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NHS
Islington
Clinical Commissioning Group

Confidentiality and Disclosure of Information Policy

1	**POLICY DRAFTED BY:**	**NELCSU INFORMATION GOVERNANCE TEAM**
2	**ACCOUNTABLE DIRECTOR:**	**DIRECTOR OF QUALITY AND GOVERNANCE**
3	**APPLIES TO:**	**ISLINGTON CLINICAL COMMISSIONING GROUP STAFF**
4	**COMMITTEE & DATE APPROVED:**	**EMT 7th December 2016**
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DOCUMENT CONTROL

Date	Version	Action	Amendments
07/09/2016	1.0	New policy for Islington CCG in line with policies issued by NELCSU in accordance with SLA	

Contents

1. Summary

Islington Clinical Commissioning Group (CCG) has put this policy in place to ensure staff are fully aware of their responsibilities when collecting and using confidential information. This policy is important as it should help you understand how to effectively maintain compliance with the Data Protection Act when handling information.

Information is a valuable asset to a commissioning organisation. Information enables the CCG to make effective and informed decisions. Therefore it is important to ensure we maximise the value of information as an 'asset' in compliance with legal requirements. In complying with this policy we will ensure information is:

- **H**eld securely and confidentially;
- **O**btained fairly and lawfully;
- **R**ecorded accurately and reliably;
- **U**sed effectively and ethically; and
- **S**hared and disclosed appropriately and lawfully.

The CCG is committed to ensuring that information, in whatever its context, is processed as permitted by law, statute and best practice. Compliance with all the CCG's policies is a condition of employment and a breach of policy may result in disciplinary action.

2. Scope

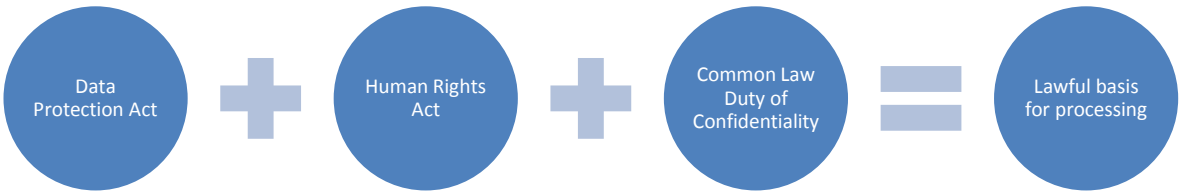
This policy covers all aspects of compliance with confidentiality and data protection when holding, obtaining, and recording, using, sharing or disclosing data / information. It applies to records held in a manual (paper) or electronic format, held by or on behalf of the CCG.

This policy applies to, but is not limited to; staff employed by the organisation; those engaged in duties for the organisation, those with an honorary contract or on a work experience programme; volunteers and any other third party such as contractors, students or visitors.

3. Introduction

The CCG will hold some personal and confidential data relating to patients, the public and its employees. With ever-easier ways by which information can be accessed and shared it is important that a consistent approach is adopted to safeguard the organisation information as an asset.

It is recognised as a commissioner that access to personal confidential data will be limited but may on occasion happen. Any collection or use of such data will need to comply with:



The CCG, as a commissioner, will not always have the primary contact who collected information. As a result it would be this first interaction with the data source that needs to be considered when trying to establish the expected level of confidentiality.

4. Purpose

The Policy is intended to achieve and maintain the following Information Governance objectives:

Confidentiality

- Enuring that sensitive information/ data is accessible to only authorised individuals, and is not disclosed to unauthorised individuals or the public unless appropriate and lawful.

Integrity

- Safeguarding the accuracy and completeness of information and software, and protecting it from improper modification.

Availability

- Ensuring that information, systems, networks and applications as well as paper records are available when required to departments, groups or users that have a valid reason and authority to access them.

Accountability

- Users will be aware of their responsiblities in relation to their collection, use and processing of data/ information.

5. Roles and responsibilities

Confidentiality is everybody's business and therefore it is everybody's responsibility to ensure information is processed appropriately. This section describes the responsibilities, in relation to Information Security, of those processing information. Some individuals will hold more than one role.

Role	Responsibilities
Governing Body	In line with the Guidance for NHS Boards: Information Governance, the governing body will ensure that its organisation has taken appropriate steps to meet IG standards. In particular it will seek assurance against following questions: 1. "What have we done, as an organisation, to ensure we have implemented adequate policies and procedures, and are addressing the responsibilities and key actions required to support effective IG?" 2. "What were the outcomes of our most recent annual IG assessment, and what measures (if any) have been put in place to address any identified deficiencies?" 3. "What plans do we have in place to ensure our organisation remains compliant with national standards for IG? 4. "Do we as an organisation have the capacity and capability to guarantee our plans for IG can be implemented?" 5. "Do our IG arrangements adequately encompass all teams and work areas that we are legally accountable for?" 6. ''What plans do we have in place to ensure compliance with the Caldicott 2 recommendations?'' 7. ''What plans do we have for protected disclosures as a result of the Public Sector Information Regulations 2015? 8. ''Are all significant IG Risks being managed effectively and considered at an appropriate level? Have there been any serious incidents requiring investigation reported? ''
Accountable Officer	Has overall accountability and responsibility for governance within the organisation. Is to provide assurance that all risks to the organisation, including those relating to information, are effectively managed and mitigated.
Senior Information Risk Owner (SIRO)	Has overall responsibility for ensuring that effective systems and processes are in place to address the IG agenda. 1. Foster a culture for protecting and using data. 2. Ensure information risk requirements are included in the corporate Risk and Issue Management Policy. 3. Ensure Information Asset Owners (IAOs) undertake risk assessments of their assets. 4. Be responsible for the Incident Management process ensuring identified information security risks are followed up, incidents managed and lessons learnt. 5. Provide a focal point for the management, resolution and/or discussion of information risk issues. 6. Ensure that the CCG's approach to information risk is effective in terms of resource, commitment and execution and that this is communicated to all staff. 7. Ensure the Governing Body is adequately briefed on information risk issues. 8. Be accountable for information risk. The SIRO roles and responsibilities are defined in Appendix 1 of the NHS Information Risk Management Guidance. The role holder will be supported and advised by the IG Team.
Caldicott Guardian	The role of the Caldicott Guardian is an advisory role acting as the conscience of the organisation for management of patient information and a focal point for patient confidentiality & information sharing issues. To ensure that the CCG completes all requirements in the Caldicott plan relevant to the CCG

