Barnsley Hospital NHS
NHS Foundation Trust

POLICY CONTROL SHEET

Policy Title & ID number	**Patient Information CC 4.2**			
Sponsoring Director:	**Chief Nurse**			
Implementation Lead:	Deputy Chief Nurse			
Impact:	*(a) To patients*	Access to accurate information to support informed choices regarding care		
	(b) To Staff	Guidance to ensure best practice		
	(c) Financial	Possible reduction in the number of complaints		
	(d) Equality Impact Assessment (EIA)	Completed: **Yes / No** *(delete as applicable)*		
	(e) Counter Fraud assessed	Completed: **Yes / Not required** *(delete as applicable)*		
	(e) Other	NHSLA requirement		
Additional Costs:			*Budget Code*	*Revenue or Non Revenue*
	(a) Training:	*£*	*Within divisions*	
	(b) Implementation:	*£*		
	(c) Capital:	*£*		
	(d) Other	*£*	*Audit Department*	
Training implications:	*To be incorporated into induction:* **Yes / ~~No~~** *(delete as applicable)*		*Other: local induction*	
Date of consultation at:	*Board of Directors*			
	Executive Team			
	Divisional Medical Directors/Clinical Directors			
	Assistant Divisional Directors/Heads of Department			
	Board Committee (Governance – Clinical Policy Group)		*04.02.10*	
	Joint Partnership Forum			
	Local Negotiating Committee			
	Infection Control Committee:			
	Health & Safety Committee			
	Other (state name/s):			
Alignment	*HR:*		Training and Development	
	Strategic Direction:		Improving clinical care and standards	
	Board Assurance:		Risk reduction	
	Clinical Governance:		Ensuring excellence	
Date of Final Draft:			Issue Number:	2
Date of Final Approval:			Approved by:	Clinical Policy Group
Implementation Date:	*Immediately*			
Date of last review:	July 2007	Date of next review:	February 2012	
Circulation Date:				

Circulation:		Yes	Comment
	Directors	√	
	Non Executive Directors		
	Divisional Medical Directors/Clinical Directors	√	
	Medical Staff Committee/SMSF		
	Assistant Divisional Directors	√	
	Assistant Nursing Directors	√	
	Heads of Department	√	
	H&S Committee Members		
	Policy database/warehouse	√	
	Others (to be listed):		

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PATIENT INFORMATION POLICY

POLICY ID: CC 4.2

IMPLEMENTED JULY 2007 – UPDATED FEBRUARY 2010

SPONSORING DIRECTOR – CHIEF NURSE

Updated: February 2010

PATIENT INFORMATION POLICY
(POLICY ID: CC 4.2)

CONTENTS

POLICY

ABBREVIATIONS AND ACRONYMS

- NHSLA NHS Litigation Authority
- SUI Serious untoward incident
- PCT Primary Care Trust

PATIENT INFORMATION POLICY
(POLICY ID: CC 4.2)

1. STATEMENT OF INTENT

The intent of the policy is to ensure that a robust framework is in place to guide staff to formulate clear information for patients. The information will be available to patients to help them to understand their options for care and treatment and subsequently aid them to make informed choices. This will be done by:

- Maintaining effective organisational processes to ensure a Trust-wide consistent approach to formulation of patient information
- Ensuring compliance with relevant NHS Litigation Authority (NHSLA) Risk Management Standards, Clinical Governance Standards, Care Quality Commission Standards and by promoting best practice
- Ensuring that the Board of Directors and Chief Executive have assurance that appropriate systems are in place

Information regarding the procedures to be followed are listed.

2. INTRODUCTION

The aims of the policy are to ensure that:

- Processes are robust and fit for their intended purpose
- Processes are clear and properly understood by staff
- Information is provided for patients in a variety of media that is easily understandable

The aims will be achieved through meeting the following core objectives:

- Ensuring Board level commitment to, and leadership of the development of high quality patient information
- Ensuring a clear framework is established to guide the formulation of high quality patient information
- Ensuring widespread employee participation and consultation in the formulation of patient information
- Ensuring patient and public involvement in the formulation of patient information
- Development of clinical effectiveness and governance frameworks to demonstrate application of agreed processes
- Providing realistic resources to implement and support the strategy and policy

3. IMPLEMENTATION

On induction into their department staff will receive a local induction and as part of this, clinical staff will be informed of the process to follow to formulate patient information.

4. MANAGEMENT ARRANGEMENTS

Overall responsibility for the management of risk lies with the Chief Executive as Accountable Officer.

All Trust Directors are responsible, collectively, for the Trust's systems of internal control and management. The Board of Directors needs to be satisfied that appropriate policies and procedures are in place and that systems are functioning effectively. The Board of Directors has delegated its accountability arrangements for patient information to the Chief Nurse.

The responsibility for patient information involves the whole management chain of command, and all members of staff have a responsibility to ensure the effective implementation of the policy and procedures.

Within that system there are certain key officers and specific functions are outlined below:

4.1 Chief Nurse

- Ensure that policy and procedures are agreed through consultation with relevant staff groups
- Ensure that the overarching policy is updated regularly in line with national guidance and audit reports
- Keep the Chief Executive and Board of Directors up to date with progress and highlight any areas of concern

4.2 Divisional Medical Directors/Divisional Managers/Heads of Departments

- Ensure that staff are aware of, understand and follow the policy and supporting procedures
- Ensure that a forum for agreeing the clinical content of patient information is established and supported within Divisions
- Ensure that patient information relevant to treatment and care provided within the Division is formulated following agreed procedures
- Ensure that patient and public involvement is sought to support the formulation of patient information at Divisional level
- Ensure that adequate resources are available within the work area to follow correct procedures
- Ensure that patient information is accessible
- Ensure that patient information is updated in a timely manner
- Ensure that regular audit of agreed processes and procedures takes place to monitor the effectiveness of practice and that remedial action is implemented where required

4.3 Advancing Practice Group

- Review patient information formulated by Divisions to ensure it contains essential generic criteria
- Ensure that guidance and procedures regarding patient information is updated at least every two years to reflect requirements of NHSLA and Care Quality Commission Standards
- Agree monitoring and audit processes
- Ensure cascade of information to Divisions and relevant support departments

4.4 Chair of the Advancing Practice Group (currently the Deputy Chief Nurse)

- Ensure timely review of patient information by the advancing practice group
- Inform Divisions of any amendments required to patient information following reviews by the advancing practice group

- Confirm to Divisions when patient information has been approved by the advancing practice group
- Keep an accurate archive of patient information
- Co-ordinate monitoring and audit processes

4.5 Supplies Department

- Ensure that confirmation of approval of patient information by the advancing practice group is in place prior to arranging printing for Divisions
- Ensure that a copy of any new patient information is sent to the Chair of the advancing practice group for archiving

4.6 Staff

- Access appropriate training and information
- Work within agreed procedures and guidance
- Assist where required with audit processes

5. AUDIT AND EVALUATION

Audit of processes and procedures will take place at least once annually and be reported to the Senior Nurse Forum. Any incidents will be reported via the IR1 incident reporting system. Any serious untoward incidents (SUIs) will be reported through the Patient Safety Board and to the PCT via the Trust SUI group.

6. REVIEW DATE

February 2012

7. REFERENCES

Department of Health (2006) *Standards for better health.* April, HMSO, UK

NHSLA (2007) *Risk management standards for acute Trusts.* April, Willis, UK

CROSS REFERENCE DOCUMENTS/POLICIES

BHNFT Patient Information Guidance