

Checklist for the Review and Approval of Procedural Documents

To be completed and attached to any document which guides practices when submitted to the appropriate committee for consideration and approval.

	Yes/No/ Unsure	Comments
Title of Document		Information Sharing Policy
Could this policy be incorporated within an existing policy?	no	
Does this policy follow the style and format of the agreed template?	yes	
Has the front sheet been completed?	yes	
Is there an appropriate review date?	yes	
Does the contents page reflect the body of the document?	yes	
Are there measurable standards or KPIs to support the monitoring of compliance with and effectiveness of the document?	yes	
Are all appendices appropriate and/or applicable?	yes	
Have all appropriate stakeholders been consulted?	yes	
Has an Equality Impact Assessment been undertaken?	yes	
Is there a clear plan for implementation?	yes	
Has the document control sheet been completed?	yes	
Are key references cited and supporting documents referenced?	yes	
Does the document identify which Committee/Group will approve it?	yes	



Plans for communicating policy to – staff; practice membership; public (as appropriate)	Via weekly staff briefing
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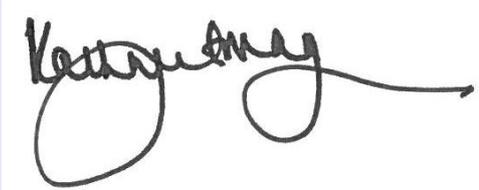
Individual Approval

If you are happy to approve this document, please sign and date it and forward to the chair of the committee/group where it will receive final approval.

Name	Chief Finance Officer	Date	07/08/17
Signature			

Committee Approval

If the committee is happy to approve this document, please sign and date it and forward copies to the person with responsibility for disseminating and implementing the document and the person who is responsible for maintaining the organisation’s database of approved documents.

Name	Chief Executive Officer	Date	07/08/17
Signature			



Information Sharing Policy

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1. INTRODUCTION

In a healthcare setting, sharing Information in line with agreed protocols, can add a number of benefits. It can contribute towards making services more efficient and accessible to those in need. It ensures that all patients including the vulnerable are provided with the protection they need. It also enables collaboration amongst different organisations so that they can deliver the care that all patients, including those with complex needs may be reliant upon.

Sharing information can present risks, which must be adequately managed, at every stage. Information systems are consistently becoming more complex and widespread, with the potential for more information about our private lives, which is often highly sensitive, to become known to more and more people.

This Information Sharing Policy and accompanying set of procedures, detail the obligations and commitments, that staff must follow at all times, to ensure that legislation is not breached, and that patients/clients/families/carers/staff/employees confidentiality is maintained at all times.

The Data Protection Act 1998, the Common Law Duty of Confidentiality and Human Rights Act 1998 play a major role in the use and protection of information used in healthcare.

The Freedom of Information Act 2000 provides the right for anyone to request non-person identifiable information held within a public authority, to be told whether the information is held and for it to be provided to them within 20 working days of the request being issued, unless a relevant exemption applies preventing that disclosure.

2. PURPOSE

The main objectives of this policy are:

- To provide a framework to clarify HVCCG procedures relating to the safe sharing of information
- To ensure that everyone working with personal information fully understands the importance of information sharing, where it improves care for service users and for the direct continuing care of service users

- To ensure that only the minimum amount of information deemed necessary for the purpose of the delivery of a care episode is, and should be, shared.
- To ensure that when information sharing occurs, the sharing complies with the law, stipulated guidance, best practice and agreed protocol
- To ensure that service users' rights are respected
- To ensure that confidentiality is adhered to unless there is a robust public interest in disclosure or a legal justification to do so
- To outline the importance and associated benefits of effective information security and confidentiality training

3. DEFINITIONS

Person Identifiable Information: (This list is not exhaustive)

Any of the following information that may be obtained during the course of a care episode of a service user's care, will constitute as being *person identifiable information*:

- Name
- Address
- Post code
- Date of birth
- NHS Number
- National Insurance Number
- Employee Number
- Carer's details
- Next of kin details
- Contact details (phone number / email addresses)
- Bank details
- Lifestyle
- Family details
- Voice and visual records (e.g. photographs, tape recordings)

During a care episode, further sensitive personal information that may also be recorded within a service user's record may be:

- Racial or ethnic origin
- Political opinions
- Religious beliefs
- Trade union membership
- Physical or mental health condition
- Sexual life
- Offences alleged or committed or the sentencing from any court

proceedings

4. ROLES AND RESPONSIBILITIES

The CCG, will ensure that information sharing protocols exist for all transfers of person identifiable information outside of the NHS (and within the NHS where appropriate). To ensure that, at all times, there is a safe and secure environment for sharing information, the CCG agrees to oversee / do the following:

- Always keep information confidential, ensuring it is effectively protected against inappropriate disclosure at all times.
- Seek patient consent for disclosure of information wherever possible unless there is a legal requirement, or an overriding public interest in favour of the disclosure.
- Develop processes that encourage the sharing of good information management practices to help organisations work in collaboration.
- To ensure that those partners providing requested information, also authorise us accordingly, with the permission to share it where authorised.
- Implementation of a common set of goals for information sharing for use by all

4.1 Roles and Responsibilities within the Organisation

Senior Information Risk Owners (SIRO)

The CCG has appointed a SIRO, who will lead on, and act as an advocate for information risk on the Board and during internal discussion. They will provide written advice to the Chief Executive in regard to Information Governance risk.

