPT must have due regard to the different needs of different protected equality groups in their area.

This applies to all the activities for which LPT is responsible, including policy development and review.

### Due Regard

This policy has been screened in relation to paying due regard to the general duty of the Equality Act 2012 to eliminate unlawful discrimination, harassment, victimisation; advance equality of opportunity and foster good relations.

This is evidenced by the references and consideration given throughout the policy to how patients/service users should be actively engaged in their care and treatment, and the alternative communication methods that should be employed to take account of those with different needs from across all protected characteristics.

There is no likely adverse impact on staff or patient/service users from this policy as clear guidance is provided on the considerations for all patients/service users in how they can be engaged in receiving copy letters.

## Definitions that apply to this Policy

<b>Access</b>	The availability of or permission to consult records.
<b>Correspondence</b>	Communication by letter.
<b>Due Regard</b>	<p>Having due regard for advancing equality involves:</p> <ul style="list-style-type: none"> <li>• Removing or minimising disadvantages suffered by people due to their protected characteristics.</li> <li>• Taking steps to meet the needs of people from protected groups where these are different from the needs of other people.</li> <li>• Encouraging people from protected groups to participate in public life or in other activities where their participation is disproportionately low.</li> </ul>
<b>Health Professional</b>	Individual accredited by a professional body upon completing a course of study, and usually licensed by a government agency, to practice a health related profession such as dentistry, medicine, nursing, occupational health, physical therapy.
<b>Letters</b>	Written or printed communication addressed to a person and transmitted by mail.
<b>Patient</b>	A person who is receiving medical care, or who is cared for by a particular doctor or dentist.
<b>Service User</b>	People who receive care and/or treatment through services provided by the organisation.

## **1.0. Purpose of the Policy**

Since April 2004, it has been Government policy in England that clinicians should send copies of their clinical letters to their patients (Department of Health, 2003b). This policy has been written to provide guidance to clinicians working within Leicestershire Partnership NHS Trust (LPT) on how to ensure that they meet the requirements of the NHS Plan 2000 and the commitment that patients/service users receive copies of clinicians' letters about them as of right.

All letters/assessments/reports written by professionals within the Trust to other professionals within or outside the Trust should be copied to the person to whom they refer. Where the people who use services are not legally responsible for their own care (for instance a young child, or a child in care), letters should be copied to the person with legal responsibility, for instance a parent or guardian.

The copying of letters should not be a substitute for good verbal communication.

This policy does not relate to Enhanced Care Plans and Risk Assessments. The policy relating to these is covered in Leicestershire Partnership Trust's Care Programme Approach Policy and Practice. This indicates that, where possible, these should be shared with the service user to whom they refer.

## **2.0. Summary and Key Points**

This policy summarises the Department of Health (DH) best practice guidelines for implementation within the Trust. Clinical letters written by healthcare professionals of all disciplines to other clinicians, either within the Trust or to others outside of the Trust, should be copied to the patient to whom they refer.

- 2.1 The clinician in charge of the care of the patient/service user must make a record in the patient/service user's notes that they have asked the patient/service user whether they wish to have a copy of the clinical correspondence and the patient/service user's response. This can be recorded within the electronic patient record (SystemOne, RiO or Tiara) or the patient/service user can be asked to complete a form such as the example at Appendix 1. If a form is used, it must be saved to or placed in the patient/service user's clinical record.
- 2.2 The patient/service user's decision must be kept under review and the clinician must update the patient/service user's record to note the discussion regarding the copying of letters.
- 2.3 Each Service Group may set a standard for the review of the decision with the patient/service user. This policy recommends that this is done as part of the Care Programme Approach (CPA) review or if the patient/service user is not under or subject to CPA, then at least annually.
- 2.4 The clinician writing the letter is responsible for ensuring a copy is made available to the patient/service user. All recipients of the letter should be listed on

the letter. The Trust's copy of the letter will be saved in the patient/service users health record in accordance with the Trust policy on managing health records.

### **3.0. Introduction**

The NHS Plan 2000 made a commitment that patient/service users should be able to receive copies of clinician's letters about them as of right. A working group convened by the DH in 2001 set out the background to the initiative in a report in February 2002. The DH subsequently issued Good Practice Guidelines in April 2003. The principal aim of the DH policy was (and is) to improve communications between healthcare professionals and patient/service users and to increase patient/service user involvement in their care and treatment.

The provision of information to patient/service users to support their decision making in their care is a standard set by the NHS Litigation Authority (Risk Management Standards 2013/14, standard 6.2). Trusts are no longer assessed against these standards but they remain available to use to promote best practice.

