

Patient information policy			
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1. Introduction

Staff, service users and carers should have access to patient information produced by both the Trust and other organisations. This Policy focuses on information produced and developed by the Trust, which explain:

- How local services work and can be contacted;
- What treatment is available;
- The risks, benefits and alternatives to treatment, medicines or care;
- People's rights and choices.

It also embraces the richness of patient information produced and provided by other organisations that is routinely used to support our staff, service users and their carers. Key independent providers of patient information include:

- Royal College of Psychiatrists
- Choice and medication website
- Local mental health voluntary sector services, self help, user or carer groups;
- Other NHS, health and social care organisations – for example local councils, Patient Advice and Liaison Service (PALS), services in other NHS organisations and NHS Direct;
- Advocacy service;
- National service providers and charities – for example MIND or Rethink;
- Professional bodies like NICE (National Institute for Clinical Excellence) or relevant professional bodies.

2. Purpose

The policy aims to make sure that service users, patients and carers get the right information at the right time. Patient information:

- plays an important role in involving service users and carers in their own treatment and care;
- is essential for mental well being and recovery;
- underpins people's access to services and the choices that service users and carers may make at different times along the care pathway.

This policy supports staff in the production of effective patient information for service users and carers.

The policy covers :-

- Patient information for service users and carers about treatments, services, procedures and conditions;
- Getting the basics right in patient information and making information accessible;
- Responsibility and accountability for patient information and its use;
- Key principles in how patient information is developed.

This policy does not cover issues around

- Confidentiality and consent
- The Care Programme Approach (CPA)
- Information governance and records management
- Choice of mental health provider

- Communication and information to the public
- Patient information related to research governance and informed consent

All of these are addressed elsewhere in the Trust or directly covered by other Trust wide policy and strategy documents.

2.1 What do we mean by patient information?

Patient information is key to improving the experience of our service users and their carers and is essential to empower and inform decision making.

It supports service users and carers through the recovery process, contributes to the tools that our staff use to facilitate that and can be a lifeline to getting the right support at the right time in a crisis.

It needs to be available at different steps along the care pathway where individuals will need patient information. This may be the same information repeated or new information that is relevant to that part of the illness or recovery process.

2.2 Describing patient information

In this policy patient information refers to:

- Trust services;
- Drug and non-drug treatment;
- Procedures;
- Prevention and health promotion;

Related services from other service providers.

2.3 Making patient information available

Patient information assists communication between staff and service users and carers. It helps build and sustain trust and a partnership of care between staff (including clinicians), service users and carers.

Patient information must be disseminated in context with other information given to service users and carers – for example letters, appointments, the provision of written copies of an individual's care plan (Care Programme Approach - CPA) and verbal information.

Staff play a vital role in identifying what patient information is needed, developing it and disseminating it to service users and carers at the right time as part of their duty of care. Patient information is used across the Trust on our wards, in teams and in our buildings.

Patient information is not just about leaflets. Print, video and increasingly electronic and web based tools are the principal media used in patient information. To be accessible to the range of people using it including those with learning difficulties, people with visual impairment and those whose first language isn't English, patient information must be available in a range of formats. It is provided in a number of ways including:

- Making information available in printed form - for example as leaflets, booklets, newsletters, posters or information packs;
- Access to information through a range of electronic and visual media (for example web sites, easy read, internet, CDs and DVDs);
- Access to information through a range of electronic and audio media where service users, carers, clinicians and nurses can talk directly to service users (for example tapes, CDs, digital broadcast, internet download);

- By the Trust PALS service that can signpost people to information and aims to provide quick resolution of concerns raised by service users and carers.

3. Scope

This policy is for AWP staff who are responsible for ensuring that service users, carers and visitors are provided with accessible, timely, relevant and effective information.

4. Duties and responsibilities

4.1 Trust board

The role of the Trust Board is to have a strategic overview and final responsibility for setting the direction for patient information in the Trust. It will be responsible for:

- Agreeing the patient information policy;
- Reviewing it after three years or before if deemed necessary;
- Declaring each year to the Care Quality Commission (CQC) as part of Quality and Safety Registration Outcomes that the relevant standards for patient information have been complied with.

