

Information Sharing Every Day in Health & Social Care

The Information Sharing Every Day in Health & Social Care partners are:

East and North Hertfordshire NHS Trust

Hertfordshire Partnership University NHS Foundation Trust

East and North Hertfordshire Clinical Commissioning Group

Herts Valleys Clinical Commissioning Group

Hertfordshire Community NHS Trust

West Hertfordshire Hospitals NHS Trust

Essex County Council

West Essex Clinical Commissioning Group

Information Sharing Every Day in Health & Social Care

Contents

A Quick Reference Guide to the Seven Golden Rules of Information Sharing	2
Introduction	2
Myth-busting	3
Personal information collected by one organisation cannot be disclosed to another organisation	3
The Data Protection Act 1998 is a barrier to sharing information	4
Consent is always needed to share personal information	4
Flowchart of when and how information is shared	5
Information Sharing Case Studies	6
Scenario 1: Sharing information where there is possible abuse of a child with learning disabilities	6
Scenario 2: Sharing confidential information in a case of underage sex	6
Scenario 3: Sharing Information with the Looked after Children Health Team	7
Public Interest Disclosures	8
Sharing Information for Indirect Care	11

Information Sharing Every Day in Health & Social Care

A Quick Reference Guide to the **Seven Golden Rules** of Information Sharing

- 1. Remember that the Data Protection Act is not a barrier to sharing information** but provides a framework to ensure that personal information about living persons is shared appropriately.
- 2. Be open and honest** with the person (and/or their family where appropriate) from the outset about why, what, how and with whom information will, or could be shared, and seek their agreement, unless it is unsafe or inappropriate to do so.
- 3. Seek advice** if you are in any doubt, without disclosing the identity of the person where possible.
- 4. Share with consent where appropriate** and, where possible, respect the wishes of those who do not consent to share confidential information. You may still share information without consent if, in your judgement, that lack of consent can be overridden in the public interest. You will need to base your judgement on the facts of the case.
- 5. Consider safety and well-being:** Base your information sharing decisions on considerations of the safety and well-being of the person and others who may be affected by their actions.
- 6. Necessary, proportionate, relevant, accurate, timely and secure:** Ensure that the information you share is necessary for the purpose for which you are sharing it, is shared only with those people who need to have it, is accurate and up-to-date, is shared in a timely fashion, and is shared securely.
- 7. Keep a record** of your decision and the reasons for it – whether it is to share information or not. If you decide to share, then record what you have shared, with whom and for what purpose.

Introduction

This booklet had been produced by the Health & Social Care Partners within Hertfordshire; the target audience is health & social care professionals and other staff working in this setting that have a duty to share patient information as part of their work activity, this maybe within the direct care team or further afield.

Sharing information between practitioners and organisations is essential for getting the right care to the right person when they need it. Fears about sharing information should not stand in the way of the need to safeguard and promote the welfare of adults, children and young people at risk of abuse or neglect.

There are many useful guides already available; however this booklet aims to capture the key points in one central place. You may also want to look at the following guides:

- [Information Sharing: Advice for Practitioners providing safeguarding services to children, young people, parent and carers, HM Government \(March 2015\)](#)
- [Working Together to Safeguard Children \(2015\)](#)

Information Sharing Every Day in Health & Social Care

- [A Guide to Confidentiality in Health & Social Care produced by the Health & Social Care Information Centre \(2013\)](#)
- [Confidentiality NHS Code of Practice, Supplementary Guidance: Public Interest Disclosures \(2010\)](#)
- [Centre of Excellence on Information Sharing](#)

Myth-busting¹

Personal information collected by one organisation cannot be disclosed to another organisation

This is not the case, health & social care organisations are legally obliged to share information with each other for direct care² of adults.

In the case of a child or young person at risk of harm, the Children Acts 1989 and 2004 also encourage information sharing between professionals.

It is important to remember that sharing for direct care can take place across departmental and *organisational* boundaries and the direct care³ team may include:

- Doctors
- Pharmacists
- Physiotherapists
- Nurses, Midwives
- Occupational therapists
- Social care staff
- Others on a regulated professional register
- Administrative staff who support care provision

¹ [Information Sharing: Advice for Practitioners providing safeguarding services to children, young people, parent and carers, HM Government, March 2015](#)

² Health & Social Care (Safety & Quality) Act 2015, Section 251B

³ The term 'direct care' is defined as a clinical, social or public health activity concerned with the prevention, investigation and treatment of illness and the alleviation of suffering of an individual (all activities that directly contribute to the diagnosis, care and treatment of an individual. It **does not** include research, teaching, financial audit, service management activities or risk stratification. [A Guide to Confidentiality in Health & Social Care produced by the Health & Social Care Information Centre, 2013](#)

Information Sharing Every Day in Health & Social Care

The Data Protection Act 1998 is a barrier to sharing information

The Data Protection Act 1998 provides a framework to ensure that personal information about a living individual is shared appropriately. In particular, the Act balances the rights of the person and the need to share information about them.