This Policy relates to letters/assessments/reports.

#### **3.1 What constitutes a letter?**

A 'letter' for the purposes of this policy includes communication between professionals and other agencies. The following are examples of different types of 'letter'. This is not exhaustive:

- Letters of referral forms (including hand written referral forms) to other services;
- Letters from professionals to other professionals in the Trust;
- Letters from professionals to other agencies (e.g. social services, housing associations, employers etc.);
- Reports, if replacing a letters;
- Assessments, if replacing a letter.

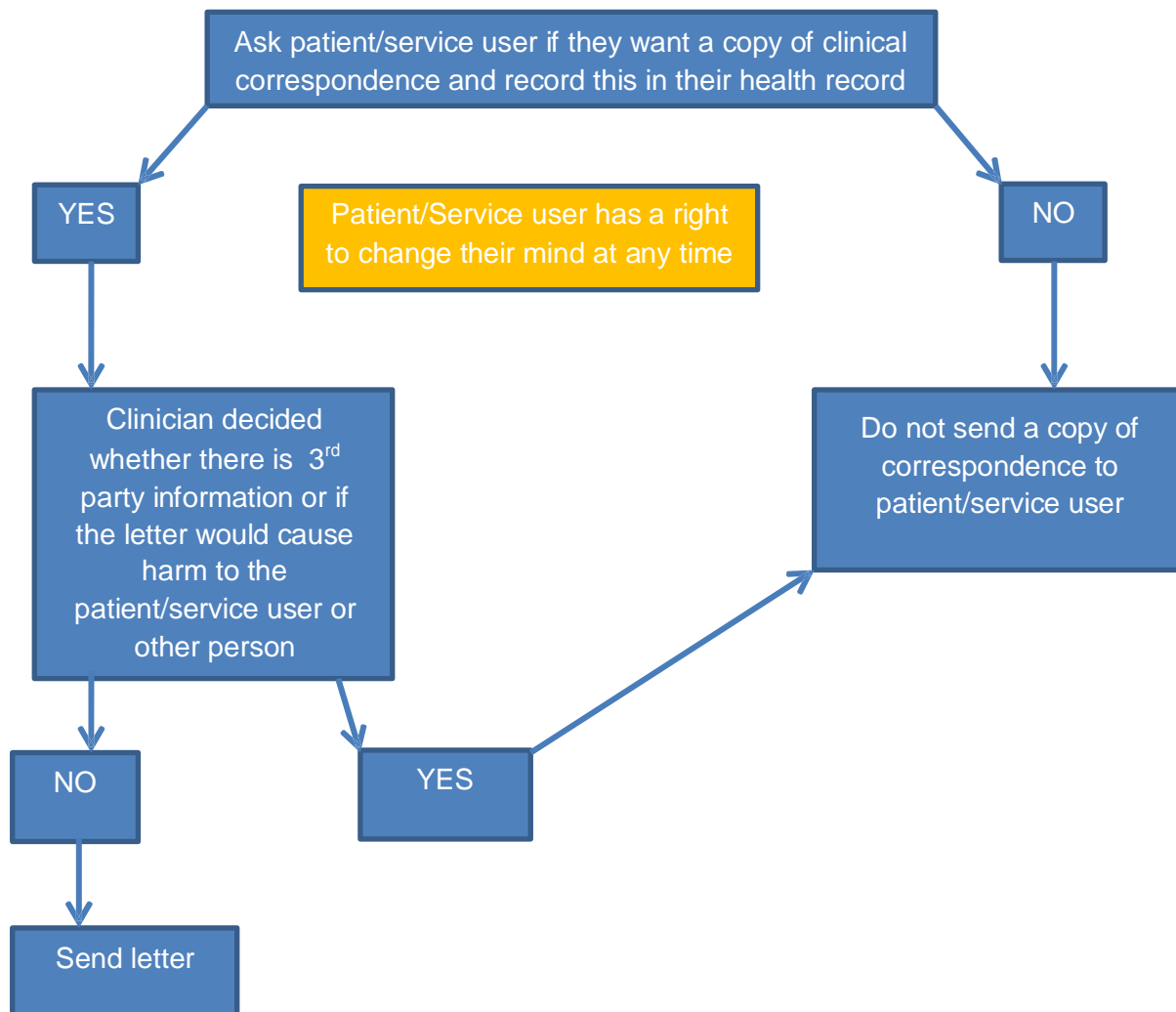
The DH guidance relates particularly to letters, but the principles of sharing information can be applied to any documentation that refers to the patient/service user. Care plans and discharge summaries are documents that should be copied to the patient/service user, provided exemptions outlined below do not apply.