	The Caldicott Guardian is supported in this role by the IG Lead and IG Team who provide the Caldicott Function for the organisation. To be informed of the final IG Toolkit submission status for the CCG as the Caldicott assurance and compliance report are then available from the IG Toolkit.
Information Asset Owners	All senior staff at Director level are required to act as Information Asset Owners for the information assets within their remit. They will provide assurance to the SIRO that information risk is managed effectively for the information assists identified as within their remit. They will also: • Ensure all Information Assets and flows of data within their remit are identified and logged ensuring each has a legal basis to be processed. • Identify, manage and escalate all information security (for example, dependencies and access control) and information risks as appropriate. The IAOs will be supported by IAAs who will ensure the above takes place. The detailed roles and responsibilities are defined in Appendix 1 of the NHS Information Risk Management Guidance
Information Asset Administrators	Information Asset Administrators (IAAs) are the most senior individual user or direct users of systems and have an understanding as to how they work and how they are used. They will ensure there are procedures for using them, control access to them and understand their limitations. The detailed roles and responsibilities are defined in Appendix 1 of the NHS Information Risk Management Guidance
Information Governance Lead	Senior CCG Manager responsible for ensuring suitable advice, guidance support, tools and training are available to those with the CCG who handle data, to ensure they do so appropriately. This role will be the main point of contact for the NEL CSU IG Team.
NEL CSU IG Team	Provide specialist advice and support, under contract, to the organisation in relation to IG subject matters. They will also form part of the Caldicott function.
All Substantive/Permanent Staff	All those working for the CCG have legal obligations, under the Data Protection Act and common law of confidentiality; and professional obligations, for example the Confidentiality NHS Code of Practice and professional codes of conduct to manage information appropriately. These are in addition to their contractual obligations which include adherence to policy, and confidentiality clauses in their contract.
Third parties	The same responsibilities as for permanent staff apply to those working on behalf of the organisation, whether they are volunteers, students, work placements, contractors or temporary employees. Those working on behalf of, but not directly employed by, the organisation are required to sign a third party agreement outlining their duties and obligations.

CCG Member Practices	This policy should be followed where any member is processing information on behalf of or in relation to the CCG delivery of its functions. However it is recommended that similar policy standards are in place within each member practice regarding the management of its own data and information.
Managers	All staff with a management or supervisory role have a responsibility to ensure that all staff have been shown how to access this and related policy, supporting guidance and training.

6. Policy Standards

This policy document, as part of a suite of supporting Information Governance related policies, sets out the standards that those working for or on behalf of the CCG are expected to adhere to when handling data or information.

6.1 Accountability and Governance

The CCG will put in place suitable controls to:

- Assign responsibilities to oversee the delivery of standards set out in this policy
- Report compliance against Information Governance requirements to a suitable committee within the CCG
- Ensure that all staff have been made aware of their responsibilities, how to comply with them and have available advice and guidance and training to do so
- Ensure the consistency of information governance across the CCG;
- Develop information governance policies and procedures;
- Ensure compliance with the Data Protection Act, and other information security related legislation;
- Provide support to the Caldicott Guardian and Senior Information Risk Owner (SIRO).

6.2 Managing Information Risk

The CCG will put in place suitable mechanisms to ensure staff identify and manage information risks in line with existing risk management policy and processes. A failure to effectively implement information governance controls could lead to the following risks.

Risk	Example
Reputational Damage	• Making decisions based on inaccurate information could undermine any commissioning decisions which could then be challenged. This could have an effect on organisational reputation.
Financial Loss	• Loss of person identifying information could lead to financial penalties of up to £500,000. • Inefficient use of information may lead to duplication and wasted time.
Failure to comply with	• There are a number of legal requirements to manage information in addition to the Data Protection Act such as the Freedom of Information

legal, regulatory or NHS requirements	Act and the Public Sector Information Regulations 2015 which could also lead to reputational or financial loss • Failure to comply with the NHS Constitution, the NHS Care Records Guarantee or CCG Authorisation requirements could also have serious implications for the CCG.

The Information Asset Owners (IAOs) must ensure that information assets are regularly assessed for risk, in line with the CCG's Risk Management Policy and guidance. Results of risk assessments should be placed on risk registers and escalated as outlined in the Risk Management Policy and guidance.

6.3 Confidentiality

A duty of confidence arises when one individual discloses information to another where is expected that the information will be held in confidence.

This is:

- A legal obligation
- Established within professional codes of conduct
- A requirement within CCG employment and service contracts

Patient Confidentiality (NHS Confidential)

All patients, carers and staff should be able to expect that any information given to a member of staff within the CCG will be held in a secure and confidential manner and will not be divulged to others without their express permission except in the following circumstances:

- It is with the consent of the individual
- By law: the order of a court
- In the public interest including for the protection of a child
- For assuring and improving quality of care and treatment (e.g. clinical audit)
- For investigating complaints or potential legal claims
- For the purposes of direct care, relevant personal confidential data can be shared among the registered and regulated health and social care professionals who have a legitimate relationship with the individual (data subject).

Any member of staff who is in doubt their right to view confidential information should consult their Line Manager.

