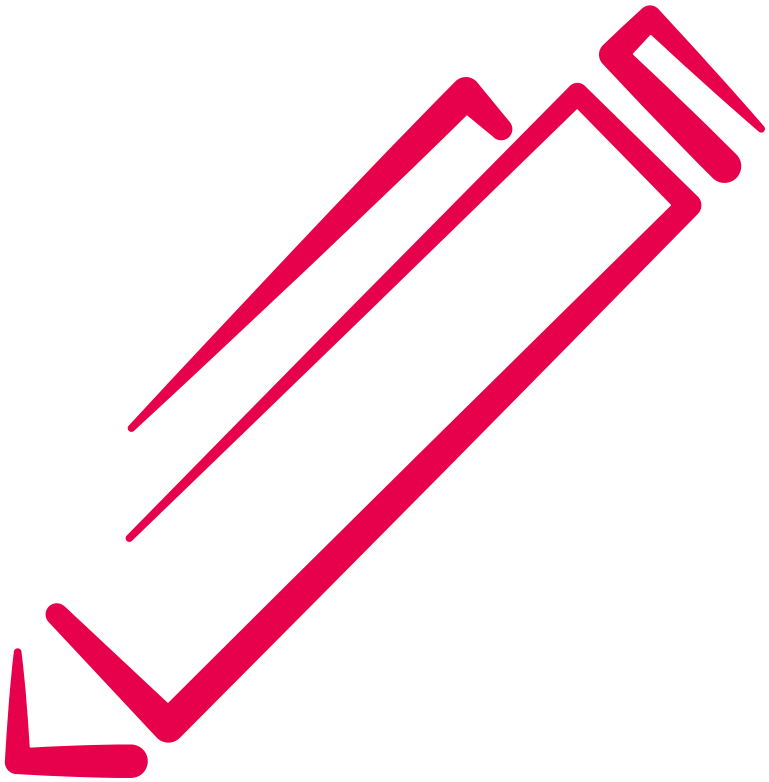
April 2026

Academy of Medical Royal Colleges

Please write to me

Guidance for writing directly to patients



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Contents

Introduction

This guidance provides information and advice to encourage and support healthcare professionals to communicate directly with patients in writing.

This guidance was first published in 2018. As a result, many clinicians began writing directly to patients in plain English following outpatient clinic consultations. This has since been recommended as best practice by professional and NHS bodies, the General Medial Council, and the UK Government.

This update extends the guidance to include writing a section of discharge summaries directly to patients following a hospital admission.

We encourage medical schools, royal colleges, faculties and specialist societies to use this document to help produce their own specific guidance. This guidance can be included in undergraduate[1] and postgraduate teaching materials[2] and used when assessing written communication skills.

This guidance and governance safeguards should also be applied when developing and using AI systems to create clinical documents for use in training and practice.

We recommend hospital trusts, clinical teams, medical schools and patient groups support this initiative and provide help and training in writing effectively to patients.

Background

Poor communication is one of the biggest problems experienced by those using the NHS and is a cause of growing dissatisfaction with the service. In 2023, 45% of members of the public who had experienced poor communication in the NHS over the previous five years said it made them worry about the quality of care the NHS provides.[3]

Shared decision making should be part of everyday care in all healthcare settings.[4] People need to be able to understand information about their health in order to make informed decisions and to use health services effectively. Poor communication disproportionately affects those with lower levels of health literacy, who are more likely to have poorer health outcomes [NHS Health literacy toolkit[5]]. Improving the way clinicians communicate with patients is central to addressing these issues.

In England in 2023/24, there were 135.4 million outpatient visits[6] and 17.6 million admissions to NHS hospitals.[7] If the written communication that followed these appointments was centred on patients' needs and written in a way the patient could easily understand, it is likely that the care of millions of people would be improved [Appendix 1].

This guidance covers general aspects of writing to patients effectively and applies to paper and electronic correspondence. While it is aimed primarily at clinicians it is relevant to all members of the multidisciplinary team. You should also refer to guidance produced by the appropriate body for your area of practice [Appendix 4].[8,9]

Structure and content of outpatient letters and discharge summaries

Outpatient letters and discharge summaries are an essential means of sharing information between clinicians and patients. If written well, they can enhance the relationship between clinician and patient.