The guidance does not relate to the copying of 'raw data' such as test results or reports. 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/service user.

Since the DH issued guidelines in 2003 the method of communicating has changed considerably and correspondence is now frequently sent by secure email. Most letters will be sent electronically, as an attachment to an email between healthcare professionals. This is still a letter and a copy should be provided to the

patient/service user via the appropriate means.

#### 4.0 Flowchart/process chart



#### 5.0 Duties within the Organisation

5.1 The Trust Board has a legal responsibility for Trust policies and for ensuring that they are carried out effectively.

5.2 The Medical Director is responsible for the strategic implementation of this policy

5.3 Service Group Directors and Heads of Service are responsible for ensuring that the Service Groups are implementing the policy within their service areas

5.4 Managers and Team leaders are responsible for:

- Ensuring that the staff for whom they are responsible are aware and adhere to this policy
- Supporting standard operating procedures (SoPs) for the management of

clinical correspondence are in place and adhered to

- Reporting any incidents where by clinical correspondence does not meet the quality expected, is sent to the incorrect patient/service user or address, and ensures that processes are in place to manage this

## 5.5 Responsibility of Staff

- Healthcare and medical professionals:

- Clearly identify in the patient/service user record, their decision around receiving clinical correspondence
- Follow their local SoP for managing clinical correspondence
- Quality assure the content of any clinical correspondence including inclusion of third party information and any additional recipients to the correspondence are clearly identified

- Administrators/ Medical Secretaries:

- Follow their local SoP for managing clinical correspondence
- Ensure patient/service user contact details are accurate and up to date on the patient/service user record and that this is reflected in the clinical correspondence

## 6.0 Systems and recording

**6.1 Where recorded:** In almost all cases, the discussion with the patient/service user and his/her response to having copies of letters will be recorded on their electronic patient record i.e. SystemOne, RiO or Tiara. If this is not possible or the service is not currently using electronic patient records, clinicians should use the paper health record.

**6.2 Recorded by who:** Usually, the clinician in overall charge of the care of the patient/service user will complete the record. For detained patient/service users, this will be the Responsible Clinician; however, other clinicians can make entries in the record when relevant

**6.3 When recorded:** The patient/service user should be asked about receiving copy letters as early as possible in their care and treatment episode (or pathway) within the Trust. Their reply should be kept under review by the clinician in charge of treatment.



## **7.0 The principles of copying letters to patient/service users**

### **7.1 Improving communications**

As a general rule and where patient/service users agree, letters written by one health professional to another about a patient/service user should be copied to the patient/service user or, where appropriate, parent or legal guardian. This applies to all patient/service users, voluntary or detained. The underlying principle is that all letters that help to improve a patient/service user's understanding of their health and the care they are receiving should be copied to them as of right. Where a patient/service user is not legally responsible for their own care (for instance in the case of a young child, or a child in care), letters should be copied to the person with legal responsibility, for instance a parent or legal guardian. When letters are copied to person other than the patient/service user, the Mental Health Act (MHA) Code of Practice provides guidance on confidentiality (Chapters 2 and 18).

### **7.2 No Surprises:**

Where the letter contains abnormal results or significant information that has not been discussed with the patient/service user, it will be important for arrangements to be made to give the patient/service user a copy of the letter after its content have been discussed in a consultation with the receiving professional. As a general rule the contents of the copy letters should reflect the discussion in the consultation between the patient/service user and the healthcare professional and there should no new information in the letter that might surprise or distress them.

### **7.3 Writing directly to patient/service users:**

In many cases, healthcare professionals (or services, such as screening services) write directly to patient/service users or parents of patient/service users, copying the letter to the GP or others as necessary. The DH guidelines endorse this practice.

## **8.0 Circumstances when copying letters is not appropriate**

8.1 There may be reasons why the general rule of copying letters to patient/service users should not be followed. These include:

- Where the patient/service user has expressed the wish not to receive a copy. A reason does not have to be given
- Where permitting access to information contained in the letter would be likely to cause serious harm to the physical or mental health condition of the person to whom the letter relates or any other person (including a health professional)

Where information in the letter relates to a third person unless that person has consented to the disclosure or could be fully anonymised. Another health professional is not deemed to be a third party (refer to the Trust Data Protection, Caldicott and Confidentiality Policy for more detail on this exemption)

- Where there are specific security considerations particularly in secure settings
- Where a case is particularly sensitive, for example, child protection, it may not be appropriate to copy the letter. A child protection matter may have been reported and is under investigation. The best interests of the child must come first
- Giving of 'bad news' is not in itself enough to justify not copying a letter. When the DH introduced this initiative, pilot studies showed that sometimes the case that health professionals are anxious to protect patient/service users, who themselves often wish to have as much information as possible, even if it may be 'bad news' or uncertainty.