Caldicott Guardians

The CCG has appointed a Caldicott Guardian who will act as the 'gatekeeper' of all held service user information. The Caldicott Guardian will be familiar with current legislation, guidance and best practice, and is the 'conscience of the organisation'. They can be contacted for advice or to discuss, in detail, any concerns that staff may have in relation to disclosure.

Responsibilities of Individuals

Information sharing will almost, in every circumstance require some form of

consent. Every member of staff contemplating sharing information should refer to Appendix 1 **Consent Guidance for Information Sharing** for a detailed explanation of the following areas:

- What is consent?
- An overview as to when information can and cannot be shared
- Examples of best practice

4.2 Consultation and Communication with Stakeholders

This policy will be approved by the Risk Management Group, and either the Senior Leaders Team or Executive Team (whichever is deemed more appropriate).

5. Sharing of information

Deciding whether to share or withhold personal information

Any information sharing must be both absolutely necessary and authorised. Information that is shared must be relevant and not excessive. Before sharing information with anyone you should decide:

- Why do you need to share personal information?
- Do you need to share information in a personally identifiable form or would anonymised, pseudonymised, or statistical information be sufficient?
- What legal provisions exist that require or permit you to share the information, if any?
- What subsequent negative consequences may arise as the result of sharing confidential or sensitive information?
- Is consent from the individual required, and, if so, how would you obtain consent, and record it appropriately?
- What action/s would you take if consent is not given as requested?

Legal Duties and Powers to Share Information in Relation to Children and Young people

In addition to legislation about information sharing, there are a large number of specific acts of Parliament that give a duty or power to share information about children and young people for various purposes. *Appendix 2* provides further information about these statutory duties and powers.

Process for Information Sharing

In order for the CCG to meet its legal obligations, and to achieve compliance

with the standards stipulated within the Information Governance Toolkit, the CCG has devised appropriate information sharing protocols with all non NHS organisations and, where appropriate, NHS organisations. All staff prior to sharing person identifiable information must ensure that a protocol exists and that it is in effect valid before any information is released.

Any information that is to be shared in an electronic format, (e.g., by e-mail or on disc etc.) must first be encrypted (*compliant to encryption standards as stipulated within encryption policy and in line with NHS standards*). When submitting an information sharing protocol request for consideration, staff should provide all details of the methods in which data may be shared so that the CCG can ensure the information is secured in transit.

Secondary Uses of Information

Health professionals may receive requests for disclosure of patient information from those who are not directly involved in the patient's care.

Such secondary use of patient information falls into three broad categories:

- Use within the NHS for administration, planning, auditing, commissioning and payment by results (PbR).
- Use by agencies commissioned by the NHS to carry out such roles on its behalf
- Use where identifiable information goes beyond health care provision in the NHS to include research and education

Patient data may be disclosed to an appropriate and secure authority and used for secondary purposes if and when:

- The information has been effectively anonymised or pseudonymised. (*See Appendix 1*)
- The information is required by law
- The patient has given their explicit consent to the disclosure
- The health professional is satisfied, in some limited circumstances, that the patient is aware of the use and has not objected to it and so has effectively provided implied consent
- Disclosure is authorised by the Ethics and Confidentiality Committee of the National Information Governance Board under S251 of the NHS Act 2006.
- The health professional is satisfied that the legal and professional criteria for disclosure without consent in the 'public interest' have been met and has sought advice from the Caldicott Guardian, professional body or defence organisation in the case of any doubt.

In the absence of patient consent, anonymised or pseudonymised data should be used for any secondary purpose, in which it is practicable to do so. Some secondary uses of patient data are for social purposes unconnected with the provision of health care, e.g. for insurance or employment purposes. Such disclosure does require explicit patient consent.

6. MONITORING COMPLIANCE

The Information Governance team will undertake, on at least an annual basis, an audit of understanding and compliance against this policy in the format of a detailed questionnaire that will be sent to a number of random staff within the CCG. The outcomes from this questionnaire/audit will then be fed back to the Risk Management Group for further discussion and subsequent actions.

7. EDUCATION AND TRAINING

All staff must attend, as part of their induction, mandatory training sessions on Information Governance. Top-up training will be provided to all staff through mandatory annual online training using the NHS Information Governance Training Tool (IGTT).

8. REFERENCES

Data Protection Act 1998
Human Rights Act 1998
Freedom of Information Act 2000
Access to Health Records Act 1990 (Where not superseded by the Data Protection Act 1998)
Computer Misuse Act 1990
Copyright, designs and patents Act 1988 (as amended by the Copyright Computer Programs Regulations 1992)
Crime and Disorder Act 1998
Electronic Communications Act 2000
Regulation of Investigatory Powers Act 2000
Children Act 1989

9. ASSOCIATED DOCUMENTATION

Information Governance Policy
Data Protections and Confidentiality
Safe Haven Policy
Information Security Policy.

Appendix 1

Appendix 1

Consent Guidance for Staff: Information Sharing

Introduction

The aim of this document is to provide clear guidance to staff, that will enable personal information, concerning patients, to be appropriately shared between organisations without compromising confidentiality, unless there is a legal requirement, or an overriding public interest in the disclosure.

Confidentiality is an essential requirement for the preservation of trust between patients and healthcare professionals and is subject to legal and ethical safeguards. Patients should be able to feel assured that information about their health which they may provide in confidence will be kept as confidential unless there is a compelling reason why it should not be. There is also a strong public interest in maintaining confidentiality so that individuals will be encouraged to be open and where necessary, to seek appropriate treatment and share any important information relevant to it.