Never assume sharing is prohibited – it is essential to consider this balance in every case.

Consent is always needed to share personal information

You do not necessarily need the consent of the individual to share their personal information.

Wherever possible, you should seek consent or be open and honest with the individual from the outset as to why, what, how and with whom, their information will be shared.

You should seek consent where an individual may not expect their information to be passed on and where they have a genuine choice about this. Their wishes should be respected about who their information is shared with unless there is an overriding public interest.

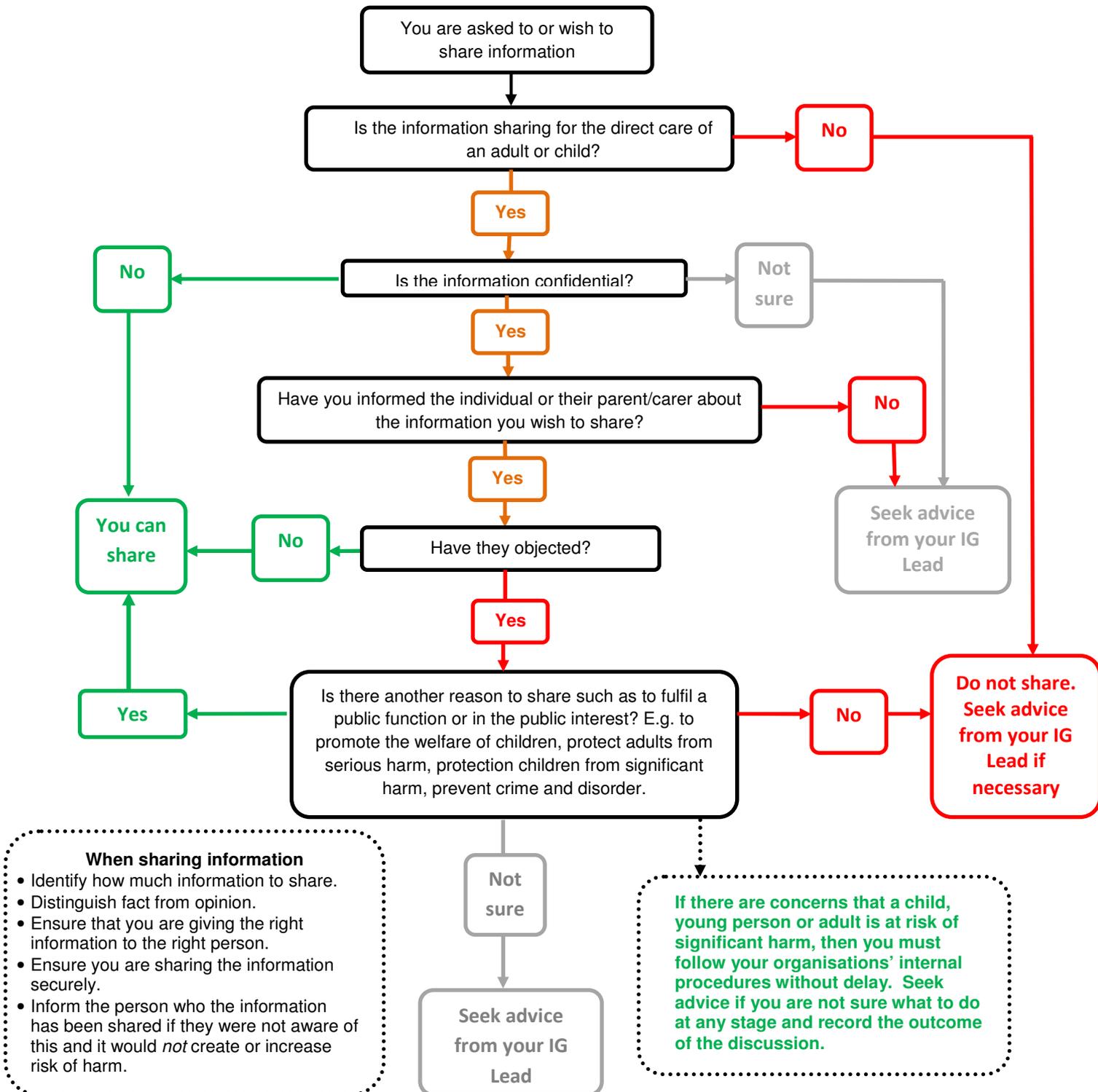
Consent isn't needed if it would:

- place a child at increased risk of significant harm; or
- place an adult at increased risk of serious harm; or
- prejudice the prevention, detection or prosecution of a serious crime; or
- lead to unjustified delay in making enquiries about allegations of significant harm or serious harm.