6.4 Staff Confidentiality (NHS Confidential)

Personal information about members of staff must be regarded as confidential at all times. This includes information such as:

- Illness
- Current or previous disciplinary procedures
- Employment references
- Personal living arrangements such as family life and sexuality
- Home address and telephone number

- Any other information which has been given in confidence

The Trust will ensure there are adequate procedures in place to protect against the unauthorised processing of information and against accidental loss, destruction and damage to this information. See the Information Security Policy.

6.5 Confidential business information (NHS Protect)

Information used for the planning and delivery of business services may be regarded as confidential. Although the majority of corporate information relating to the CCG is available under the Freedom of Information Act there may be certain exemptions to this. Where the release of the information would compromise the commercial interests of the CCG the information should not be released. For more information and guidance on the release of business information please discuss with the IG and FOI teams.

7. Disclosures of Information

This policy will formally adopt the guidelines set out Confidentiality: NHS Code of Practice (2003) by the Department of Health.

The CCG will follow the principles of information disclosure as laid down by the Confidentiality: NHS Code of Practice (2003). The Code is relevant to anyone working in and around health and social care. In particular it provides a steer on how to make decisions regarding the disclosure of NHS Confidential Information (Appendix 2)

7.1 Disclosures for Health and Social Care purposes

As a commissioner of services the CCG will not generally have a role in the day to day sharing of information to support direct care provision although it may facilitate data sharing agreements, for example, between parties from whom it commissions services and the GPs in its area. In circumstances where this is the case any collection and disclosure would be in line with this policy and be limited to:

- To NHS staff involved in the provision of healthcare (Limited to relevant persons only)
- To social workers or other non-NHS staff involved in the provision of healthcare (Limited to relevant persons only)
- Parents, i.e. those with parental responsibility for patients, and guardians
- To carers without parental responsibility to the extent necessary for care.

Particular attention should be given to:

Parents, i.e. those with parental responsibility for patients, and guardians

Those children competent to consent to treatment will be entitled to the same duty of confidence as adults, and their consent is required to disclose and use information. Staff should encourage those children to involve parents, particularly where making significant decisions. They should however respect the choice made. In situations involving refusal of treatment in life threatening situations, disclosure may be appropriate. See the consent to treatment policy for further information.

Carers without parental responsibility

Only information essential to a patient's care should be disclosed. Where this occurs patients should be made aware that this is the case. However, the explicit consent of a competent patient is needed before disclosing information to a carer. The best interests of a patient who is not competent to consent may warrant disclosure.

7.2 Disclosures for Audit and Investigation purposes

- Clinical audits should not normally require disclosure of Personal Confidential Data (PCD). Where this is deemed necessary, guidance should be sought from the relevant IG lead and the CCG Caldicott Guardian.

- Investigations may require the provider to have access to the relevant PCD, but ordinarily there should be no requirement to disclose this level of detail to the CCG.

7.3 Disclosures for non-healthcare provision but a medical purpose in legislation

There are a number of work activities that are required for the CCG to carry out its functions that are legally defined as a medical purpose.

In order to use or collect information for the activities listed below, in most cases reliance will be placed on obtaining explicit consent. Otherwise anonymised or pseudonymised data must be used instead. The purposes concerned are:

- Researchers

- Activities carried out by NHS managers and the Department of Health, e.g. commissioning, prescribing advisors, financial audit, resource allocation etc.

- Complaints processes

- Cancer registries (consent is usually sought however there is currently a legal gateway for such disclosure without consent)

It is not always practical to obtain this consent however unless there is a legal power that enables disclosure without consent in place (e.g. under the regulations made under Section 251 of the NHS Act 2006 or bodies with statutory investigative powers) the disclosure must not take place.

Anonymised or pseudonymised information may be used for CCG purposes as it is no longer identifying personal data. The NHS Number must not be used as the pseudonymised key as it can easily be used to identify individuals.

7.4 Disclosures unrelated to healthcare or another medical purpose

There are a number of other situations that may require information to be disclosed, where you would ordinarily **rely on consent to release** unless exceptional circumstances exist. Such examples include disclosures to:

- Religious persons e.g. chaplains or priests

- Non- statutory investigations, e.g. Members of Parliament

- Government departments (excluding the Department of Health for Healthcare purposes)

- The police

- The courts, including a coroner's court, tribunals and enquiries

- Sure Start Teams, Children's Centres or equivalent

- The Media

- Solicitors

7.5 Informing Individuals about the Uses of Their Information

The CCG will ensure compliance with Data Protection Act requirement to inform individuals about the use, including disclosure, of their information.

As a commissioner of health services, the CCG will need to ensure any flow of data from a provider is compliant with this requirement. This forms part of contractual obligations. As such the Health

Professional(s) involved in their care, will communicate any changes of use of personal information to the patient. Patients will either be informed verbally or in writing, depending on the nature of changes.

Staff will be informed by their line managers about the use of their information.

7.6 Information Assets & Register

Information should be seen and recorded as an asset, which can take many forms. For the purpose of this policy the key assets that CCG Information Asset Owners (IAOs) should be identifying are those which contain personal information (such as HR or patient information) and the electronic systems that store/ process the data within.

Software and non-portable hardware assets will be recorded by the NELCSU IT Service and staff will be recorded by Human Resources.

Once information assets (records or data) have been identified, the IAOs must log each on a local register and identify any associated assets along with the risks and corresponding controls.

Where suitable controls are not in place an action plan is to be agreed with the relevant IAO, IAA and IG Team on behalf of the SIRO to address any shortfalls and risks recorded on the corporate risk register.