Written correspondence should repeat and add to information shared during a consultation or hospital stay. There should be no 'nasty surprises' – written correspondence is rarely, if ever, the best way to give new or upsetting information. This is best done face-to-face.

Written correspondence should be tailored to the individual patient. It is good practice to ask each patient whether they have any accessibility needs to help with the way they read and process information. Record this in their health record so other clinicians are also aware.

Outpatient letters

An outpatient clinic letter should include:[10]

- The reason for the visit
- A summary of the history and relevant examination findings
- Questions asked by the patient and GP with your answers[11] [Appendix 2]
- Documentation that any decisions made were shared decisions
- An agreed management plan
- A list of medications with explanations about new or changed treatments
- Actions to be taken by the
  - patient
  - secondary care clinician
  - primary care team
- A hospital phone number and email address for follow-up questions and correcting errors.[12]

There can be a list of problems or diagnoses at the start of the letter.

There can be a section written directly to the GP or other relevant individuals. This should highlight who is responsible for each action.

Links to charities, support organisations and online sources of information and decision aids[13] can be included. Check the Patient Information Forum Trusted Information Creator database[14] to find trusted sources. Information may be available in multiple languages.[15]

Discharge summaries

- A hospital discharge summary should include:[16]
- A list of the patient's problems or diagnoses
- A brief description of the episode of care
- A record of investigations and procedures requested, results and plans
- Any known allergies, intolerances or adverse reactions
- Medications and medical equipment, with changes highlighted
- Actions to be taken by the patient, secondary care clinician and primary care team.

A section of the discharge letter should be written to the patient that describes and explains:

- The reason they came to hospital
- What was done during the hospital stay
- What they can do to help themselves
- What they should watch for or monitor
- What they should do if they have questions or concerns, with a hospital telephone number and email address (known as safety-netting).

Making your writing easier to read and understand

Make your writing easier to read

Writing to patients should be simple and to the point:[17]

- Use bullet points to break up paragraphs
- Write in short sentences rather than using commas
- Remove redundant words. For example, 'the pain is exactly the same' is better written as 'the pain is the same'
- Cover one topic per paragraph.

Avoid complex words and sentences. Measure the Flesch reading ease score and the UK reading age using the NHS Medical Document Readability Tool.[18] Aim for a Flesch reading ease score of 70 or above and a UK reading age of 9–11 years.[19]

Avoid small print. Use at least 12 point. If the patient has a visual disability, ask if large print would help – at least 16 point is recommended. Emailing correspondence allows patients to use a screen reader if needed.

Making writing easier to understand

Use plain English whenever possible, for example, 'kidney' instead of 'renal'.[20] Avoid medical phrases when plain English can be used. For example, 'Your presenting complaint was…', can be written in plain English as 'You went to your GP because…'. 'On examination, there was swelling of your ankles' is more simply stated as 'Your ankles were swollen'.

Recognise and be mindful of terms that have different meanings in lay and professional use. For example, 'acute' means 'severe' in lay use,[21] 'end-stage' suggests imminent death, 'failure' can be demoralising, [22] 'risk' implies a negative outcome whereas 'chance' is neutral.[23]

Patients accept the need for medical terms to be used in written correspondence.[24] Explain any medical terms you use, for example, 'Your ECG (electrocardiogram – a tracing of your heart's electrical activity) showed that you have atrial fibrillation (your heart rhythm is not regular)'.

People with a learning disability may find brackets harder to understand. This wording may be easier, 'Your heart is not beating with a regular rhythm. We call this atrial fibrillation'.[17]

In the medication list, use English instead of Latin. For example, 'twice daily' instead of 'bd'. Highlight any changes you have made in bold print – **'furosemide increased to 80 mg, morning and lunchtime'.**

Include the clinical indication for the medication. For example, 'amlodipine 5 mg once daily to lower blood pressure; aim less than 140 mmHg systolic'.

Explain acronyms, these are often unclear to non-specialists as well as to patients. For example, CRT-D = Cardiac Resynchronisation Therapy – Defibrillator. You can refer to the NHS Abbreviations you may find in your health records website.[25]

Provide technical information in short sentences, preferably 15 words or fewer.

When writing test results, explain their significance. Don't include unexpected and potentially upsetting results. These are best given face-to-face or by telephone.