As a general principle all personal information must only be collected, held and shared on a strict 'need to know' basis and all further decisions made to share information that are not directly associated with the direct continuing healthcare of the patient should be recorded.

Purpose

The purpose of this document is to provide specific guidance to all staff on consent and information sharing issues that they may encounter. This document forms an appendix to the CCG Information Sharing Policy and Procedure.

Consent

Consent is required in all cases of sharing service user identifiable information, unless disclosure of the information is required by law, or there is an overriding public interest in the disclosure.

Definition of Consent

Consent to disclosure may be *explicit or implied*. It may also be consent to disclosure of specific information relating to a particular person or body for a particular purpose or it may be consent to general future disclosure for particular purposes. In either case consent should be informed and freely given. Consent is defined in "Confidentiality: NHS Code of Practice, Part 1 and Part 2 as follows:

Informed Consent

All consent should be informed. Every patient should be informed about what happens to the information that they give to the NHS (it is also a minimum requirement under the Data Protection Act 1998). For each episode of care you should ensure that your service user is fully aware of who else may have access to their information and for what purpose/s. The service user should always be provided with the option of saying 'no' to information sharing. It is their information, so it is therefore their choice to decide who they wish to share the information with, unless legislation overrides this decision in any way.

All service users should receive the following information:

- Who the Data Controller is
- Why the information is needed
- The purposes for which the information will be processed
- Who will see the information
- Any disclosures that may need to be made to other organisations (e.g. Acute Hospitals, Social care, Clinical audit, GP, Mental Health Teams, Drug Teams etc.).
- The circumstances in which information may be disclosed without having to gain consent, where there is an overriding public interest (e.g. child protection cases, or serious crime.)
- Information restricted by legislation (e.g. serious communicable diseases.)
- Information that must be passed on because of legislation (e.g. births, deaths, cancer registries, abortion.)

If service users have any reservations about information sharing and refuse to consent, healthcare professionals are obliged to clearly explain that their direct continuing care could be adversely affected by restrictions placed on sharing. In order to make the correct well informed decisions healthcare professionals may require access to other relevant, related information in connection with that service user. If service users still wishes to refuse to share any information then you have not gained consent for that particular information and the service user's wishes must be respected (unless there is a legal requirement, or an overriding public interest in the disclosure.)

Implied Consent

Patient agreement; that has been, 'signalled' by the behaviour of an informed patient.

Implied consent is not a lesser form of consent but in order for it to be valid it is important that patients are made aware that information about them is to be shared, with whom it will be shared, and of their right to refuse to the sharing take place. Healthcare professionals bear full responsibility for the disclosures they make, so when consent is taken to be implied, they must be able to demonstrate that the assumption of consent was made in the context of good faith and based upon good information. Without this, it is not consent to share and some other justification will be required prior to disclosure taking place. In addition to information provided

face to face, during the course of a consultation, any leaflets, posters and other informative information included with an appointment letter can play a key part in conveying to patients the importance for, and necessity of information sharing in order to provide that patient with high standards of healthcare. Implied consent is usually sufficient for direct patient care (see paragraph 4.1 below).

Express/Explicit Consent

An articulated; service user agreement. Clear and voluntary indication of, preference, or choice. Usually given orally or in writing and freely given in circumstances where the available options and the consequences have been made clear. Explicit consent is the ideal as there is no doubt as to what has, and what has not been agreed.

Recording Consent

State/record in the patients' health record if a patient has been provided with and understands the notice/leaflet/ informative material/s provided, regarding information sharing and has not refused or said 'no' to sharing any part of their information.

Where a patient has refused to share information this should be recorded in the patient's record, dated and time stamped. That information must **not** be shared (unless there is a legal requirement or an overriding public interest in disclosure.)

Keeping consent up to date

- It is essential that children, once they gain capacity, are asked to confirm their own choice, as a previous recorded choice regarding consent will have been made by another party, or on their behalf, which may not reflect their own choice
- It may also be essential to revisit the consent issue at other times e.g. when changes which impact on how information is used and shared are introduced. Consent should also be reviewed whenever there are changes to information sharing/disclosure during an episode of care.

What you need to know before sharing information

Sharing information with other healthcare professionals

In the absence of evidence to the contrary, patients are normally considered to have given implied consent for the use of their information by health professionals for the purpose of the care that they receive. Information sharing in this context is acceptable to the extent that health professionals share what is necessary and relevant for patient care, but only on a strict 'need to know' basis. Health care and social care, although often closely related, do not always fall into the same category, and disclosures of information to social care will usually require explicit consent from competent patients. Sometimes two competing interests come into conflict, such

as the patient's informed refusal to allow disclosure, and the essential underlying need to provide effective treatment to that person. A patient's refusal to allow information sharing with another health professional may, in effect, compromise patient safety, but if this is an informed decision, made by a competent person it should be respected.

Multi – Agency Working

Healthcare professionals, during the course of their duties in providing treatment to patients will have contact with other partner organisations from time to time. Involvement will vary from patient to patient. Examples include social care, housing and benefits agencies. Healthcare professionals should from the first instance discuss with patients, their intention or wish to share information with other agencies as appropriate, in order to adequately provide the delivery of their healthcare to that patient. Other agencies may wish to be involved in discussions about patients at various points throughout the delivery of their treatment, or to attend case conferences, or multi- disciplinary meetings. Healthcare professionals may also be invited to attend external case conferences organised by partner organisations to discuss the health and welfare needs of patients. In all these circumstances information sharing should take place with explicit consent or in the absence of explicit consent where disclosure is required by law, or there is an overriding public interest in disclosure.