7.7 Data/Information Classification

Information assets should be classified using the adapted NHS national classification scheme. *Previous to this policy all information assets were classified and marked according to the following terms:*

Marking	Description
NHS Confidential	This was appropriate for documents and files containing person-identifiable clinical or staff information given in confidence not for general disclosure. Access should be tightly controlled and restricted.
NHS Protect or Restricted	This applied to corporate records where the basic principles would be to handle with care, restrict disclosure and secure.
NHS Public	Any information which did not warrant being marked with one of the above classifications is to be marked NHS Public. These records should be considered to be open and routinely made available to the public.

Since April 2014 when Government security markings were reviewed, the replacement document markings have been as listed below. These do not apply retrospectively.

Marking	Description
NHS Official	All routine CCG business, operations and services should be treated as OFFICIAL. The subset categories of OFFICIAL-SENSITIVE: COMMERCIAL and OFFICIAL–SENSITIVE: PERSONAL should be used where applicable. Ordinarily NHS Official information does not need to be marked.
NHS Official-Sensitive	This marking is necessary for person-identifiable information and commercially sensitive information and is applicable to paper and electronic documents/records.
NHS Official-Sensitive: Commercial	Commercial information, including that subject to statutory or regulatory obligations, which may be damaging to the CCG, other NHS body or a commercial partner if improperly accessed.

NHS Official-Sensitive: Personal	Personal information relating to an identifiable individual where inappropriate access could have damaging consequences.

Where existing information is marked NHS Confidential it should be treated as NHS Official: Sensitive

NHS Official-Sensitive (including NHS Official – Sensitive: Commercial and NHS Official – Sensitive: Personal Information should be secured using the standards set out in this policy for as long as they are held until securely disposed of.

EXAMPLES OF USE OF NHS PROTECTIVE MARKINGS:

7.8 Information Security Incident Management

All staff are responsible for ensuring that any actual or potential Incidents are reported in line with the Islington CCG Incident Reporting Policy. This policy is relevant to actual or suspected breaches of confidentiality as outlined in the Islington CCG Information Security Policy.

8. Consent for Sharing Information

It is CCG policy that in all but exceptional cases (where law permits), individuals will be informed about and consent to their information being collected, used, stored and shared.

Everyone aged 16 or over is presumed to be competent to give consent for themselves unless the opposite is demonstrated. Those under 16 years old who have the capacity and understanding to make decisions about their treatment are also entitled to decide on the use of their personal information.

In the case of those without capacity, every effort should be made to obtain consent from the individual concerned or from an individual with legal responsibility for the care of that individual (e.g. parent or guardian).

Any decision to share information without consent must take into consideration the patient's best interests. As with consent to treatment, all such decisions should be documented.

8.1 For Health and Social Care purposes

It is impracticable to obtain explicit written consent of the patient every time that health care information needs to be shared with another health professional, or other staff involved in the health care of that patient. Consent in these instances can be implied provided that it is known and understood by the patient that such information needs to be made available to others involved in the delivery of their care.

Consent is required if the purposes for which the collection of the information changes.

In order to inform patients correctly, staff should:

- Check where practicable that information leaflets on patient confidentiality and information disclosure have been given to the patient, read and understood.
- Make clear to patients when information is recorded or health records are accessed including who they will be disclosing information to.
- Check patients are aware of choices of how their information may be disclosed and used, checking to see if they have any concerns or queries.
- Answer any queries personally or direct the patient to others who can answer their questions.
- Respect the right of patients including their right to have access to their health records.

8.2 Non healthcare disclosures

Many proposed uses of confidential patient information do not directly contribute to or support the healthcare that a patient receives. It cannot be assumed that patients will consent for their information being used in these ways.

Unless there is a legal requirement to disclose without consent, the following should take place:

- Individuals are asked before their personal information is used in ways that do not directly contribute to or support the delivery of their care
- Respect individuals decisions to restrict the disclosure or use of their information except where exceptional circumstances apply (see appendices E to G)

8.3 Withholding consent

In some cases, it may not be possible to restrict information disclosure without compromising care. This should be discussed with the patient, explaining fully the consequences of refusal.

It is essential that complete records are kept of all care provided and of any restrictions placed on disclosing information by patients. If patients impose constraints, it is important to demonstrate that neither patient safety, nor clinical responsibility for healthcare provision, has been neglected.

8.4 Disclosures in the Public Interest

In certain exceptional circumstances an individual's right to confidentiality may be overridden by the public's interest in having access to the information, for example where it may prevent or detect serious crime.

Such decisions must not be taken be taken lightly, and should be made by the health care professional concerned. This should occur following consultation with fellow practitioners and with their line manager.

Advice and guidance may also be obtained from the Information Governance team or the CCG Caldicott Guardian who may in turn seek legal advice.

All decisions should be appropriately documented and kept on an individual's file.

8.5 Investigation of Complaints

Implied consent can be applied in the use of a patient's personal information to investigate a complaint. This only applies to information relevant to the investigation of the complaint and only disclosed to those people who have a demonstrable need to know it for the purpose of investigating the complaint or incident.

It must be explained to the patient that information from their health records may need to be disclosed to the manager handing the complaint, to clinical assessors, and any others likely to access the information. If the patient objects to this, then the effect on the investigation will need to be explained. The patient's wishes should always be respected unless there is an overriding public interest in continuing with the matter.

Where a complaint is made on behalf of a patient who has not authorised someone to act for them, care must be taken not to disclose personal health information to the complainant, unless the patient has expressly consented to its disclosure.

9. Caldicott Compliance

It is important to minimise the amount of information to only that which is absolutely required. It is important to consider how much information is needed before disclosing it. When seeking to share information, it is important to:

- Justify the purpose
- Not use patient identifiable information unless it is absolutely necessary;
- Use the minimum necessary patient identifiable information;
- Ensure that access to patient identifiable data and information occurs on a strict 'need to know' basis;
- Be aware of all relevant policies and their responsibilities
- Understand and comply with the Law
- Remember the duty to share can be as important as the duty to protect patient confidentiality. (for direct patient care)

10. Anonymisation and pseudonymisation

It is recognised that the CCG is required to manage and plan services; this will be considered a secondary use of information and requires consent to process. It is therefore expected that such information will be either anonymised or pseudonymised in order to allow this use to take place without identifying the individual concerned.