However, as noted in the section above, a health professional may make a decision not to disclose a letter or report applying the 'serious harm' test. This will be a matter of clinical judgement. The provision to withhold information has a statutory basis in the Data Protection (Subject Access Modification) (Health) Order 2000. If a letter is withheld, the reason must be recorded in the patient/service user health records.

### **9.0 Consent to receipt of letters: identifying appropriate recipients**

In line with the overall NHS policy of informed consent, it is for each patient/service user to decide whether they wish to receive copies of letters written about them by health professionals, as an Opt-In mechanism. The copying letters policy is underpinned by a presumption of the patient/service users' informed consent to the receipt of any letter. The aim is that within a consultation, the possibility of receipt of the letter should be raised as part of the wider discussion about 'what will happen next'. In other words, patient/service users should routinely be asked during a consultation and any related tests or interventions, and there should be a clear process for recording their views, similar to that for recording their consent to treatment.

If there are any doubts about the patient/service user's mental capacity to make a decision about receiving copies of letters, an assessment of their capacity can be undertaken by the treating clinician and recorded in the patient/service users clinical records.

9.1 To raise awareness of patient/service user rights, posters should be put up in reception areas informing them that they may have a copy of any letter written about them from one health professional to another (Appendix 2). In addition, the

'Copying Clinical letters to Patients/Service Users' leaflet should be made available by teams (Appendix 3)

### 9.2 Handling records:

The circumstances of letters about an individual patient will vary. It might be sufficient to seek consent once rather than each time a letter is written as long as it is explained at the start of the treatment that copies of letters will be sent routinely to the patient/service user or responsible person unless the patient decides to opt out of receiving copies of letters, which can be done at any time. Good practice suggests, however, that the patient be reminded each time a letter is to be copied.

Where a letter is to be written at the request of an outside agency, other factors apply in addition to the question of whether the letter should be copied to the patient/service user. Organisations and practices must be sure that relevant legislation on data protection (and writing letters to insurance companies) is complied with.

There may be occasions when one healthcare professional wishes to comment on the clinical care provided by another and offer advice on the care of future patients/service users with a particular condition or symptoms. It may not be appropriate for such information to be copied to the patient/service user, but it is important for continuing professional development and clinical governance that such an opportunity for professional development is not lost. The professional concerned should write a separate letter that is not copied to the patient/service user, and minimal patient information used in such circumstances

### 9.3 Carers:

Some adults have carers, family members or others who are actively involved in their care. Frequently patients/service users want information shared with their carers and/or family members. With patient/service user consent, copies of letters can be sent to these persons. Copies of letters to carers may be particularly important where medication is changed following discharge from hospital. Again, in the absence of a clear legal framework for deciding what to do, health professionals will often have to exercise judgement in deciding whether it is in the patient/service user's best interests to share information with a carer. If the person is a young carer, any information must be appropriate to age and understanding of the young person. Best interest decisions made by clinicians on behalf of patients/service users who lack capacity to make a decision on the involvement of a carer must be fully recorded in the patient/service user's record.

Sometimes the patient/service user will not want a letter copied or shown to the carer. Both the patient/service user and the carer have the right to expect that information provided to the service will not be shared with other people without

their consent. In such circumstances, unless there is an over-riding reason to breach confidentiality, the wishes of the patient/service user must be respected. The DH expects that carers of people with mental illness should be provided with as much information as possible to enable them to carry out their caring role as effectively as possible without breaking the patient/service user's confidentiality.

#### 9.4 Children and young people:

It is expected that young people aged 16 and 17 will be offered copies of letters. It is up to healthcare professionals to assess the competence of younger children to understand and make a decision (referred to as Gillick competence). It is good practice to offer adolescents consultations alone so that they have the opportunity to speak freely and give information that they may be unwilling to talk about in front of their parents. In such cases, young people may prefer to collect in person copies of letters giving personal information rather than having them sent to their home.

The issue may arise as to whether a letter should be copied to the young person or their parents. Some initiatives in copying letters have been developed in children's services, and the general reported experience is that there are few difficulties, as long as the issue is discussed with the family. Often adolescents appreciate the letter being sent to them. Where parents are separated, it is important to discuss who should receive the copies of letters.