For children and young people, include information that is appropriate for their age and development.[26]

Use images, such as charts, graphs or diagrams, as well as words to describe the natural history of disease, present results,[27] and explain risk, prognosis and treatment.[28] Natural frequencies such as 1 in 100 are easier to understand than percentages. Use the same denominator when comparing risks. Icon arrays, sometimes called pictographs, are an effective tool.[29] These aids can be especially helpful for people with a learning disability.[17]

Style and grammar

How you write is a personal matter and we don't want to be prescriptive about style or grammar. However, the following general guidance may help.

Consider how formally or directly you want to present information. At the start of a clinic letter a familiar style may be best. For example, you might say 'It was a pleasure to meet you and your husband for the first time'. At other times a more distant or formal style might be better, such as 'This letter summarises the information we discussed regarding your heart condition'. It depends on what you are discussing and your relationship with the patient.

You can soften the impact of potentially sensitive information by using a more distant or noncommittal style, such as '...during the examination, the tremor and stiffness in your right arm suggest that you have Parkinson's disease'.

You may be more direct when you recommend treatments, for example, 'If the swelling of your legs does not improve, please increase the dose of furosemide water tablets to 80 mg daily (2×40 mg tablets)'.

Use the second (You) and first persons (I, We), such as 'I explained that your airways are narrowed and together we agreed that I would make a referral to a chest specialist'. This is clearer than 'The peak flow rate is low. A referral to a chest specialist is indicated'.

Consider how you use active and passive voices. The passive voice is often used in scientific writing but the active voice is easier to read. The active voice is also more direct and intimate than the passive voice. Consider the difference between 'You decided to have the heart bypass operation' (active voice) and 'A decision was made to go ahead with the heart bypass operation' (passive voice).

Avoid stigmatising words and comments that may offend or annoy.[30] For example, 'You have diabetes' is more appropriate than 'You are a diabetic'.

Conversely, people with neurodiversity may prefer 'You are autistic', to 'You have autism'. If in doubt, ask the patient and mirror the language they use.

Be careful not to impose your point of view when describing a patient's emotions or thinking.[8] For example, 'One of the reasons you decided not to have another baby was the chance of the baby having Down's syndrome' is less upsetting than 'You decided not to have another baby because of the chance of Down's syndrome'.

If you and the patient have different opinions about a treatment, diagnosis or cause, reflect the value and importance of both opinions with sensitivity and balance. It is possible to convey a clinical interpretation without excluding a patient's view and understanding.[31]

Consent and confidentiality

Ask the patient how they would like to be communicated with and record this in their health record so other clinicians are aware.

Ask the patient's verbal permission to write them a letter, for example 'Is it alright if I write a letter to you about today's consultation and send a copy of the letter to your GP?' They may not want sensitive information about themselves posted in a letter to their home. They may prefer an email or text.

Make sure you follow your employer's policy for using email to send letters to patients, as well as the patient's wishes. Ensure your patients are aware of the security and confidentiality issues.[32]

Patients often share their letters with family and carers. Ask if they want copies to be sent to others.

For adults who lack capacity, it is usual practice to write to the GP and send copies to relatives or carers as appropriate.

Children under the age of 16 years can give their own permission to be treated if they are believed to fully understand and appreciate what is involved in the treatment. Young people aged 16 or 17 are considered, like adults, to have the capacity to decide their own medical treatment unless there is significant evidence to suggest otherwise.[33]

For children and young people who are judged to lack capacity or where you are unsure, usually write to the parents or guardians. You may wish to also write a separate, simpler letter to the child.

If there is a court order preventing the sharing of information between parents, for example in cases of domestic abuse, make sure that the email address of the custodial parent and child cannot be shared with the other parent.

If you use an AI-scribe to create documents, obtain verbal consent from the patient for the conversation to be recorded for this purpose at the start of each clinical encounter. Inform the patient that the document they will receive will be written with the help of AI and checked by you before being sent. You must be able to reassure the patient that their information will be stored safely.[34]

When to consider writing only to the GP

If the patient has capacity, they have the right to view all letters following a subject access request to NHS Digital[35] or a request addressed to the hospital or GP.[36] Letters sent to the GP are routinely shared with the patient via the NHS App.