Assessment of capacity

All people aged 16 years and over are presumed, by law, to have the capacity to give or withhold their consent to disclosure of confidential information unless there is evidence to the contrary. A patient who is suffering from a mental disorder or impairment or judgement does not necessarily lack the capacity to give or withhold their consent. Equally, patients who would otherwise be competent may be temporarily incapable of giving valid consent due to factors such as extreme fatigue, drunkenness or intoxication, shock, fear, severe pain or sedation. The fact that an individual has made a decision that appears to others to be irrational or unjustified should not be taken on its own as conclusive evidence that the individual lacks the mental capacity to make that decision. However, if the decision is clearly contrary to previously expressed wishes, or is based on a misperception of reality, this may be indicative of a lack of capacity occurring, and subsequently further investigation will be required.

There is no presumption of capacity for people under 16 in England and Wales and those under this age limit must demonstrate their competence by meeting certain standards, as set out by the courts. The central test is whether the young person has sufficient understanding and intelligence to understand fully what is proposed.

To demonstrate capacity individuals should be able to:

- Understand in simple language (with the use of communication aids, if appropriate) what is to be disclosed and why it is being disclosed
- Understand the main benefits of disclosure
- Understand, in broad terms, the consequences of disclosure

- Retain the information long enough to use it and weigh it in the balance in order to arrive at a decision
- Communicate the decision (by any means)
- Make a free choice (i.e. free to decide from undue pressure)

Adults who lack capacity

Temporary or permanent mental incapacity

Patients with mental health disorders or learning disabilities should not automatically be regarded as lacking the capacity to give or withhold their consent to disclosure of confidential information. Unless unconscious, most people suffering from a mental impairment can make valid decisions about some matters that affect them. An individual's mental capacity must be judged in relation to that particular decision that is being made. Therefore, if a patient has the requisite capacity, disclosure of information to relatives or third parties requires patient consent. One of the most difficult dilemmas for healthcare professionals arises where the extent of such patient's mental capacity is in doubt. In such cases health professionals must assess the information which is actually available from, the patient's health record and from third parties. They should attempt to discuss with patients their essential needs and preferences, as well as assess their ability to understand their condition and prognosis. If there is still doubt about a patient's competence to give or withhold consent, healthcare professionals should seek a second opinion.

Relatives, carers and friends

If a patient lacks capacity, health professionals may need to share information with relatives, friends or carers to enable them to assess that patient's best interests. Where a patient is seriously ill and lacks capacity, it would be unreasonable always to refuse to provide any information to those considered close to the patient on the basis that the patient has not given explicit consent. This does not, however, mean that all information should be routinely shared, and where the information may be sensitive, a judgement will be need to be made about how much information the patient is likely to want to be shared, and with whom. Where there is evidence that the patient did not want certain information shared, this must always be respected.

Next of kin

Although widely used, the phrase 'next of kin' has no legal definition or status. If a person is nominated by a patient as next of kin and given authority to discuss the patient's condition, such a person may provide valuable information about the patient's wishes to staff caring for the patient. However, the nominated person cannot give or withhold consent to the sharing of information about the patient and has no rights of access to the patient's medical records. The

patient may nominate anyone as next of kin. In the absence of such a nomination, no-one can claim to be their next of kin.

Proxy decision-makers

In England and Wales, the Mental Capacity Act 2005 allows people over 18 years of age who have capacity to appoint a welfare attorney to make health and personal welfare decisions once capacity is lost. The Court of Protection may also appoint a deputy to make these decisions. Where a patient lacks capacity and has no relatives or friends that can be consulted, the Mental Capacity Act requires an Independent Mental Capacity Advocate to be appointed and consulted about all decisions about 'serious medical treatment', or place of residence. An attorney or deputy can also be appointed to make decisions relating to the management of property and financial affairs. In the case of health information, healthcare professionals may only disclose information on the basis of the patient's best interests.

Abuse and neglect

Where healthcare professionals may have concerns about a patient lacking capacity who, as a result, may be at risk of abuse or neglect, it is essential that these concerns are acted upon and information is given promptly to an appropriate person or statutory body, in order to prevent further harm occurring. Where there is any doubt as to whether disclosure is considered to be in the patient's best interests, it is recommended that the healthcare professional discusses the matter on an anonymised basis with a senior colleague, the Caldicott Guardian, Data Protection Officer or Trust Solicitor. Health professionals must ensure that their concerns and the actions they have taken or intend to take, including any discussion with the patient, colleagues or professionals from other agencies, are clearly recorded in the patient's medical records.

Children and Young People

Competent children

There is no presumption of capacity for people under 16 in England, Wales and Northern Ireland and those under that age must demonstrate they have sufficient understanding of what is proposed. However, children who are aged 12 or over are generally expected to have capacity to give or withhold their consent to the release of information. Younger children may also have sufficient capacity. When assessing a child's capacity it is important to explain the issues in a way that is suitable for their age. If the child is competent to understand what is involved in the proposed treatment, the health professional should, unless there are convincing reasons to the contrary, for instance abuse is suspected; respect the child's wishes if they do not want parents or guardians to know. However, every reasonable effort must be made to persuade the child to involve parents or guardians particularly for important or life-changing decisions.