## 10.0 How is it to be done?

### 10.1 Frequency of copies

Where there is frequent communication, the person responsible for writing the letter should consider if it would be useful for the patient/service user to have a copy every time. The decision should be based on a discussion with the patient/service user about whether receiving a copy will improve communication with them and assist them to understand their own healthcare and treatment.

### 10.2 Where there is no safe address to receive mail

Patients/service users who do not have a safe postal address should be able to collect letters

### 10.3 Writing style and standard letters

Letters between healthcare professionals are 'personal data' forming part of the patients/service user's record therefore it is important that they:

- Are adequate for their purpose and accurate
- Are written clearly

- Avoid unnecessary complex language and subjective statements
- Avoid extraneous information
- Use plain English to improve readability
- Avoid giving offence unintentionally or generating misunderstandings
- Avoid (where possible) unnecessary technical terminology and acronyms
- Set out the facts and avoid unnecessary speculation
- Confirm information given in discussion with the patient in the consultation in a language that the recipient can read and understand

A balance is required between simplification for the patients/service user's understanding and what is needed for the primary purpose of a letter between healthcare professionals discussing symptoms, test results and possible diagnoses or treatment. Clinical accuracy and ensuring the professional receiving the letter has all the information he/she needs is the main purpose of the letter. It is important not to compromise this in order to make the letter easier to understand.

Some healthcare professionals prefer to write letters directly to patients/service users, with a copy to the GP or other healthcare professional. Evidence shows that patients/service users appreciate such practices, which give the clinician the option of adding additional information and advice about lifestyle and management of the illness or condition.

#### 10.4 How copies are provided

Options for providing copies of letters include:

- A printed copy of the letter. Envelopes should be marked 'Private and Confidential' and should not be stamped with a hospital/Trust logo or address
- Copies in large print, or in some other format, such as audio tape
- Viewing letters on screen in the hospital with the aid of a healthcare professional
- Sending by post, or collection from an appropriate place, where there are concerns about privacy at home
- Copies of letter dictated in the presence of the patient/service user

As improved information systems evolve, it should become easier to generate an extra copy of a letter for a patient/service user. When patients/service users are able to access their records through safe internet sites, paper copies of letters may not be required.

#### 10.5 People with information and communication support needs

In line with the Accessible Information Standard (July 2015), patients/service users and their carers should be able to receive copies of letters in a form they can understand and use. The Trust must comply with the Equality Act 2010, the Data Protection Act 1998 and the Human Rights Act 2000.

Some people cannot read well enough to understand a copied letter. Such people are often reluctant to admit the problem, and it may fall to them to seek someone to help them to read the letter.

Consideration should be given to the needs of people with all types of information and communication needs, including learning disabilities. Identifying their needs is key to ensuring that we are able to support their right to receive clinical correspondence.

#### 10.6 Correcting inaccurate records

Healthcare professionals who routinely share records with patients/service users report that patients/service users and carers often identify inaccuracies or mistakes. There should be arrangements to amend/annotate their records to ensure they are correct. Whilst it may initially be time-consuming, the result should be improved and more accurate records that comply with the provisions of the DPA 1998 and benefit the overall quality of the service<sup>1</sup>.

A data subject (the patient/service user) has a right to have inaccuracies corrected and also to have opinions revised if based on inaccurate information. In every case where the accuracy of data is challenged by the data subject the matter must be fully and promptly investigated. A challenge to the accuracy of data should normally be made in writing; however if the challenge is made by the data subject in person and their identity is not in doubt, the challenge can be dealt with.

All reasonable steps should be taken to resolve the issue and the data subject must be informed of any corrections made. Where it is not possible to resolve the matter or the requested change is clearly incorrect the record should be annotated and the data subject advised accordingly. It may be appropriate to agree with the data subject that their alternative account is filed alongside the original that they wish to object to.

In all cases where a correction cannot be made, or the data subject is dissatisfied with the outcome, the Trust's Head of Information Governance must be informed.

If the data subject is not satisfied with the outcome they should be referred in the first instance to the Trust's complaints procedure. If the matter cannot be resolved they have the right to apply to a court for correction.

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<sup>1</sup> The Data Protection Act defines information as inaccurate either if it is inaccurate or misleading or if an opinion is based upon inaccurate information

## 10.7 Protecting confidentiality

In reviewing their security and confidentiality procedures, health professionals copying letters should assess and take steps to minimise the following risks:

- Breaches of confidentiality of information of third parties
- Breaches of confidentiality of the patients/service users own information where communications are misdirected or read by someone other than the patient or his or her authorised agent
- Breaches of confidentiality of letters kept insecurely

Procedures must be in place to minimise the likelihood of information being accessed by unauthorised people and ensure patients/service users who choose to have information posted are aware of the risks. Envelopes must be marked 'Private and confidential' and the patients/service user's address routinely checked. Patients/Service user's full names, rather than initials, should be used as a matter of good practice. It is also good practice to check whether two people with the same name live at one address.