4.2 The Director of Nursing and Quality

The Director of Nursing & Quality is the executive director for patient information. This director is responsible for ensuring the Trust's overall duty for patient information management is discharged appropriately and has lead responsibility for the implementation and further development of this policy.

4.3 Executive directors, directors and managers

All Executive Directors, Directors and Managers are responsible for identifying, developing, producing, communicating and managing patient information in accordance with the framework set out in this policy. They are responsible for developing patient information where gaps are found through patient feedback incidents and complaints.

4.4 The Internal Communications Executive

The Internal Communications Executive is responsible for

- co-ordinating the management of the Trust's patient information processes
- ensuring that all information has been reviewed by service users
- ensuring patient information complies with meets plain English and readability guidelines
- develop guidance and templates for use across the Trust, advising staff on good practice;
- updating and maintaining the patient information pages on Ourspace and the Trust website.
- they will manage the translation and interpreting contract with the Trust's preferred supplier.

4.5 Employees and contractors

All employees and contractors are expected to understand the importance of developing and providing effective patient information within a culture of customer care as described in this policy. All staff have a responsibility to provide patient information to service users and carers, including those with learning difficulties, as part of their duty of care.

All front line staff have a responsibility to provide patient information to service users and carers as part of their duty of care. This is a normal day to day function for Trust staff and is part of their ongoing communication with service users and carers and approach to good customer care. Patient information needs to be provided on a regular and repeated basis, so that it is relevant to changing needs and circumstances. Patient information should be provided routinely and be part of the discussion about care, treatment, rights and options. Staff will document on RiO /and or the care plan library what information they have provided and that the content has been explained.

Team managers, care co-ordinators and ward managers must ensure that they have access to up to date, approved patient information to make available to staff, service users and carers in wards, teams and in all buildings where care is provided by AWP. Easy read versions should be available in all areas where people who use the service may have learning difficulties.

5. Policy statement

Our vision and values

The Trust is fully committed to the delivery of safe, high quality mental health services. Patient information plays an important role in this and is essential for mental well being and recovery.

Our core values in patient information are to:

- Develop our own information, with input and feedback from service users and carers that use a service;
- Embed patient information in an active culture of customer care;
- Ensure patient information is cost effective by making best use of limited resources and capacity;
- Integrate patient information into the delivery of high quality, sustainable mental health services;
- Produce patient information that is culturally appropriate and respects individuals;
- Develop the role of patient information in delivering quality and service improvement.

6. Standards

The need to provide effective patient information is recognised in the quality standards that all NHS organisations are required to meet. The standards are described by the Department of Health and further developed and regulated by an independent body the Healthcare Commission. In particular patient information is addressed by standards within the patient experience quality and safety outcomes standards 1, 4, 7 and 17.

These quality standards are further consolidated by standards set by the

Information standard and Accessible standard which require clear documentation on the:

- Process for developing service user and carer information
- Clarity on the content in leaflets and other media
- Process for reviewing patient information
- Process for recording the discussion and provision of information to patients
- Archiving arrangements for any information given to patients that support their decision making
- Monitoring arrangements

7. Training

The Trust lead for patient information will participate in a programme of continuous professional development to ensure they remain up to date and keep abreast of developments in this field.

It has been agreed that staff will use the Ourspace patient information pages to guide them on how to develop high quality produced patient information. Further support and advice can be sought from the communications team.

8. Monitoring or audit

The Director of Nursing and Quality is responsible for developing monitoring arrangements for this policy.

Compliance with this policy will be monitored via reporting to the Integrated Governance Group and learning from annual patient surveys and FFT feedback.

The patient information policy will be initially reviewed after one year, then three years, or earlier, if deemed necessary. The review process will include:

- Feedback from staff.
- Any issues arising from the audit and monitoring that will aid and inform wider learning will be communicate via the Trust's programme of thematic reviews

9. Associated and related procedural documents

- [Confidentiality](#)
- [The Care Programme Approach \(CPA\)](#)
- [Information Governance](#)
- [Liberating the NHS \(2010\) consultation document](#)
- [Procedure for producing Patient information](#)

10. Document lifecycle control

The lifecycle of this document is controlled by the document development management policy and the records management policy.

Version History				
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1.0	18 Jan 2011	Minor changes following feedback from Quality and Healthcare Governance Committee	AG	Approved
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