MASS PATIENT\STAFF CONTACT POLICY

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Development & Approval Group or Team:	**Health Records Managers Team**
Endorsing Body:	**Information Governance Committee**
Governance or Assurance Committee:	**Healthcare Quality Assurance & Improvement Committee**
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Responsible Person:	**Head of Information and Records Management**

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CONSULTATION AND DISTRIBUTION RECORD	
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Consultation Process/Stakeholders:	• Medical Director • Patient Safety • Human Resources • Director of Nursing • Divisional Management Teams • Health Records Managers
Distribution:	CMT

CHANGE RECORD			
Date	**Author**	**Change**	**Version No.**
October 17	JD	First draft approved patient mailing standard operating procedure	0.1
20/11/17	JD	Updated to incorporate minor comments from service	0.2
Nov 2017	JD	Approved by CMT	0.3
02/02/2018	JD	Additional point added to confirm managers to advise Head of Health Records if policy is breached (requested by Geraldine Reilly HR)	1.0
May 2018	Risk Department	GDPR statement added into section 3 and updated name of Data Protection Act	1.0
November 2018	JD	Policy updated to cover all forms of communication and policy name changed	0.1
January 2019	JD	Updated to reflect eHealth HoF changes and recommendations from the Radiology SAER	0.2
January 2019	JD	Updated to include staff	0.3
January 2019	JD	Updated to include staff Passed to HR and IG for comments	0.4
January 2019	JD	Minor spelling etc updates from HR Submitted to Feb IGC for approval	1.0
February 2019	JD	Approved at IGC	1.0
October 2019	JD	Policy due for review in Feb 2020. Issued to key stakeholders for comment. Additional advice re mass email and compliance with email policy added. Advice re use of 2nd Class mail as standard added.	Draft 0.1 Draft 0.2
October 2019	JD	Final version to be approved at 10 December IGC	1.1
January 2020	JD	Approved at Jan IGC and minor layout changes.	1.1
29 January 2020	JD	File note to confirm change of policy name from Patient Mailing Policy to Mass Patient\Staff Contact Policy	1.1
May 2020	KT	Extended until Month May 2022 (COVID-19)	1.1
April 2022	LT	Change of author to Lorraine Taggart, Head of Information and Records Management	1.2
April 2022	LT	Development & Approval Group or Team line added on main page as per new template	1.2
April 2022	LT	Change of title: Head of Health Records amended to Head of Information and Records Management	1.2
October 2023	LT	Addition of guidance around BCC	1.3
May 2025	LT	Removal of outdated hyperlink and small QA changes made.	1.4

1. INTRODUCTION

This policy must be followed when undertaking a mass patient\staff contact exercise out with core NHS Lanarkshire systems i.e. Trakcare. A mass patient\staff contact is where a cohort of patients\staff being contacted about a particular subject. In effect this means more than one patient\staff. A mass patient\staff contact will constitute the following component parts:

- Authority to undertake
- Identification of cohort
- Creation and proof reading of communication
- Confirmation of correct demographic details
- Staff Communication
- Delivery
- Contact process for patients\staff to respond
- Reminder

The normal route of communication will be letter but could include email, text or telephone contact.

Irrespective of the communication type the principles of the policy and all relevant IT security policies must be applied.

2. AIM, PURPOSE AND OUTCOMES

These are to:

- Maximise the response to the mass contact
- Quickly alleviate any concerns
- Comply with Information Governance standards

3. SCOPE

3.1 Who is the Policy intended to Benefit or Affect?

This policy is for all staff who undertake mass patient\staff contacts out with NHS Lanarkshire administration systems e.g. Patient Administration System, Radiology Information System and Human Resource systems.

Third party contractors acting on behalf of NHS Lanarkshire will also follow this policy.

3.2 Who are the Stakeholders?

The stakeholders are:

- Managers

- Clinical Staff
- NMAHP staff
- Management

Roles and responsibilities are detailed elsewhere in the policy. All other stakeholders without specific roles and responsibilities must be aware of the main principles of the policy.

"NHS Lanarkshire take care to ensure your personal information is only accessible to authorised people. Our staff have a legal and contractual duty to keep personal health information secure and confidential. In order to find out more about current data protection legislation and how we process your information, please visit the Data Protection Notice on our website at www.nhslanarkshire.scot.nhs.uk or ask a member of staff for a copy of our Data Protection Notice."

4. PRINCIPAL CONTENT

Mandatory content of the letters and mailing checklist are available in the appendices.

4.1 Mailing Management Team

A mailing management team must be convened comprising representatives of the management team wishing to undertake the mass contact, Information Management, Health Records and Information Governance. If the mailing is in response to an Information Governance breach it will be the service undertaking the mailing which will be responsible for ensuring that staff have the IT skills and knowledge to undertake the mailing and to ensure that the policy is followed at all times.

4.2 Authority to undertake

This requires authorisation from senior management. A Privacy Impact Assessment should be completed and approved by the mailing management team. This should clearly state why the core system cannot be used and the need for any reminder process. The Head of Information and Records Management must also be contacted in advance to discuss the requirement for a mass patient contact. An Equality and Diversity Impact Assessment should also be considered but is not mandatory.

Letters should be sent 2nd class mail unless approved by the relevant Director.

4.3 Identification of cohort

The cohort will be identified by the service leading the mass contact and must ensure that the source of the cohort correctly covers the patient\staff population to be contacted.

If this requires an extract from systems then an Information Management ad-hoc request form should be completed which clearly defines the selection criteria, data items required and the exclusion of deceased patients.

4.4 Creation and proof reading of communication

The communication must clearly define the purpose of the contact and must be proofread and authorised by a senior manager. The communication should be clear and unambiguous to prevent misunderstanding. The originating department and address should be clear. The Communications Department should be involved in the process.