There must be clarity about who is responsible for checking and recording:

- The patient/service user's address and full name for addressing a letter
- The patient/service user's preference on the method of communication and format.

The above should be included in a local standard operating procedure.

## 11.0 Training needs

There is no training requirement identified within this policy. The principles of information governance, data sharing and patient confidentiality are part of the Trust Information Governance Training which is mandatory for all Trust staff.

## 12.0 Dissemination

Copies of this policy will be made available to all staff and patient/service user through the Trust websites

All staff will be notified of the reviewed Policy via eSource and the weekly Newsletter.

This document will be included in the LPT Publication Scheme in compliance with the Freedom of Information Act 2000.

## 13.0 Monitoring Compliance and Effectiveness

Ref	Minimum Requirements	Evidence for Self-assessment	Process for Monitoring	Responsible Individual / Group	Frequency of monitoring
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<b>Ref</b>	<b>Minimum Requirements</b>	<b>Evidence for Self-assessment</b>	<b>Process for Monitoring</b>	<b>Responsible Individual / Group</b>	<b>Frequency of monitoring</b>
	Consent for receiving copy letters is obtained at the point of consultation	Section 9	Included in the record keeping audit	RIGG/Service Group IG Group	Annually
	Consent is record in the patient/service users health record	Section 6	Included in the record keeping audit	RIGG/Service Group IG Group	Annually
	Information and communication support needs identified in order to provide information in the appropriate medium	10.4	Included in the record keeping audit	RIGG/Service Group IG Group	Annually
	Responsibility for recording and checking patient/service user details is clear	10.6	Reduction in incidents of misdirection/ unauthorised disclosure	RIGG	Quarterly trend review
	Style and format	Document	Quality Assurance Committee	RIGG	Two yearly
	An explanation of any terms used	Definitions that apply to this policy	Quality Assurance Committee	RIGG	Two yearly
	Consultation process	Appendix 5	Quality Assurance Committee	RIGG	Two yearly
	Adoption process		Corporate Affairs Administrator holds database of all policies	QAC	In line with Risk Management Strategy & Procedural Document review
	Review arrangements		QAC policies	RIGG	Two yearly



Ref	Minimum Requirements	Evidence for Self-assessment	Process for Monitoring	Responsible Individual / Group	Frequency of monitoring
	Control, including archiving arrangements		Trust secretary	RIGG	Two yearly

#### 14.0. Standards/Performance Indicators

TARGET/STANDARDS	KEY PERFORMANCE INDICATOR
<ul style="list-style-type: none"> <li>• Care and treatment must be appropriate and reflect service users' needs and preferences.</li> <li>• Service users must be treated with dignity and respect.</li> <li>• Care and treatment must only be provided with consent.</li> </ul>	<ul style="list-style-type: none"> <li>• Documented procedures are in place for ensuring patient/service users are given the opportunity to receive copy letters</li> <li>• Consent is captured at the point of contact and documented in the health records</li> </ul>
Compliance with the Accessible Information Standard	Patients/Service Users and Parent/Carers information and communication support needs are identified at the point of contact, recorded and shared with those professionals supporting their care and treatment

#### 15.0 Review

This Policy will be reviewed every 3 years by the Trust Records and Information Governance Group or as and when significant changes to national policy make earlier review necessary.

#### 16.0 References and Bibliography

The policy was drafted with reference to the following:

- The NHS Plan, Department of Health 2000
- Copying Letters to Patients, A Report to the Department of Health and draft good practice guidelines for consultation: A report of the Working Group on Copying Letters to Patients <https://www.ucl.ac.uk/dclinpsy/training-handbook/chapters/handbook-pdf/appendix8>
- Good Psychiatric Practice: Confidentiality and Information Sharing, Royal College of Psychiatrists 2006
- NHS Litigation Authority, Risk Management Standards, 2013/14
- Data Protection Act 1998
- Equality Act 2010
- Mental Health Act 1983 (as amended by the Mental Health Act 2007)
- Mental Health Act Code of Practice, 2008, Chapters 2 and 18

Supporting documents (Trust documents)

- Consent to Examination or Treatment Policy
- Data Protection, Caldicott and Confidentiality Policy
- Deprivation of Liberty Policy
- Mental Capacity Act Policy
- Care Programme Approach Policy
- Information Lifecycle and Records Management Policy

## WOULD YOU LIKE COPIES OF THE LETTERS THAT GO TO YOUR DOCTOR?

Whenever you attend a hospital your doctor receives a letter from the doctor or healthcare professional in charge of your care, or who saw you in clinic, telling him/her about your diagnosis and what treatment is necessary.