Anonymisation itself does not allow long term management and planning therefore pseudonymisation will be the preferred option which will mean. All systems will be required to:

1. Provide a unique pseudonymisation key that a recipient would only be able to re-identify by returning to the organisation
2. Remove Demographics and provide the following:
    a. Age instead of date of birth
    b. The first half of postcode a postcode (and up to the first character of the second half)
    c. lower Superannuated output area (if possible)
3. Conduct a risk assessment to identify the likelihood of re-identification based upon the information contained within the data, the potential information the recipient has and what is also available in the public domain in line with Anonymisation Standard for Publishing Health and Social Care Data

11. Sharing of Personal Information & Transfer of data/information

The transfer of any information using the previous classifications of NHS Confidential or NHS Protect or Restricted information must:

1. Be reviewed and a lawful basis established to transfer it
2. Follow the principles and underpinning guidance to maintain the security of the information in transit.

11.1 Data Flow Mapping

Routine transfers should be logged regardless of size to allow review of security procedures in place and compliance with Information Governance requirements. The CCG's Information Asset Owners (IAOs) are required to identify and log the routine transfers of data that will take place including

- Lawful basis
- Use of approved method
- Volume
- Frequency
- Risks
- Compensating controls

11.2 Information Sharing Agreements

The CCG will enter into information sharing agreements with relevant organisations to formally document routine transfers of information. It will include details about what will be shared, when, why and what the legal justification for disclosure is.

Where the request is to be reviewed and signed by specific individuals for example the Caldicott Guardian; it is the CCGs position that it will be the responsibility of the Service Manager disclosing or receiving the information to review and sign. The Service manager will be supported by the Information Governance Team and the Caldicott Guardian if required.

Additional guidance will be provided to ensure any agreements contain suitable information and controls.

11.3 Methods of Information exchange/sharing

Once and appropriate basis for sharing information has been identified, a secure method should be chosen that complies with this and other relevant policies.

11.4 Sharing Information by Phone

Staff member must:

- Confirm the name, job title, department and organisation of the person requesting the information;
- Confirm the reason for information request if appropriate;
- Take a contact telephone number, for example, the main switchboard number;
- Check whether the information can be provided. If in doubt, tell the enquirer you will call them back;
- Provide the information only to the person who has requested it and not for example leave such information in the form of a message; and

- Ensure that keep a record of the date and the time of disclosure, the reason for it and who authorised it. Also record the recipient's name, job title, organisation and telephone number.

11.5 Sharing PCD Information by Post

When sharing information by post, the staff member must:

- Confirm the name, department and address of the recipient;
- Seal the information in a robust envelope;
- Mark the envelope 'Private & Confidential – to be opened by Addressee only';
- When appropriate, send the information by Recorded Delivery; and
- When necessary, ask the recipient to confirm receipt.

11.6 Transporting Information

Information must be secure at all times and not left visible to others.

11.7 Sharing PCD Information by Fax

The CCG will make available guidance on how to securely exchange information however will specifically discourage the use of faxes to transfer information unless absolutely necessary and must.

- Telephone the recipient of the fax to let them know they are going to send information;
- Ask them to acknowledge receipt of the fax;
- Double check the fax number; (test if it's not been used before)
- Use a fax cover sheet states who the information is for, and mark it 'Private & Confidential'; and
- Ask the recipient to confirm safe receipt
- If appropriate, request a report sheet to confirm that transmission was OK.

12. Training requirements

Information Security is fundamental in everyone's training, and therefore will form part of mandatory training. This will be reviewed and documented within the IG training needs analysis and delivery plan, to ensure it meets the relevant job roles within this policy.

13. Relationship with Service Providers

As a commissioner of clinical and support services the CCG will ensure that any organisations from which buy's services from meets expected information governance standards.

13.1 Clinical Services

All clinical services commissioned by or on behalf of the CCG will be required to:

- Have a suitable contract in place to form a joint data controller relationship in relation to the information required to effectively monitor commissioned services
- Ensure the services commissioned meet the requirements of the Data Protection Act when providing services including, but not limited to fair processing, maintaining a registration with the Information Commissioners Office
- Complete the annual Information Governance Toolkit and undertake an independent audit to be disclosed to the CCG on request in order to provide assurance they have met expected requirements.

- Ensure privacy notices make individuals aware of a CCGs role in commissioning and the personal and sensitive data it may receive to undertake such a role
- Ensure that where any IG incidents occur that they are reported to the CCG via routes determined within the contract
- Ensure the contract stipulates sufficient security controls to meet or exceed requirements set out in this policy.

13.2 Support services

All support services that process information on behalf of the CCG will be required to ensure:

- The contract stipulates sufficient security controls to meet or exceed requirements set out in this policy. This should be in the relevant standard NHS contract.
- A suitable contract is in place to form a Data Controller to Data Processor relationship where Personal or Personal Sensitive data is managed on behalf of the CCG.
- Ensure the services commissioned meet the requirements of the Data Protection Act when providing services including, but not limited to, fair processing and maintaining a registration with the Information Commissioners Office
- Completion of the annual Information Governance Toolkit and undertake an independent audit to be disclosed to the CCG on request to provide assurance they have met expected requirements.
- That any new processing is within the remit of the contract or seek written confirmation if there is any ambiguity
- Report any known incidents or risks in relation to the use or management of information owned by the CCG

14. Equality and Diversity

As part of its development, this policy and its impact on staff, patients and the public have been reviewed in line with expected Legal Equality Duties. The purpose of the assessment is to improve service delivery by minimising and if possible removing any disproportionate adverse impact on employees, patients and the public on the grounds of protected characteristics such as race, social exclusion, gender, disability, age, sexual orientation or religion/belief.