Children who lack capacity

The duty of confidentiality owed to a child who lacks capacity is the same as that owed to an adult. Occasionally, young people may seek medical treatment, for example, contraception, but are judged to lack the capacity to give consent. An explicit request issued by a child that information should not be disclosed to parents or guardians, or indeed to any third party, must be respected. However, in the event of most exceptional circumstances occurring, for example, where it puts the child at risk of significant harm, disclosure may take place on the basis that it was in the 'public interest' to disclose without consent. Therefore, even where the healthcare professional considers a child to be too immature to consent to the treatment requested, confidentiality should still be respected concerning the consultation, unless there are very convincing reasons to the contrary. Where a health professional decides to disclose information to a third party against a child's wishes, that child should generally be told before the information is disclosed. The discussion with the child and the reasons for disclosure, against their will should be clearly explained and be documented within the child's health record.

Parental responsibility

Anyone with parental responsibility can give or withhold consent to the release of information where a child lacks capacity. Not all parents have parental responsibility.

- In relation to children born after 1 December 2003, both of a child's biological parents have parental responsibility if they are registered on a child's birth certificate.
- In relation to children born before these dates, a child's biological father will only automatically acquire parental responsibility if the parents were married at the time of the child's birth or some time thereafter. If the parents have never been married, only the mother automatically has parental responsibility, but the father may acquire that status by order or agreement. Neither parent loses parental responsibility should a divorce take place.
- Where the child has been formally adopted, the adoptive parents are the child's legal parents and automatically acquire parental responsibility
- Where the child has been born as a result of assisted reproduction, there are rules under the Human fertilisation and Embryology Act 2008 that determine the child's legal parentage
- In some circumstances people other than parents acquire parental responsibility, for example by the appointment of a guardian or on the order of a court
- A local authority acquires parental responsibility (shared with the parents) while the child is the subject of a care or supervision order
- In some circumstances parental responsibility can be delegated to other carers such as grandparents and child minders or carers.

If there is doubt about whether the person giving or withholding consent has parental responsibility, legal advice should always be sought.

Where an individual who has parental responsibility refuses to share relevant information with other health professionals or agencies and the healthcare professional considers that it is not in

the best interest of the child (for example, it may place the child at risk of significant harm), disclosure may take place in the public interest without consent.

Safeguarding children

Where health professionals have concerns about a child who may be at risk of abuse or neglect, it is essential that these concerns are acted upon and information is given promptly to an appropriate person or statutory body, in order to prevent further harm occurring. The best interests of the child or children involved must guide decision-making at all times. Knowing 'what to do' for the best when patients do not want confidential information to be disclosed, despite this being the best way to ensure that they do not suffer further harm or abuse, is a very difficult situation for health professionals to have to deal with. Healthcare professionals should be mindful not to make promises to the child about confidentiality that they may not be able to keep but, as in the case of any patient, trust is best maintained if disclosure is not made without prior discussion between the health professional and the child, unless to do so would expose the child or others to an increased risk of serious harm.

Where there is any doubt as to whether disclosure is in the child's best interests, it is recommended that the healthcare professional discusses the matter anonymously with an experienced colleague, Safeguarding Children and Families Team, the Caldicott Guardian, Data Protection Officer, Trust Solicitor, their professional body or defence body.

Healthcare professionals must ensure that their concerns, and the actions they have taken, or intend to take, including any discussion with the child, colleagues or professional's within other agencies, are clearly recorded in the child's medical record. Healthcare professionals may be involved in case reviews for which the child's records may need to be disclosed, but care should be taken not to disclose the notes of other family members without consent unless it can be justified in the public interest.

Best interests

Any decisions taken on behalf of someone who is considered to lack capacity must be taken in their best interest only. A best interest judgement is not an attempt to determine what the patient would have wanted. It is as objective a test as possible, of what would be in the patient's actual best interests, taking into account all relevant factors. A number of factors should be addressed including:

- The patient's own wishes (where these can be ascertained)
- Where there is more than one option, which option is least restrictive of the patient's future choices
- The view of the parents, if the patient is a child

- The views of people close to the patient, especially close relatives, partners, carers, welfare attorneys, court-appointed deputies or guardians, about what the patient is likely to see as beneficial

Public interest

General Principles

In the absence of patient consent, a legal obligation or ‘anonymisation’, any decision as to whether identifiable information is to be shared with any third parties must be made on a case by case basis and must be justifiable in the ‘public interest’. Public interest is the general welfare and rights of the public that are to be recognised, protected and advanced. Disclosures made in the public interest based on the common law are made where disclosure is essential to prevent a serious and imminent threat to public health, national security, the life of an individual or a third party or to prevent or detect other serious crime. Ultimately, the public interest can only be determined by the courts. However, when considering disclosing information to protect the public interest, health professionals must always:

- Consider how the benefits of making the disclosure balance against the harms associated with breaching the patient’s confidentiality both to the individual clinical relationship and to maintaining public trust in a confidential service
- Assess the urgency of the need for disclosure
- Make all attempts to persuade the patient to disclose voluntarily
- Inform the patient before making the disclosure and seek his or her consent, unless to do so would increase the risk of harm or inhibit effective investigation
- Disclose the information promptly to the appropriate body
- Reveal only the minimum amount of information necessary to achieve the objective
- Seek assurance that the information will be used only for the purpose for which it is disclosed
- Clearly document the steps taken to seek or obtain consent, and the reasons for disclosing the information without consent
- Be able to fully justify the decision taken
- Document both the extent of and grounds for the disclosure

Healthcare professionals should be aware that they risk criticism, and even legal liability, if they fail to take action to avoid serious harm. There is no specific legislation which tells healthcare professionals whether or not to disclose information in a particular case, but general guidance about the categories of cases in which decisions to disclose may be justifiable are below. Guidance should be sought from the Caldicott Guardian, Data Protection Officer, Trust Solicitor, A professional body or defence body where there is any doubt as to whether disclosure should take place in the public interest.