In exceptional circumstances, a letter may be written only to the GP and not copied to the patient. This is usually at the patient's request. If the content should not be seen by the patient, flag this clearly in a box at the top of the letter, asking the GP practice not to release it for viewing by the patient. Follow local policy to make sure the content is not displayed in the hospital patient portal.

Information may be shared without consent if the sharing of information is in the best interests of a child or vulnerable adult.[37] In these cases, keep a record of who has been given the information and for what reason.

Translation into other languages

In Wales there is a legal obligation to provide information in both English and Welsh. When translating letters into other languages, use a resource that is endorsed by your employer.

Be aware that text translated by computer software into a language you do not understand may contain errors that you cannot see.

Electronic Patient Records and Artificial Intelligence

Templates for creating letters within the Electronic Patient Record (EPR) should be consistent with the sections listed above. The default format should be a letter addressed to the patient. It should capture information about items such as diagnoses, other medical conditions and medications from within the EPR.

Generic Natural Language Processing (NLP) models should use annotated coded electronic communication tools, such as Medical Subject Headings (MeSH),[38] to ensure that letters end up in the correct patient record and are appropriately coded.

A generative AI-scribe[39] captures information from the conversation between the clinician and the patient. Only use an AI system that has been designed, tested and monitored to work with the EPR and clinical scenario you work in. It should have included diverse patient groups in its development and testing. Writing to patients should be the default setting.

Follow your local policy regarding data protection and the use of AI.[40] Submitting data to non-approved AI providers is likely to breach governance rules, even where the data is anonymised.

The content and reading level of letters produced using an AI-scribe should be appropriate for each individual patient.

Check every document produced for you by the AI-scribe. AI models 'hallucinate' and can produce statements that are untrue or misleading. Remember, you bear responsibility for the accuracy, quality and appropriateness of any document produced in your name.

Example letters

Below is an example of an outpatient letter written to the GP followed by a version containing the same information written directly to the patient. The readability statistics give a measure of how easy it is to read and understand each letter.

Written to the GP

Dr G Practitioner
The Medical Centre
Tamworth
B79 1XX

6th January 2025

Dear Dr Practitioner

Re: Joseph Bloggs, DOB 12/09/1955, NHS Number 123 234 4567, PID N123456
1 The Street, Tamworth, Staffordshire, B79 1ZZ

Cardiology clinic - Dr Specialist. 3rd January 2025

Diagnoses:	Cardiac echo and MRI scans show left ventricular hypertrophy, bi-atrial dilatation and signs possibly of amyloidosis – awaiting rectal and possible myocardial biopsy Diabetes Hypertension
Medications:	Omeprazole 20 mg od Insulin Metformin 1g bd Atenolol 100 mg od Irbesartan plus hydrochlorothiazide 300 mg/12.5 mg od Doxazosin 8 mg od Simvastatin 40 mg once nightly Clopidogrel 75 mg once daily Restart furosemide 40mg once daily
Allergies:	Penicillin – rash

It was a pleasure to see this pleasant 60-year-old gentleman in the Cardiology Outpatient Clinic today on behalf of Dr S. He had recently presented to the Rapid Access Chest Pain Clinic with increasing shortness of breath on exertion and atypical chest pains. Following this he had an echo scan and MRI scan which are suggestive of cardiac amyloidosis.

On discussion with him about his symptoms, he continues to get shortness of breath on exertion particularly noticeable when climbing hills or stairs but this is not associated with any particular chest tightness.

He also gives a history of intermittent palpitations occurring once every couple of days but denies any dizzy spells or blackouts. He previously had some leg swelling although this has now improved with a recent course of diuretics. He was also suffering with symptoms suggestive of orthopnoea and PND which have improved recently.

Currently he is able to undertake all of his normal activities of daily living at a slightly slower pace than normal.

In his family history, his sister died recently at the age of 47. The cause of her death is unknown and they are waiting on a post-mortem examination. There are no other unexplained deaths in the family.

On examination today his weight was 87 kgs. Right arm seated BP was 124/76, resting pulse approximately 72 bpm and regular. Clinically his chest was clear and resonant, JVP was not elevated but there was some pedal oedema to his mid-shins. His heart sounds were normal.

Therefore, in summary, Mr Bloggs has investigations which are suspicious for amyloidosis and I have explained and discussed about the diagnosis with him today. The plan will be to arrange for blood tests in the form of serum immunoglobulins and electrophoresis as well as urinary free light chains looking for signs of amyloid.