The equality impact assessment has been completed and has identified impact or potential impact as “minimal impact”.

15. Dissemination and Implementation

This policy will be made available to all relevant stakeholders via the CCG internet site. Additionally they will be made aware via email and this policy will be included for reference where necessary.

The policy will be supported by additional related policies and resources to support implementation. This will include the availability of, and access to, written and verbal advice, guidance and procedures where necessary.

16. Non-conformance with this Policy

Should it not possible to meet the requirements within this policy and associated guidelines this must be brought to the attention of the department’s Information Asset Owner. Any issues will need to be documented as a risk and either:

a. Accepted and reviewed in line with this policy
b. Accepted with a view to implementing an action plan to reduce the risk

c. Not accepted and the practice will stop until such time as the risk can be reduced

Failure to comply with the standards and appropriate governance of information as detailed in this policy, supporting protocols and procedures can result in disciplinary action. All staff are reminded that this policy covers several aspects of legal compliance that as individuals they are responsible for. Failure to maintain these standards can result in criminal proceedings against the individual. These include but are not limited to:

- Common law duty of confidentiality
- Computer Misuse Act 1990
- Data Protection Act 1998
- Freedom of Information Act 2000
- Human Rights Act 1998
- Public Records Act 1958
- Health & Social Care Act 2012

17. Monitoring and Review

Performance against the policy will be monitored against

- Availability and dissemination of policy, including in alternative formats where requested or need identified
- Acceptance and understanding of audience (training, spot checks, surveys)
- Reports of non-conformance i.e. incidents or risks
- Compliance against the Information Governance Toolkit

This policy will be reviewed every 2 years and in accordance with the following on an as and when required basis:

- Legislative or case law changes;
- changes or release of good practice or statutory guidance;
- identified deficiencies, risks or following significant incidents reported;
- Changes to organisational infrastructure.

17.1 Monitoring of individuals

In order to ensure compliance with the Law, organisational policies; including this one, the CCG reserves the right to monitor usage and content where it suspects that there has been a breach of policy. The Regulation of Investigatory Powers Act (2000) permits monitoring and recording of employees' electronic communications (including telephone communications) for the following reasons:

- Establishing the existence of facts
- Investigating or detecting unauthorised use of the system
- Preventing or detecting crime
- Ascertaining or demonstrating standards which are achieved or ought to be achieved by persons using the system (quality control and training)
- In the interests of national security

- Ascertaining compliance with regulatory or self-regulatory practices or procedures
- Ensuring the effective operation of the system.

In addition, communications may be monitored (but not recorded) for the purpose of checking whether those communications are relevant to the purpose of the CCG's business, and the employee's position with the CCG. Any monitoring will be undertaken in accordance with the above act and the Human Rights Act.

This will include the use or access to any Network or where the property of the Organisation is used in the communication or is accessed remotely from outside the Organisation. This includes the use of portable computers and mobile devices, including mobile phones issued to the employee by the Organisation.

18. Compliance Standards

- Common law duty of confidentiality
- Computer Misuse Act 1990
- Data Protection Act 1998
- Freedom of Information Act 2000
- Human Rights Act 1998
- Public Records Act 1958

APPENDICES

Appendix A. Evaluation protocol

Monitoring requirements 'What in this document do we have to monitor'	The management of information risks (Information Risk Management) Compliance with the law Compliance with the Information Governance Toolkit Incidents related to the breach of this policy Destruction of Information Assets Registration of Data Flows and Information Assets Compliance with Registration Authority Terms and Conditions Network Penetration testing Monitoring of inappropriate access to systems (where possible)
Monitoring Method	Information Risks will be monitored through the Risk Register and management system. Compliance with law will be monitored through audit, work directed by the Information Governance Toolkit and as directed by the SIRO The Information Governance Toolkit will be monitored by assessment of evidence against the objective of the relevant requirement. In addition, the IGT will be audited by the organisation's internal audit function before the annual submission. Incident reporting and management requirements
Monitoring prepared by	The CSU Information Governance Team and the CCG IG Lead for the relevant groups Incident reports will be produced by the nominated investigation officer
Monitoring presented to	Relevant CCG committees or groups with oversight of Information Governance Senior Information Risk Owner Caldicott Guardian
Frequency of Review	Yearly updates will be provided to the relevant groups, the SIRO and the CG Relevant Information Risks will be added to the Corporate Risk Register and reported in line with Risk Management system Annual (as a minimum) updates to the Board will be provided. The internal audit report on IGT performance will be provided to the Board or delegated sub-committee. Incident Reports will be reviewed on an annual basis and as directed by the seriousness of the incident

Appendix B. Equality and Equity Impact Assessment

This is a checklist to ensure relevant equality and equity aspects of proposals have been addressed either in the main body of the document or in a separate equality & equity impact assessment (EEIA)/ equality analysis. It is not a substitute for an EEIA which is required unless it can be shown that a proposal has no capacity to influence equality. The checklist is to enable the policy lead and the relevant committee to see whether an EEIA is required and to give assurance that the proposals will be legal, fair and equitable.

The word proposal is a generic term for any policy, procedure or strategy that requires assessment.