If in doubt, please seek advice from your Caldicott Guardian and Information Governance Lead.

Information Sharing Every Day in Health & Social Care

Flowchart of when and how information is shared⁴



⁴ Based on flowchart in [Information Sharing: Advice for Practitioners providing safeguarding services to children, young people, parent and carers.](#) HM Government, March 2015

Information Sharing Case Studies

Please note: all case studies are fictional.

Scenario 1: Sharing information where there is possible abuse of a child with learning disabilities

Helen, aged seven, has a severe learning disability and has very little verbal communication. She is admitted to the children's ward for planned surgery to her legs.

During the admissions process it is noticed that she has some bruising to her legs and thighs. The admitting doctor asks Helen how this has happened. The doctor and Helen are not easily able to communicate and the doctor is not able to determine how the bruises have occurred.

The mother says that Helen has just come back from respite care, that she always comes back in a state and she is considering not sending her any more. The mother has three other children and needs this support to give her a break from her caring responsibilities.

The doctor decides to discuss the bruising with Helen's consultant paediatrician and seek their opinion on how the bruises may have been caused. The consultant is worried about the cause of the bruising and seeks the mother's consent to share her concerns with children's social care. The mother says that does not want to involve them because she is worried that Helen would not be able to continue to have the same level of respite care.

The consultant decides to override the mother's lack of consent but informs her that she intends to share information with children's social care because she is concerned that Helen may be at risk of harm when she is placed in respite care. Children's social care together with the police and the consultant will need to consider how best to respond to these concerns, keeping an open mind about the possible cause and who, if anyone, might be responsible for the bruising.

Scenario 2: Sharing confidential information in a case of underage sex

Natasha attends the local genito-urinary clinic with her friend Trina as she has symptoms of a sexually transmitted infection (STI) and she doesn't want to go to her family GP. Natasha says she is 14 years old but the health practitioner thinks that she looks younger. Natasha says she has been having a sexual relationship with her boyfriend for about three months but refuses to give any information about him, she says she is very happy with the relationship and does not feel coerced into doing anything against her will. She says she has not told her boyfriend that she has come to the clinic as she wants to find out if there is a problem first, and she does not want her parents to know anything at all. The health practitioner discusses the situation with the named nurse for safeguarding, but they are unable to persuade Natasha to involve her parents and decide on balance that Natasha is capable of giving consent to treatment for her STI. The health practitioner also offers advice about sexual health and contraception. As the tests show Natasha has an STI the health practitioner encourages her to tell her boyfriend as he will need treatment too and Natasha agrees to do so.

However at this point and given the concerns with regards to Natasha's age and recent health diagnosis it would also be appropriate to consider further sensitive inquisitive questioning regarding the nature of Natasha's relationship with her "boyfriend". Depending

on Natasha's answers, (or indeed her reluctance to disclose any further information) professionals should consider speaking with Natasha's GP or indeed children's services to gather further information allowing all parties to possibly ascertain a more accurate picture of Natasha's circumstances. This action could uncover the fact that Natasha's "boyfriend" is actually much older than her, and that she is subject to both duress and indeed elements of Child Sexual Exploitation (CSE).

Some months later Natasha returns to the clinic with further symptoms, the health practitioner notices that her physical appearance has deteriorated; she appears to have lost weight and she has some faded bruises round the left side of her face. On examination Natasha is found to be pregnant as well as having a different STI than previously. Natasha still refuses to have her parents involved and says she wants a termination of her pregnancy. The health practitioner comments on her bruises and Natasha becomes agitated and says she will come back later for treatment and wants to leave the clinic.

The health worker persuades her to stay and discovers that Natasha is upset because she has discovered that her boyfriend has other girlfriends, he has been seen in his car with girls from his workplace, and has tried to persuade her to have group sex with his friends.

Natasha says she walked into a door and bruised her face. From this the health worker concludes that Natasha's boyfriend is probably a lot older than her if he is working and driving, that he is also trying to coerce her into sexual activity that she is unhappy about and may have been violent towards her.