I will also arrange for an outpatient 24-hour heart monitor given the history of palpitations to make sure there is no significant underlying conduction disease.

The next step will be to take a biopsy to prove whether this is amyloid. In the first instance, we will try for a rectal biopsy and I will therefore discuss his case with one of our Colorectal Surgeons to see if he can arrange this, hopefully within the next four weeks. If the rectal biopsy is not diagnostic, the next step would be a cardiac biopsy.

I have explained to him today there may be no specific treatment if the diagnosis of amyloid is confirmed but we would potentially be able to refer him on to a Specialist Centre in London for this. I would be grateful if you could please arrange for him to restart his furosemide 40 mgs OD given that there are still some signs of fluid.

I will write to you further once I have the above investigations. Please contact me via 0121 333 4444 if you have questions in the meantime.

Yours sincerely

Dr ST4 – Doctor – Cardiology
GMC 1234567

Written to the patient

Mr Joseph Bloggs
1 The Street
Tamworth
Staffordshire
B79 1ZZ

6th January 2025

Dear Mr Bloggs

Re: Joseph Bloggs, DOB 12/09/1955, NHS Number 123 234 4567, PID N123456
1 The Street, Tamworth, Staffordshire, B79 1ZZ

Cardiology clinic - Dr Specialist. 3rd January 2025

Diagnoses:	Cardiac echo and MRI scans show left ventricular hypertrophy, bi-atrial dilatation and signs possibly of amyloidosis – awaiting rectal and possible myocardial biopsy No known family history of heart disease Diabetes Hypertension – Clinic right arm seated BP 124/76, pulse 72 bpm SR Weight 87 kg
Medications:	Omeprazole 20 mg once daily Insulin Metformin 1 g twice daily Atenolol 100 mg once daily Irbesartan plus hydrochlorothiazide 300/12.5 mg once daily Doxazosin 8 mg once daily Simvastatin 40 mg once nightly Clopidogrel 75 mg once daily **Re-start furosemide 40 mg once daily to reduce leg swelling**
Allergies:	Penicillin – rash

It was a pleasure to meet you in the clinic today. I saw you on behalf of Dr S.

I was very sorry to hear that your sister died recently.

You recently came to the Chest Pain Clinic. You were getting breathless when doing exercise. You also had pains in your chest.

You do not feel tight in the chest when walking up hills or stairs. You do not feel breathless when you lie down. You can do all your normal jobs but at a slower pace.

There was no sign of heart weakness or fluid on the lungs. However, there was swelling halfway up to your knees.

We agreed you would start the water tablets again to reduce the swelling. Your GP surgery will prescribe them. Please take one tablet each morning.

Every couple of days you feel your heart beating fast. You have not had dizzy spells or blackouts. We agreed you would wear a heart rhythm recorder for a day at home. The team will contact you about this.

Your heart scans were not completely normal. There might be some protein called amyloid in the heart. I have taken blood and urine tests for this.

We agreed you would have a sample taken from your back passage. One of our surgeons will do this, I hope within four weeks. We will test the sample for the protein. It may not give a definite answer. The next step would be to take a sample of heart muscle.

As we discussed, treatment of amyloid can be difficult. We would ask a specialist centre in London to see you. You can find out more at the amyloidosisuk.org website.

I will write to you again when I have the test results.

Please contact me via 0121 333 4444 if you have questions.

Yours sincerely

Dr ST4 – Doctor – Cardiology
GMC 1234567

Information for GP

Test results awaited:
24-hour ECG
serum immunoglobulins and protein electrophoresis
urinary free light chains
rectal mucosa biopsy for amyloid
No action required by GP

Medication changes:
Please restart furosemide 40 mg once daily in the morning to reduce the leg oedema

Readability statistics for the text in the body of the letters

	Letter to the GP	Letter to the patient
UK reading age *	18.6 years	12 years
Flesch reading ease score out of 100**	48	84
Word count	472	300
Average words per sentence	18.9	9.4
Sentences	25	32
Average sentences per paragraph	2.3	2.9

* The average reading age of adults in the UK is 9 to 11 years. 18% of adults have level 1 literacy proficiency or less. At level 1 they can understand short texts and organised lists when information is clearly indicated, find specific information and identify relevant links.[41]

** The recommended Flesch reading ease score is 70 or above.

Appendix 1
Why doctors should write directly to patients

The primary reason why doctors should write directly to patients is that patients want it. This applies to outpatient clinic letters[23] and hospital discharge summaries.[42]

The benefits of writing directly to patients, rather than sending them a copy of a letter written to their GP, have long been recognised, notably in Clinical Genetics.[43] In a randomised trial in a haematology clinic, patients and referring clinicians were very positive about letters written directly to patients[44] [Appendix 2].