	Challenge questions	**Yes/ No**	**What positive or negative impact do you assess there may be?**
1.	Does the proposal affect one group more or less favourably than another on the basis of:	No	
	▪ Race		
	▪ Ethnic origin (including gypsies and travellers, refugees & asylum seekers)		
	▪ Nationality		
	▪ Gender		
	▪ Culture		
	▪ Religion or belief		
	▪ Sexual orientation (including lesbian, gay bisexual and transgender people)		
	▪ Age		
	▪ Disability (including learning disabilities, physical disability, sensory impairment and mental health problems)		
2.	Will the proposal have an impact on lifestyle? (e.g. diet and nutrition, exercise, physical activity, substance use, risk taking behaviour, education and learning)	No	
3.	Will the proposal have an impact on social environment? (e.g. social status, employment (whether paid or not), social/family support, stress, income)	No	
4.	Will the proposal have an impact on physical environment? (e.g. living conditions, working conditions, pollution or climate change, accidental injury, public safety, transmission of infectious disease)	No	
5.	Will the proposal affect access to or experience of services? (e.g. Health Care, Transport, Social Services, Housing Services, Education)	No	

An answer of 'Yes' to any of the above question will require the Policy lead to undertake a full Equality & Equity Impact Assessment (EEIA) and to submit the assessment for review when the policy is being approved.

Appendix C. Definitions

Term	Definition	Source
Data	Data is used to describe 'qualitative or quantitative statements or numbers that are assumed to be factual, and not the product of analysis or interpretation.'	Definition taken from The Information Governance Review, Mar 2013 (Gateway Ref: 2900774)[1] based on the Cabinet Office definition
Information	Information is the 'output of some process that summarises interprets or otherwise represents data to convey meaning.'	Definition taken from The Information Governance Review, Mar 2013 (Gateway Ref: 2900774)
Personal Confidential Data or PCD	This term describes personal information about identified or identifiable individuals, which should be kept private or secret. For the purposes of this review 'personal' includes the Data Protection Act definition of personal data, but it is adapted to include dead as well as living people and 'confidential' includes both information 'given in confidence' and 'that which is owed a duty of confidence' and is adapted to include 'sensitive' as defined in the Data Protection Act.	Definition taken from The Information Governance Review, Mar 2013 (Gateway Ref: 2900774)

[1] See https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/192572/2900774_InfoGovernance_accv2.pdf,

Appendix D. Confidentiality and Information Sharing - Quick Reference Guide

This summary is intended to be a helpful reminder for all employees. It is not intended to be a comprehensive list of user responsibilities and does not reduce or alter the standards or principles in the Confidentiality and Information Sharing Policy.

All Staff should:

Understand what is

1. NHS Official- Sensitive; NHS Official- Sensitive: Commercial NHS Official- Sensitive: Personal marked information

1. Treat NHS Official- Sensitive; NHS Official- Sensitive: Commercial NHS Official- Sensitive: Personal information in the strictest of confidence.

2. Store all NHS Official- Sensitive; Commercial: Personal securely to prevent unauthorised access,

    a. Manual (Paper information) should, for example, be locked away when unattended

    b. Electronic information should be in systems with restricted access (Based upon user rights)

    c. Information on portable media/devices must be encrypted

    d. Destroy all out of date information securely

3. Unless justified and for the healthcare only use or disclose information that wouldn't identify the individual. I.e. anonymised/pseudonymised information.

4. Only give information to those individuals who need-to-know that information, and have a legitimate right to receive it.

5. Ensure that all information received from, or sent to, another individual is secure in transit, whether the information is sent manually or electronically.

6. Maintain secrecy of computer passwords and security codes to locked areas.

7. Always log off or lock your information away before leaving your desk. (Computers or cupboards)

8. Be vigilant of where conversations take place to prevent unintentional disclosure of information through overheard conversations.

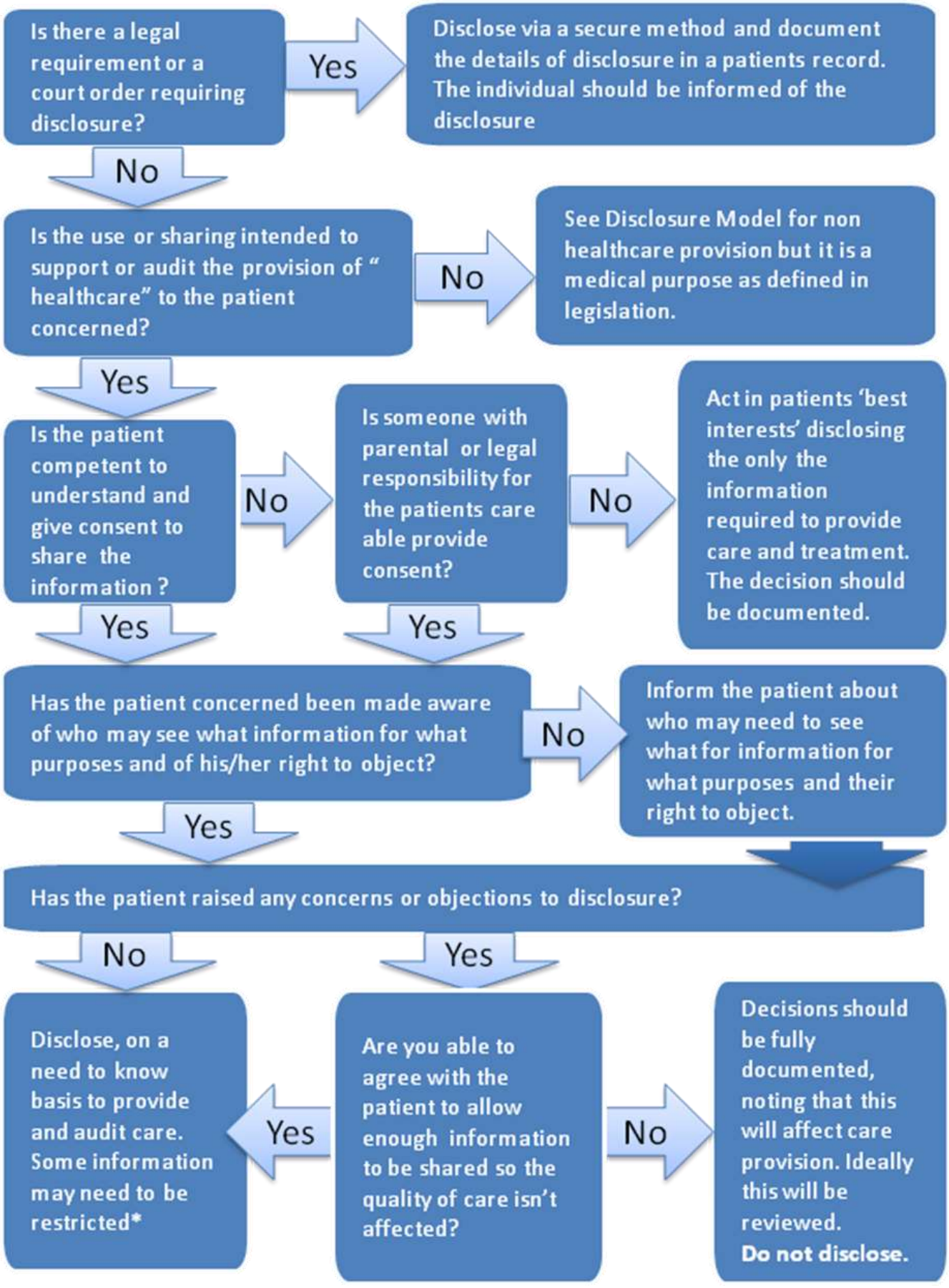
9. Never give person identifiable information over the telephone to an incoming caller without confirming the identity of caller and legitimacy of request.