Up to now, you have not always had the opportunity to have these shared with you, but from now on this will change and patient can choose to receive a copy of the letter sent to their doctor.



Our Leaflet, '**Copying Clinical Letters to Patients**' gives more detailed information and includes a short form to fill in if you want to arrange to receive copies of your letters

## Copying Clinical Letters to Patients/Service Users

### Introduction

In response to Government guidelines, this Trust is giving patients/service users the option to receive copies of letters sent to their doctor after an outpatient appointment or inpatient admission.

The patient/service user is the only person who can ask for a copy of the letter. In the case of children up to the age of 16, parents and guardians can ask for a copy letter.

This leaflet will explain the arrangements in more detail, help you decide if you want to receive a copy letter and will tell you what you have to do to make this happen.

### What kind of letters will I receive?

Whenever you attend hospital your general practitioner (GP) receives a letter from the doctor or healthcare professional in charge of your care, or the person who saw you in clinic, telling him/her about your diagnosis and what treatment is necessary. Up to now these letters have not always been shared with patients/service user. From now on this will change and patients/service user can choose to receive a copy of the letter sent to their GP about their attendance at hospital.

It is important to remember that the purpose of the letter is to give your GP medical information about your illness, care and treatment. There are many other important and valuable sources of patient/service information for you to use to find out more about condition.

### How can this help me?

These are just some of the benefits:

- Seeing a copy of the letter could help build up trust between you and the staff caring for you
- You and your carers may have a better understanding of your condition and how you can help yourself
- You will be more informed and more able to make decisions about your illness and treatments
- When you receive copies of letters you can identify any information which is wrong, especially names, addresses, and dates of birth and help us put it right
- You will be better prepared for your treatment which may help you to be less worried or anxious
- Letters may help you to remember advice on self-care and life-style which you have been given at hospital.

### **Are there any reasons why I would not receive clinical letters?**

There are some reasons why it might not be helpful for you to be given a copy of your letter, for instance if:

- The doctor or healthcare professional in charge of your care may feel that the information in the letter would be harmful to you.
- The letter includes information about someone else who has not given their permission to their details being provided.
- You choose not to receive a copy letter

If you have asked for a copy letter and are not to receive one, the reason for this will be explained to you by the doctor or healthcare professional in charge of your care.

### **Why would I choose not to receive the letters?**

Some possible reasons include:

- You believe you have all the information you need.
- You have problems maintaining privacy at home or do not want other family members to know about your illness or attendance
- You do not want written details of what you have been told
- You feel uncomfortable asking for a copy of the letter.

### **What if I need the information in a different format?**

You can use the form at the end of this leaflet to tell us how you would like the letter to be provided, for instance on an audio tape, in Braille or translated into another language.

### **Can I have the letter sent to a different address or to someone who is caring for me?**

Yes, let us know the details of this when you attend and we will arrange for the letter to go to another address or to a carer acting for you.

### **Will I need to ask for a copy each time I come to hospital?**

No, but you will need to tell us if you decide that you want to stop receiving copies of your letters. You should do this by telling staff at your next visit.

### **What happens if there is something I don't understand in the letter?**

You should ask your GP when you next see him/her about your condition or ask the hospital doctor or healthcare professional in charge of your care at your next attendance.

### **Which letter will you send?**

We will only send the letter written after your last attendance and those written after future attendances until you tell us to stop.

### **What do I do if I want more information from my health/medical records**

If you want to receive more information in relation to your care and treatment and would like to have detailed information from your health/medical record, then you will need to apply for 'Access to Records'. There is usually a charge for this and you will need to write to:

Information Requests Officer  
Information Request Team  
Suite P1  
Bridge Park Plaza  
Bridge Park Road  
Thurmaston  
LE4 8BL

### **How will I get a copy of the letter?**

This will be sent to you, by second class post, at the same time that this is sent to your GP. This could take up to three weeks.

### **What happens next?**

**If you want to receive a copy of your letter**, fill in the form at the end of the leaflet and hand it to the clinic or ward staff.

If you do not fill in a form or we are unable to read the details provided we will not be able to send a copy letter to you.