See Appendix 1 and 2 for standard communication contents and checklist.

The communication and any accompanying documents should be proofread and sampled:

- Clarity and understanding
- Spelling and typographical errors
- Accuracy of any contact details (undertaken by 2 independent people)

4.5 Confirmation of correct demographic details

Prior to the mailing the patient\staff unique ID (CHI number\employee staff number) must be passed back to Information Management to obtain the most up to date set of demographics and exclude any recently deceased patients. This must be done as close to the posting date as possible but must not exceed 3 working days. Only CHI, SCI store and eESS can be used for the demographics. This decision must be taken by the mailing management team.

4.6 eMail

All email communication with patients\staff must follow the email policy and as such, mass mailing of patients using email would only be undertaken where the information is unclassified (or using the traffic light system for data sensitivity classification – Green), and where a risk assessment has been undertaken by the Head of Information and Records Management. Blind carbon copy (BCC) should not be used to send emails containing sensitive personal information.

4.7 Staff Communication

Depending on size of mass patient\staff contact the senior manager should consider the need to undertake a wider staff briefing as well as contacting relevant switchboards to advise of mass patient\staff contact and the contact details of responsible manager.

4.8 Delivery

The timing of the delivery should avoid patients\staff receiving the letter on a non- working day. If this is unavoidable then consideration should be given to contact details over the weekend.

4.9 Contact process for patients\staff to respond

If the patient\staff has to contact NHS Lanarkshire the following routes are available:

- To a specific email address (only if non sensitive data is being provided)
- Stamped addressed envelope
- By telephone

At all times patients\staff should be provided with a contact number if they have any queries or concerns. Staff should be trained to handle these calls. Consideration should be given to the volume of calls that may be expected and ensure adequate call handlers are in place.

If the letter is very important you may also wish to think about a receipt process.

4.10 Reminder

If a reminder is required then the above process must be repeated. In addition a process for logging responses must be established so that reminders are only sent to patients\staff who have not responded in any way to the mailing.

5. ROLES AND RESPONSIBILITIES

It is the responsibility of the manager authorising the patient\staff mailing to ensure that this policy is adhered to.

5.1 Chief Executive

Will ensure that there is an effective policy relating to the management of mass patient contact.

5.2 Head of Information and Records Management

As the designated Senior Manager the Head of Information and Records Management will be responsible for coordinating the implementation of this policy throughout NHS Lanarkshire and ensure that the policy is relevant and up to date.

5.3 Information Governance Manager

Will help investigate any exceptions to the policy.

5.4 Medical Director and Executive Director of NMAHPs NHS Board

Have professional accountability for their respective professions and a responsibility to ensure that this policy is distributed and implemented.

5.5 The Caldicott Guardian

Is responsible for ensuring patient identifiable information is shared in an appropriate and secure manner.

Has responsibility for reflecting patients' interests regarding the use of patient identifiable information.

Will act as advisor to the Chief Executive on use of person identifiable information.

5.6 **Operational Directors (Acute and Health and Social Care Partnerships)**
Will oversee the effective implementation of the Policy within their area of responsibility.

5.7 **Unit and Divisional General Managers/Clinical Leads/Service Managers/Senior Nurses/Operational Service Managers/Directorate Support Managers.**
Are responsible for implementing the policy.

It is the responsibility of the manager authorising the mass patient contact to ensure that this policy is adhered to.

To report any breaches arising from non-compliance with policy to the Head of Information and Records Management.

5.8 **Medical, Nursing and Allied Health Professional Staff**
Will ensure they adhere to the standards for record keeping as laid down by their respective professional bodies.

5.9 **Administrative Support Staff**
Will adhere to this policy and supporting procedures.

6. RESOURCE IMPLICATIONS

No resource implications.

7. COMMUNICATION PLAN

To be deployed through Executive Directors and Divisional Management Teams.

8. QUALITY IMPROVEMENT – MONITORING AND REVIEW

The policy will be reviewed on a regular basis. Monitoring will be on an exception basis by the Information Governance Committee.

9. EQUALITY IMPACT ASSESSMENT

This policy meets NHS Lanarkshire's EQIA ☐ (tick box)

There is no requirement for EQIA as its an administration policy that applies to all patients.

10. SUMMARY OR FREQUENTLY ASKED QUESTIONS (FAQs)

Not applicable.

11. REFERENCES

The current Data Protection legislation
NHSL Information Security Management System

12. CHECKLIST

To be sent to corporate policies:

- Copy of completed policy
- Copy of EQIA
- Copy of Assurance process document for all policies
- Copy of fast-track document if applicable

Appendix 1 - Mandatory letter content

Letter should use font size 12 and only justified to the left and contain the following.

- Business Address
- Date
- Patient Demographics
- DOB
- Community Health Index Number
- Subject Header
- Contact numbers and opening times
- Text of letter
- 'We apologise if this letter has reached you at a difficult time'
- Author

Appendix 2 –Mailing Checklist (can also be used for reminder)

Task	Comments
Authority from senior manager to undertake patient mailing	
PIA completed	
Head of Information and Records Management * contacted For non-patient mailings the relevant Senior Manager should be contacted	
Information Management contacted and deceased patients excluded	
Letter proofread for clarity and understanding	
Letter proofread for spelling and typographical errors	
Letter proofread for accuracy of any contact details (telephone numbers phoned and email address used)	
Double check email address contains all the @ and . (dots)	
Refreshed demographic details obtained from Information Management within 3 working days	
Specify if Trakcare, CHI or eEESfor demographic sources	
Need for wider staff communication considered	
Specify day of week letter will be delivered (if non-working day justify reason)	
Sample of mailing to be performed	
Sufficient resources in place to handle enquiries	