The health worker in conjunction with the named nurse for safeguarding decide that they must make a referral to children's social care and the police as they are concerned that Natasha is at risk of significant harm and subject to Child Sexual Exploitation. They believe that Natasha's boyfriend may be violent towards her and committing an offence in having a sexual relationship with a young person her age.

However given the information within the 1st paragraph of this case study, inquisitive questioning and a timely referral to children's services at this earlier stage could arguably have prevented both the continued abuse by this individual and the deterioration in both Natasha's emotional and physical wellbeing.

Scenario 3: Sharing Information with the Looked after Children Health Team

Dan (aged 18) was a looked after child who has been in care for the previous 2 years following a breakdown in relationships at home. He presented with some emotional and behavioural issues which were challenging for his carers and for services as he would often present in crisis and then disengage from services. He had been referred to CAMHS three times in the previous 5 years. He was also known to Children's Services prior to coming into care and the family had been supported by TYSS at various points. Dan had a diagnosis of ADHD and was seen for regular reviews in CAMHS and would often stop taking his medication.

When Dan turned 18 (and became a care leaver) he was also discharged from CAMHS, at this point he had not been engaging. There was no further referral regarding his mental health as he did not meet threshold for adult services. 3 months after Dan turned 18 he had largely become unknown to agencies and had moved to a neighbouring county and was sofa surfing with what appeared to be some unsavoury and even sinister characters. Due to

frequent changes of address he was not always registered with a GP and there was no regular monitoring of his physical or mental health. Six months later Dan was involved in a fatal assault.

At the time when Dan was open to services, many teams were not distinguishing LAC on their systems and therefore no formal processes were in place regarding the sharing of information. Had medical information been shared by all agencies with the LAC Health Team they would have been able to have had a key role in bringing health information together and also to facilitate GP registration which may have enabled him to receive regular medication follow ups, monitoring of his physical health and continuation of support following discharge from CAMHS. Professionals' appeared to crisis manage Dan's mental health state however little consideration was given to his overall health which resulted in a lack of support and after care and he largely disappeared from view. Looked after young people like Dan are especially vulnerable and effective communication between services is vital in order to support their needs.

Public Interest Disclosures

Is there sufficient public interest to share the information?

Under a common law duty of confidentiality, you are permitted to disclose personal information to:

- prevent and support detection, investigation and punishment of serious crime, and/or
- prevent abuse or serious harm to others

Wherever possible the issue of disclosure should be discussed with the individual concerned seeking their consent. Where the individual refuses, they should be told of any decision to disclose against their wishes. This will not be possible in certain circumstances, e.g. where the likelihood of a violent response is significant or where informing a potential suspect in a criminal investigation might allow them to evade custody, destroy evidence or disrupt an investigation.

As with any information sharing decision, it is essential that you record your decision so that there is clear evidence of the reasoning and the circumstances prevailing. Disclosures in the public interest should also be proportionate and be limited to relevant details.

Scenario 4:

A receptionist at a GP surgery sees a patient leave the building and get into a car. On driving from the car park, the patient's car collides with and damages another patient's car. The driver does not stop, believing that nobody has seen the incident and instead drives away without leaving their details. Through her role at the surgery, the receptionist knows the identity of the patient.

Can the receptionist report the crime? What details can the receptionist provide about the accident and the driver?

Decision 4:

A minor crime has been committed, but no serious crime or serious harm done. Therefore there is insufficient public interest (or any other) justification for revealing confidential patient information (e.g. from within the patient's case notes or even reveal that the patient had attended the surgery). However, a crime has been committed and the receptionist would be entitled to report the incident, including the identity of the patient, to the police, but (s) he should not reveal confidential patient information.

Scenario 5:

In one evening, at separate times, two patients enter an Accident & Emergency Department. Each of the patients has been a victim of a knife crime. Both patients report that they have been attacked by an individual and both describe what seems to be the same person. The patients claim that the attacks were unprovoked and that they did not know the attacker. The attacks happen within a mile of each other in a busy city centre. One of the patients is happy to speak to police and informs A & E staff of this.

However, the other victim does not wish to have his information disclosed to the police because he does not want to be a police witness. He leaves before the police are called out.

Should the A & E staff report both incidents to the police? Should the identity of the patients and the details of the injuries be reported?