Serious crime and national security



There is no legal definition as to what constitutes a 'serious crime'. In the Police and Criminal Evidence Act 1984 a 'serious arrestable offence' is an offence that has caused or has the potential to cause:

- Serious harm to the security of the state or to public order
- Serious interference with the administration of justice or with the investigation of an offence
- Death
- Serious injury
- Substantial financial gain or serious loss

This includes crimes such as murder, manslaughter, rape, treason, kidnapping and abuse of children or other vulnerable people. Serious harm to the security of the state or to public order and serious fraud will also fall into this category. In contrast, theft, minor fraud or damage to property where loss or damage is less substantial would generally not warrant breach of confidence.

Public safety

A common example of what can be categorised as public safety occurs in connection with the assessment of patients with, for example, diabetes, epilepsy, defective eyesight, hypoglycaemia or serious cardiac conditions who have been advised accordingly, by healthcare professionals, to discontinue driving, but who nevertheless continue to do so, ignoring the advice. In these circumstances, The DVLA should be informed if anybody is thought to be at any risk.

Issues of public safety may similarly arise in circumstances where an individual who legitimately possesses firearms is thought by healthcare professionals to be 'at risk' due to drug or alcohol addiction, or a medical condition such as depression. The police should always be informed if anybody is thought to be at risk.

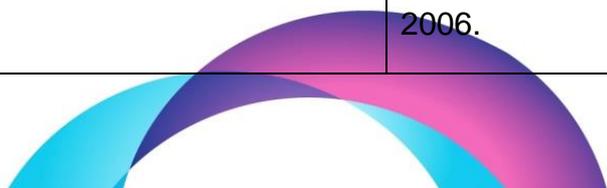
Information Sharing that requires Express Consent

National guidance has identified certain areas of information sharing that must only be carried out on an express/explicit consent basis. Consent is required for information sharing that does not directly contribute to direct continuing healthcare, unless there is a robust public interest in releasing information without the service user's consent or you have the express/explicit consent in writing, from the service user or recorded in the service users health record.

For most information sharing issues that are not for the purpose of providing direct continuing care to a service user you should always consult the Caldicott Guardian to discuss further. The following table gives further details



<p>Carers and Relatives</p>	<p>Generally where a service user has the capacity to consent express/explicit consent is required before sharing health information. Confidentiality can be a highly controversial issue. Carers want and need information about the person they are caring for, whereas professionals feel bound by codes of conduct on confidentiality</p>
<p>NHS Complaints Committees</p>	<p>Complaint Committees will invariably need service user information. However, express consent of the complainant, and any other service users whose record may need to be reviewed, is required prior to disclosure</p>
<p>Management Purposes</p>	<p>Commissioners, prescribing advisors, financial audit, resource allocation etc. There are no restrictions to be imposed if the data is anonymised</p>
<p>Occupational Health Professionals</p>	<p>Information on staff referred to occupational health departments. However, if clinicians are the patients, the powers of professional regulatory bodies for disclosure may apply</p>
<p>Researchers</p>	<p>The use of patient information for research goes beyond health care provision in the NHS, and explicit patient consent will therefore be needed</p> <p>For example, whilst most people would be happy to be included in research there may be some that might object on the grounds of, for example, 'religion orientation or beliefs'.</p> <p>However, if the research project, intention is to only use anonymised data, (which is preferable) no restrictions are imposed, (refer to Anonymisation and Pseudonymisation below.</p> <p>Alternatively, an application can be made to the Ethics and Confidentiality Committee of the National Information Governance Board under section 251 of the NHS Act 2006.</p>



	<p>Before any research project can be undertaken an application must be made to the Local Research Ethics Committee for approval and before making any application to the Ethics and Confidentiality Committee Of the National Information Governance Board under Section 251 of the NHS Act 2006.</p>
Teaching	<p>According to the Confidentiality: NHS Code of Practice teaching is not to be regarded as direct healthcare purposes and therefore explicit consent is still required</p>
Sure Start Teams	<p>Disclosures to 'Sure Start' teams for anything other than the direct continuing healthcare of young children requires explicit consent from parents.</p> <p>Example: Extracting lists of children's names who are below the age of 5 from information held by an organisation to enable Sure Start to target certain groups of families to give them toothpaste samples would require explicit consent.</p>
The Media	<p>You need explicit consent to release information to the media about care and treatment (including a service user's presence in a hospital) unless there is an exceptional robust public interest in releasing information.</p>
Police	<p>Information required by the Police either needs explicit consent of the service user, a Court Order or, where criminal activities are concerned refer to section 6.1 below on Enabling Information Sharing in the Public Interest</p>
Solicitors	<p>Solicitors requesting information must produce an up to date written signed consent from the service user before you release any information. If you have any doubts as to the authenticity of the consent or the fact that the whole of the service user's record has been requested contact the service user direct – you must obtain consent from any third parties before releasing third party information</p>



Legislation Enabling/Requiring/Restricting Information Sharing

Enabling Information Sharing in the Public Interest

The following legislation **permits** information to be shared without seeking consent e.g. if you believe someone has committed serious harm, or a serious crime, However the legislation does not require you to do so. Decisions to share should be made on a case by case basis, and in the public interest.