Patients find documents written to them more informative, supportive and useful. As a part of shared decision making, they help patients to be more empowered and informed to manage their own health safely, effectively, and confidently.

Writing directly to the patient or the parent/guardian also avoids the awkwardness and sense of exclusion caused by writing about patients in the third person.[45]

Good Medical Practice[46] states: 'You must give patients the information they want or need to know in a way they can understand'. The average reading age in the UK is between 9 and 11 years-old. However, writing in plain English is not only preferred by people with a younger reading age – instead, the more educated the person, the greater their preference for plain English.[47]

The NHS Constitution[48] states that patients 'have the right to be given information about the test and treatment options available to [them], what they involve and their risks and benefits' and have 'the right of access to [their] own health records and to have any factual inaccuracies corrected'.

The NHS Constitution also states that staff should 'involve patients, their families, carers or representatives fully in decisions about prevention, diagnosis, and their individual care and treatment'.

A large proportion of patient complaints and litigation originate from poor communication.[49] Correspondence that is delayed, not patient-centred, and lacking information is a risk to patient safety and care.[50] Writing directly to patients addresses these medico-legal concerns and was a recommendation arising from the Paterson Inquiry.[51]

Patients' comments about letters they have received

The following quotes come from patients asked about outpatient letters they have received.

Sending patients a copy of a letter or summary written to the GP can create many problems.

"I have looked up the letter written by a hospital registrar to my GP (or rather a doctor at my big London surgery I don't think I have ever met) after my Parkinson's diagnosis. At the top it says 'Impression: Extrapyramidal features', it refers to me as 'this 60-year-old right-handed gentleman who works for the BBC as a reporter', and the word Parkinson's does not crop up until the second page. I am far from convinced that the GP did more than skim it, and it did not add to my understanding of the challenges I was now facing."

A letter written directly to the patient can strengthen the doctor-patient relationship[23] and help the patient cope with their condition.

"Appreciate the letter addressed to me – the patient."

"I can now understand the treatment I am having for my illness and I'm happy to know that I'm making some progress along the way."

The letters serve as a handy reminder of important information as many patients struggle to remember things they were told during a consultation.

"I for one will have forgotten half of what you have told me by the time I get home."

Poor communication between clinical teams often harms patient care.[3] Clinic letters and discharge summaries provide useful continuity between clinicians and others involved in the patient's care. Patients may also share them with their relatives and carers.[21]

"Good to keep the letter; if you are under different consultants, you can just show them the letter instead of explaining every time."

"Keeps me informed and can update people at work with my progress when they ask."

The patient provides a valuable safety net, informing clinicians about errors and alerting them to changes.

"Wrong post code. Two medications to be added to list."

Patients can often access their own letters and test results via portals into their EPR. In the future, the NHS App will be a single digital front door for patients to access these systems. Patients should be supported and encouraged to sign up for these services.

Patient-centred pathology reports can significantly reduce worry and improve understanding of results.[52]

Clinicians' views on writing directly to patients

Some clinicians worry that writing to patients may cause them unnecessary anxiety. However, such views are largely unfounded.[53] A common response from patients is that 'the knowing is better than the not knowing.'[54]

Doctors who have adopted the practice say their communication style has become more patient-centred. Most do not find it increases the time taken to write the letters.[23]

GPs want clinic letters and discharge summaries to contain information written in language that patients can readily understand.[55] They too find such letters easier to understand and spend less time interpreting and translating the contents for the patient. A copy of the patient's letter is usually sufficient. A separate letter to the GP is rarely needed.

Appendix 2
Questions from patients

Questions from patients that may be answered in an outpatient letter.[10]

Tests, such as blood tests or scans

- What are the tests for?
- How and when will I get the results?
- Who do I contact if I don't get the results?

