The era of freedom of information sharing – help!

St Raphael's Your Local Hospice

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Background:

From 1st November 2022, patients aged 16 and over were due to have full prospective access to their medical notes via their GP records (through NHS App and other online services).

Clinicians communicating with GPs need to be aware that their written entries may be seen by the patient and hence consideration should be given to information provided accordingly.

In exceptional circumstances, GPs are able to redact items that should not be disclosed, including *"where the disclosure of, or access to the information is likely to cause serious harm to the physical or mental health of the individual or another person".*

As a health or care professional, when sending any correspondence to a GP that will be filed into the GP record, you should consider language and medical terminology—be aware that communication could be read by patients, so it's recommended that every care is taken to record clinical correspondence in a way that both conveys the necessary detail to other professionals AND considers the impact of receiving such a letter for patients.

Aims:

1) Review the quality and language of our external documentation

2) Standardise our external documentation

3) Update our Community Services Operating Policy accordingly

Method:

Community Palliative Care Team activity was reviewed over a working week (Mon-Fri), looking at all letters sent externally. Phone calls were reviewed just on one day as they were deemed less likely to produce letter writing as an outcome.

Results:

Over the 5 weekday working days, 41 patient home visits were undertaken by the CPCT. 6 other visits were originally planned, but for varying reasons these did not occur/were rescheduled.

Out of these 41 visits;

- 16 letters to GPs were created and sent
- 4 phone calls to GPs were undertaken instead of letter creation
- 21 home visits did not result in either a letter or a phone call to the GP

20 routine planned phone calls were undertaken on 1 day (these do not include phone calls made by Triage as this data was not routinely available via our EPR system). Only 1 routine call resulted in creation of a letter, which was addressed to the patient.

Of the 17 letters sent to patient or GPs;

- 8 were identified as not containing any information that a patient may find upsetting—these were mainly routine medication requests
- 9 were identified as potentially causing emotional distress to a patient/those important to them should they read in their unredacted state

The identified documentation, predominantly (7 / 9) covered concerns regarding the patient deteriorating and requesting a GP to visit for purposes of death certification. Of the remaining 2 letters, 1 contained information regarding the patient's relative finding it hard emotionally, which may cause upset to the patient should they read the letter, and the other suggested there may be an element of anxiety contributing to their symptoms, which again, could be upsetting to a patient to read if they disagree/lack insight into their own condition.

Results:

Letter creation according to Phase of Illness (POI) as identified on the home visit:

Stable: 1 / 8

Unstable: 11 / 26

Deteriorating: 1 / 2

Dying: 3 / 4

Some examples of written documentation:

"there appeared to be an element of anxiety"

"he is deteriorating and has a short prognosis, likely days/short weeks"

"I would be grateful if you could make contact and review him for death certification purposes"

"I should also like to request that she is reviewed by a GP as she is slowly deteriorating, to prevent any issues with signing of the death certificate when the time comes"

Conclusion:

There appeared to be variation in practice between clinicians in their communication with GPs after home visits, with proportionately more patients having a letter created if thought to be in the Dying phase.

Of the 17 letters, none would have resulted in immediate redaction by our Caldicott Guardian if a data request was submitted, however they do raise important questions surrounding the current style of our letter writing, use of terminology and language.

Discussion:

Are we comfortable that not every visit requires the creation of a letter, particularly if the POI has been identified as Stable —being mindful of the volume of workload GPs are managing at present?

Should we capitalise upon this opportunity and adopt the practice of addressing our letters to our patients instead, as our IPU team have already done successfully?

Standards agreed;

- Sensitive language, using less practical terminology when a patient is dying.
- Use of "**CONTAINS SENSITIVE INFORMATION – NOT FOR DISCLOSURE TO THE PATIENT**" at the top of letters where relevant.
- Education and communication to staff.

Adoption of commonly used abbreviations as listed on NHS.uk website only and reducing medical jargon eg shortness of breath instead of SOB which some patients may perceive as a derogatory term. Being mindful of "*is what I am writing going to make sense to the patient*" when we are documenting.

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References: https://digital.nhs.uk/services/nhs-app/nhs-app-guidance-for-gp-practices/guidance-on-nhs-app-features/accelerating-patient-access-to-their-record