- A. Child Protection (Children's Act 1989 and the Protection of Children Act 1999). Allows information to be shared if a child is considered at risk of any significant harm
- B. Prevention and Detection of Crime (Section 115 of the Crime and Disorder Act 1998) – e.g. request from the Police where someone is suspected of committing a serious crime.
- C. Disclosures to a health professional within a Sure Start team under the NHS Act 1997 where disclosures directly and only support healthcare of young children. (If health records are to be held within partner organisations, parents must be properly informed).
- D. Data Protection Act 1998, Section 29 (3) provides that the non-disclosure rules will not apply if information sharing is required for:
 - The prevention or detection of crime
 - The apprehension or prosecution of offenders
 - The collection or assessment of any tax or duty

The police may request information under section 29 (3) of the Data Protection Act. Section 35 of the Act provides that disclosures required by law or made in connection with legal proceedings are also exempted from non-disclosure. However, the decision to disclose must be weighed against the individual's right of data protection.

Requiring Information Sharing

Information can be shared, without consent, if requested by the following public bodies/officials but patients should be informed that disclosure has been requested:

1. **Courts, including a coroner's court, tribunals and enquiries** – Only give the information requested in the order and no more. Many different Acts give courts the powers to issue court orders.
2. **General Medical Council (GMC)** – Entitled to access confidential patient health records as part of an investigation under the Medical Act 1983. The GMC have indicated that they would always try to obtain consent first.
3. **Audit Commission** – Entitled to access confidential patient health records as part of an investigation under section 6 of the audit Commission Act 1998
4. **Health Service Ombudsman** – Has the same powers as the courts to disclose person identifiable information. Any request made should be complied with, without obtaining a court order.
5. **Public Health and Infectious Diseases** – Public Health (Control of Diseases) Act 1984 & Public Health (Infectious Diseases) Regulations 1988

6. **Immunisations and vaccinations** – Under the Education Act 1944 information must be passed to NHS Trusts from schools
7. **Births and Deaths** – The Births and Deaths Act 1984 provides for the registration of births, still-births and deaths
8. **Abortion Regulations 1991** A doctor carrying out a termination of pregnancy must notify the Chief Medical Officer, providing a reference number and the date of birth and postcode of the woman aborting
9. **Section 251 of the NHS Act 2006** – gives the Secretary of State for Health power to make regulations permitting the disclosure of identifiable information without consent in certain circumstances. Health professionals can apply to the Ethics and Confidentiality Committee of the National Information Governance Board, an independent public body which advises the Secretary of State for Health in England And wales about the lawful disclosure of patient identifiable information.
10. **Members of Parliament** – Non-statutory investigations (e.g. Members of Parliament). If an MP, states in writing that he/she has a patient's consent for disclosure this may be accepted without further contact with the patient but – carefully consider the request and if necessary contact the patient if in any doubt.

Restricting Information Sharing

Healthcare professionals are required by law to restrict the disclosure of some specific types of information, for example:-

1. Human Fertilisation and Embryology Act 2008
2. NHS (Venereal Diseases Regulations) 1974 and the NHS Trusts and PCTs (Sexually Transmitted Diseases) Directions 1992
3. The Gender Recognition Act 2004
4. The Adoption Act 1976

Anonymisation and Pseudonymisation

Anonymisation

Information can be used without patient consent and requires the removal of:

- Name
- Address
- Full postal code
- NHS number
- Date of Birth
- Local Identifiers (such as an employee number)
- Anything else that could identify a patient e.g. photograph, x-ray, dental records

Information that has been anonymised can never be reverted back to its original form.

Information may be used more freely if the subject of the information is not identifiable in any way. When anonymised data will serve the purpose, healthcare professionals must anonymise



data to this extent and, if necessary, take technical advice about anonymisation before releasing data. Whilst it is not ethically necessary to seek consent for the use of anonymised data, general information about when their data will be anonymised should be available to all patients.

Pseudonymisation

Pseudonymisation is sometimes referred to as reversible anonymisation. Patient identifiers, such as name, address or NHS number, are substituted with a pseudonym, code or other unique reference so that the data will only be identifiable to those who have the code or reference. Where those who are using data have no means to reverse the process, and so no way to identify an individual from the data they have, the data may be treated as anonymised and there is no common law requirement to seek consent for their use. For those who have access to both pseudonymised data and the means to reconstitute them, they should be treated as identifiable. The use of pseudonymised data is common in research. As with anonymised data, patients should generally be informed when it is intended that their information will be pseudonymised, regardless of the purpose for which it was pseudonymised

Deceased persons

Although the Data Protection Act 1998 does not apply to records of deceased persons the ethical obligation to respect a patient's confidentiality extends beyond death. The Information Tribunal in England and Wales has also held that a duty of confidence attaches to the records of the deceased under section 41 of the Freedom of Information Act 2000. If a patient has requested that their information is not disclosed after their death this must be respected. The Access to Health Records Act 1990 gives limited statutory rights of access to those who 'may have a claim' arising out of the death of a deceased patient. Care must always be taken when sharing records of the deceased and advice should always be sought in cases of doubt.