Treatment

- Are there other ways to treat my condition?
- What do you recommend?
- Are there any side effects or risks? If so, what are they?
- How long will I need treatment for?
- How will I know if the treatment is working?
- How effective is this treatment?
- What will happen if I don't have any treatment?
- Is there anything I should stop or avoid doing?
- Is there anything I can do to help myself?

What next

- What happens next?
- Do I need to come back and see you? If so, when?
- Who do I contact if things get worse?
- Do you have any written information?
- Where can I go for more information?
- Is there a support group or any other source of help?

Appendix 3
Frequently asked questions

What is the rationale for this guidance?
Patients like doctors to write to them in this way. Communicating effectively with patients is central to being a good doctor. Writing directly to the patient can improve communication.

What does this mean for patients?
Patients should find it easier to understand what the doctor has said to them and be better able to take in the information and advice. They will have a written record of their outpatient consultation or hospital stay that they can show to others.

What does this mean practically for hospital doctors?
Doctors will have to learn to write correspondence in plain English that is easier for patients to understand but also retains all the important content. We have produced this guidance to help doctors learn this skill. Using an AI-scribe can make this task easier.

Will this mean more work for hospital doctors?
Initially, hospital doctors may take a little longer to write these letters as the process may be unfamiliar. Doctors who have made this change find they quickly speed up with practice until there is no difference. Using an AI tool may remove any extra work.

What does this mean for GPs?
GPs will receive a copy of the document written to the patient. They may have fewer patients asking them to explain what the hospital doctor has written.

How can I see how to make my letters easier to read and understand by patients?
The NHS medical document readability tool highlights words and sentences that are difficult to read and understand. Using the tool to refine your letters is a good way of learning how to write well to patients.

How do I use the Flesch Reading Ease score in Microsoft Word?
Click on the File menu > Options > Proofing tab.
Under the 'When correcting spelling and grammar in Word' heading, you'll see a box that says 'Show readability statistics.' Check this box, then exit out of Options and go back to your document. Now, when you run a standard spelling and grammar check you will see the readability scores. Other tools are available on-line.

Does this mean I should not use medical language?
You should use medical terms in the 'Clinical summary' and 'Diagnoses' sections of a letter. However, you should explain medical terms in a way patients can understand when you write to them [page 7].

Should I change the way I write to other specialists, for example making an onward referral?

Include wording in the letter to the patient such as 'I have written to my colleague Mrs X, a specialist in Y, asking for...'. The letter to that colleague should use standard medical terms.

A copy of the letter to the colleague should be sent to the patient and a copy of both letters be sent to the patient's GP.

Do I have to produce two letters, one to the patient and one to the GP?

Not usually. The intention is to send the GP a copy of the letter written to the patient. Rarely, an extra letter specifically written to the GP is be needed.

Will this increase costs?

No. If the patient currently receives a copy of the GP letter, there is no increase in the number of letters being sent.

Are there situations where the patient may not want a letter sent to their home address?

Yes. There may be sensitive information that the patient does not want to see in a letter sent to their home. The patient should be asked for their verbal permission to write to them and may request special arrangements for it.

Can I use AI-scribe software to write letters to patients?

Yes. We recommend you use an AI-scribe that is integrated with the patient's electronic health record and that has writing to patients as a default setting.

Can the letter or discharge summary be sent electronically?

All patients will be able to view their medical documents via the NHS App.

What if the patient doesn't have access to the internet?

Documents should be sent by post if the patient prefers.

Is this guidance consistent with the NHS contractual requirement to use the Professional Record Standards Body (PRSB) Outpatient Letter Standard?

Yes. The PRSB states on their website: 'Best practice for most outpatient letters is writing directly to patients'. The headings in the PRSB Outpatient Letter Standard should be used in the letter written to the patient.

Do doctors have to do this?

This is guidance and therefore not mandatory. However, Good Medical Practice states that: 'You must give patients the information they want or need to know in a way they can understand'.[56] Writing outpatient letters directly to patients helps to meet this requirement.

Appendix 4
Resources

Training courses and webinars

Patient Information Forum. Training and events.

Royal college and speciality guidance:

Clinical genetics

Journal of Genetic Counseling. (2002) Guidelines for Writing Letters to Patients.

Paediatrics

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