Decision 5:

It is generally accepted that the reporting of knife and gun crimes will be within the public interest. A & E units should have standard procedures for informing the police that a knife crime has occurred. It should also be standard practice for staff to seek patient consent to involve the police. A knife attack may be sufficient to justify a public interest disclosure of confidential information even when consent is not given, where it is likely to assist in the prevention, detection or prosecution of a serious crime. Staff should ensure that they consider the proportionality of any disclosures. In this example, police could be called to interview the first patient, who could then be expected to identify himself, and provide a description of the attack and the attacker, and of his injuries. If the patient refused to provide some of these details, the hospital could provide them.

For the second patient, it is likely to be proportionate to provide the police with details of the patient, the attacker, the attack and the patient's injuries.

Scenario 6:

One day during surgery hours a consultant notices Mr Smith arrive, park his car and enter the building. Mr Smith had attended an appointment in the previous month with his consultant Psychiatrist. At a previous appointment, the Psychiatrist had prescribed Mr Smith with drugs and informed him that they were likely to make him drowsy, and that he should avoid driving. During the consultation Mr Smith had assured his consultant that he'd "be fine!" when accepting the prescription, he knows

Mr Smith well, and that he might ignore advice not to drive, and so has some concern over whether Mr Smith was fit to drive.

What action should his consultant take?

Decision 6:

In principle, Mr Smith could cause serious harm to others by continuing to drive.

His consultant should speak to Mr Smith and try to establish whether his medication is having the effect of making him drowsy and unfit to drive, and if so, to encourage him once more to stop driving. Discussion with colleagues may assist the Psychiatrist in assessing the risk posed to the public from the effect of Mr Smith's medication, and in weighing up whether a breach of confidence is justified. If Mr Smith is unfit to drive but nevertheless persists in driving, it would be justifiable in the public interest to inform the Driver and Vehicle Licensing Agency.

Scenario 7:

Following a series of complaints to a Member of Parliament from local residents, all of whom suffer from a particular disease and live close to a nuclear power station, a project is set up to investigate whether the proximity to the power station could contribute to the onset of the disease.

The investigation team from the Public Health Observatory seeks access to confidential information within approximately two thousand paper case notes in Newtown Hospital Trust in order to discover the prevalence of relevant symptoms. The team argues that it is not feasible to seek consent from patients within the timescales of the enquiry and that their work can be justified in the public interest.

Decision 7:

The Newtown Hospital Trust Caldicott Guardian considers that the risk of serious harm is not sufficient to breach the confidence of thousands of patients. However, she feels there is a strong public interest in the investigation. In order to minimise the potential detriment caused, she offers to assist the investigation by providing local clinical coding staff to extract relevant data from the case notes and provide it to the investigation team. Nevertheless, the data to be provided could still reveal patient identity, and so she instructs the investigation team that the information provided must be stored and processed securely, and that no identifiable patient information will be published without explicit patient consent.

Scenario 8

A hospital social worker is allocated to ensure an elderly patient recovering from a fall can return to her home. The patient is away from the ward at the time of the visit. The social worker needs to understand whether there are any mobility issues which contributed to the fall and whether a further assessment is needed in the home in order to initiate provision of adaptations to the home or additional mobility aids.

She speaks to the ward staff who are helpful and show her the current notes which includes a physiotherapist's report. The ward staff are concerned when the Social worker asks for access to the photocopier so that she can take a copy of the report away with her as she may need it to support a request for grab rails to be fitted to the home and to support the setting up of a community alarm system.

The ward staff feel they only have consent for matters relating directly to care and aren't sure whether building work and communication system is covered by this. They feel the social worker should just make her own notes or wait until the patient returns so that she can be asked for additional consent. The social worker has other visits to make and is unable to stay.

Is it OK to let the social worker take a copy of the requested information?

Decision 8:

The two elements are part of a total package of care which in conjunction with any further community treatment will enable the patient to return to her own home rather than have to possibly enter residential care. As such they are still direct care.

The decision to share was really taken when the social worker was shown the report, providing a copy simply ensures she has an accurate record of the patient's needs rather than relying on her memory. We all have a duty under the DPA to ensure that information we hold is accurate and up to date, so once you have decided to share ensure the information you provide to partners is accurate and up to date.

However it is important that only the relevant information is shared, the physio report is a good example of directly relevant information. Identify what is the relevant information and don't share a whole file unnecessarily.

Sharing Information for Indirect Care

Scenario 9

Sharing of health information (in relation to families/individuals requiring settlement in Herts), by the provider to the commissioner to enable the commissioner to establish which GP area will best meet the need(s) of the family/individual.

Decision 9

The provider must only share the gender and age(s) of the family/individual, on no account should any personal identifiable information be provided to the commissioner. The providers must redact this information before sharing.