10. Ensure you are aware of current local and national policies and procedures relevant to your job role.

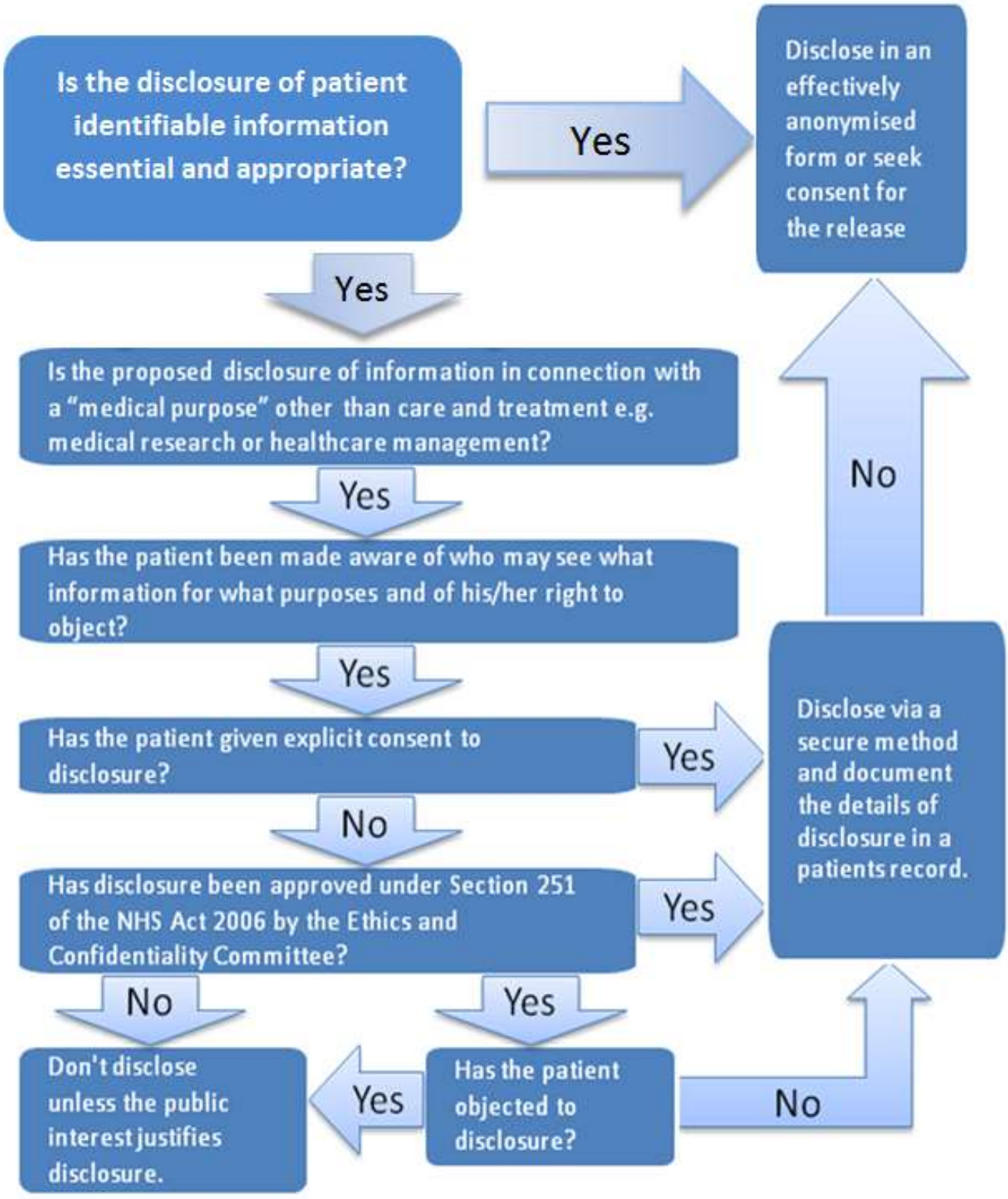
For further information, please contact the Information Governance Team.

PLEASE DESTROY ALL PREVIOUS VERSIONS OF THIS DOCUMENT

Appendix E. Disclosure Model where it is proposed to share confidential information in order to provide healthcare.



Appendix F. Disclosures for non-healthcare provision but a medical purpose in legislation.



Appendix G. Disclosures unrelated to healthcare or another medical purpose.