**If you require a special edition of this leaflet, please contact Customer Services on:**

**0116 295 0830 or 0831**

### Appendix 3

**Name**

Address details

**Department Name**

Address line 1

Address line 2

Town

Postcode

Tel: xxxx

Fax: xxxx

www.leicspart.nhs.uk

Date

Dear

You are entitled to request a copy of a letter written about you by a health professional employed by Leicestershire Partnership NHS Trust. This may help you to have a better understanding of your healthcare needs and treatment plan. If you would like to receive copies of letters please complete the details below:

	CARE PLAN	CORRESPONDENCE
I would like to receive copies	Yes/No	Yes/No
I would like to have this posted to me	Yes/No	Yes/No
I would like to be provided with copies at my next appointment	Yes/No	Yes/No
I would not like to receive my own copies but would like to read this at my next appointment	Yes/No	Yes/No
I would like my relative/carer to receive copies	Yes/No	Yes/No
*Please send documents that I have requested to the following name and address:		
Name:		
Address:		

I understand that I am responsible for the safe keeping of any care plan or correspondence that has been given to me. I understand that I must inform my health team in writing if any of the above instructions are to be changed.

If the correspondence is being sent to someone else's address, I can confirm that they have agreed to receive the information on my behalf.

**Signed:****Date:**

### The NHS Constitution

The NHS will provide a universal service for all based on clinical need, not ability to pay. The NHS will provide a comprehensive range of services

Principles that apply to this policy are:

<b>Shape its services around the needs and preferences of individual patients, their families and their carers</b>	✓
<b>Respond to different needs of different sectors of the population</b>	✓
<b>Work continuously to improve quality services and to minimise errors</b>	✓
<b>Support and value its staff</b>	
<b>Work together with others to ensure a seamless service for patients</b>	✓
<b>Help keep people healthy and work to reduce health inequalities</b>	
<b>Respect the confidentiality of individual patients and provide open access to information about services, treatment and performance</b>	✓



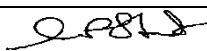
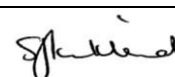
**Key individuals involved in developing the document**

<b>Name</b>	<b>Designation</b>
Jacqueline Burden	Clinical Governance Lead AMH/LD
Mary Stait	Information Governance Compliance Manager
Tracey Flannaghan	Acting Senior Cognitive Behavioural Psychotherapist
Lesley McGrain	Principal Psychotherapist
Dawn Holding	Team Manager – Assertive Outreach and Homeless Mental Health

**Circulated to the following individuals for comment**

<b>Name</b>	<b>Designation</b>
Members of Trust Records and Information Governance Group	
Member of Trust Clinical Effectiveness Group	
Members of AMH/LD Information Governance and Records Group	
Members of FYPC Information Governance and Records Group	
Members of CHS Information Governance and IM&T Group	

## Due Regard Screening Template

Section 1			
Name of activity/proposal		Copying Correspondence Policy	
Date Screening commenced		19 July 2016	
Directorate / Service carrying out the assessment		Information Governance	
Name and role of person undertaking this Due Regard (Equality Analysis)		Mary Stait Information Governance Compliance Manager	
Give an overview of the aims, objectives and purpose of the proposal:			
<b>AIMS:</b> To advise and implement best practice guidelines for clinicians.			
<b>OBJECTIVES:</b> To ensure clinicians meet the requirements of the NHS Plan 2000 and the commitment that patients/service users receive copies of clinicians' letter about them as of right.			
Section 2			
Protected Characteristic	If the proposal/s have a positive or negative impact please give brief details		
Age	None		
Disability	None		
Gender reassignment	None		
Marriage & Civil Partnership	None		
Pregnancy & Maternity	None		
Race	None		
Religion and Belief	None		
Sex	None		
Sexual Orientation	None		
Other equality groups?	None		
Section 3			
Does this activity propose major changes in terms of scale or significance for LPT? For example, is there a clear indication that, although the proposal is minor it is likely to have a major affect for people from an equality group/s? Please <u>tick</u> appropriate box below.			
Yes		No	
High risk: Complete a full EIA starting click <a href="#">here</a> to proceed to Part B		Low risk: Go to Section 4.	√
Section 4			
If this proposal is low risk please give evidence or justification for how you reached this decision:			
It ensures the patient/service user receives a copy of correspondence sent between professionals and other agencies. Most correspondence is in written form and other standards provide guidance around accessibility, e.g. Accessible Information Standards.			
Signed by reviewer/assessor		Date	19/07/16
Sign off that this proposal is low risk and does not require a full Equality Analysis			
Head of Service Signed		Date	19/07/16