Appendix 2

Legal Duties and Powers to Share Information in relation to Children and Young People

Statutory Provisions to Information Sharing – Child Protection

Agency	Why do you want to share/request information?	From whom do you wish to share/request information?	Legal basis to share/request information
Any agency or public body	There is reasonable cause to suspect that a child is suffering or is likely to suffer significant harm	Social Care	Section 47 Children's Act 1989
Children's Services	To undertake enquiries in order to decide if action should be taken to safeguard or promote the child's welfare	Any agency who may have information	Section 47 (1) Children's Act 1989
Local Housing Authority, Special Health Authority, Primary Care Trust, NHS Trust	Children's Services request for information in order to decide if action should be taken to safeguard or promote the child's welfare	Children's Services	Section 47 (9) Children's Act 1989



Child Protection – People Unsuitable to Work with Children/Vulnerable Adults

Agency	Why do you want to share/request information?	From whom do you wish to share/request information?	Legal basis to share/request information
Any organisation employing a person in child care position	An individual has been found guilty of misconduct (whether or not in the course of his/her employment)	Department of Education and Skills, Department of Health	Protection of Children Act 1999 Section 2A
Any organisation dealing with child care	The organisation wishes to offer a job to a person in a child care capacity	Department of Education and Skills, Department of Health	Protection of Children Act 1999 Section 3
Any organisation employing a person in a care of vulnerable people position	A person is found to be unsuitable to work with vulnerable people	Department of Health	Care Standards Act 2000 Section 82

Children with a Disability

Agency	Why do you want to share/request information?	From whom do you wish to share/request information?	Legal basis to share/request information
Children's Services/Local Authority	To compile and maintain a register of disabled children	Health	Children's Act 1989 Section 17 (2)
Any Local Authority Service	There is a need for health or housing provision and Health or Housing can assist with the assessment	Primary Care Trust, Health Authority or Local Housing Authority	Section 47 National Health Service Act and Community Care Act
Children's Services/Local Authority	To compile and maintain a register of blind; partially sighted; deaf with speech; deaf without speech; hard of hearing; and general classes (those	Health Services	National Assistance Act 1948 Section 29

	whose primary handicap is neither visual nor auditory)		
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Children with Special Educational Needs

Agency	Why do you want to share/request information?	From whom do you wish to share/request information?	Legal basis to share/request information
Education/Health	To assess a child's SEN	Health, Education, Children's Services. Also they should seek advice from child's parent, Head Teacher, the teacher who taught the child, the person who the authority are satisfied has experience of teaching children with SEN. Medical advice from the Health Authority. Psychological advice. Advice from social care. Any other advice which the LEA considers appropriate	Section 322 Education Act 1996 Education (Special Education Needs) (England) (Consolidation) Regulation 2001 (SI 3455/2001) Regulation 7(1)
LEA	Considering making an assessment of SEN. LEA under obligation to send copies of the notice stating they are considering an assessment of SEN	Children's Services, Health Authority, Head Teacher of School pupil registered with (if any). If the child receives education from an early education provider, to the head of SEN in relation to that provider	Education (Special Education Needs) (England) (Consolidation) Regulation 2001 (SI 3455/2001), Regulation 6

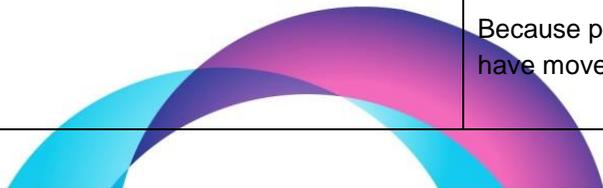


Children and Young People involved or likely to be involved in Crime and Disorder

Agency	Why do you want to share/request information?	From whom do you wish to share/request information?	Legal basis to share/request information
Police, Housing, National Park Authority, Health, Probation; Youth Offending Team	Have reasonable belief that a child or young person is likely to commit a crime and therefore to prevent crime occurring	Any appropriate agency that can assist the child or young person to prevent them from committing a crime. E.g. Health, Youth Offending, Voluntary Agency if appropriate	Crime & Disorder Act 1998 Section 115; Section 17 (1); Section 37 and Section 38. (Information disclosed must be on a need to know basis and minimum amount provided)

A Child or Young Person who is in the Care of the Local Authority

Agency	Why do you want to share/request information?	From whom do you wish to share/request information?	Legal basis to share/request information
Children's Services	Because a Looked-After Child is being accommodated at an establishment at which education is provided Because parents/carers of a LAC have moved to another area and	The Local Education Authority of the area in which the establishment is located Social care in the new area	Children Act 1989 Section 28 FPC rule 23 Family Proceedings



	<p>have another child</p> <p>To inform an assessment of a child. Because a Judge has made a finding of fact which has implications for other children</p>	<p>LEA, Health Authority, relevant agencies</p>	<p>Court (Children Act) Rules 1991 CC10.20(3) rule Family Proceedings Rules 1991</p> <p>For documents before a Court in any proceedings under the Children Act or Adoption Act leave must always be obtained prior to disclosing (sharing)</p>
<p>Any Health Authority or Local Education Authority</p>	<p>Because a child is being accommodated by them and they are obliged to inform Social care of this fact</p> <p>Social care has to ensure the child's welfare is being adequately safeguarded and promoted</p>	<p>Children's Services in area where the child is being accommodated</p>	<p>Children Act 1989 section 85</p>

A Child or Young Person who is Leaving or Has Left Care

Agency	Why do you want to share/request information?	From whom do you wish to share/request information?	Legal basis to share/request information
Children's Services	<p>Because a young person is entitled to leaving care services and social care has a duty to keep in contact with such a young person and to</p>	<p>Any agency that may have any information about the young person which enables the LA to undertake its</p>	<p>Children Act 1989 Section 23 and Section 24, as amended by Children (Leaving Care) Act 2000 sections 24,</p>

	provide advice and assistance A young person is eligible if he/she has been in care for a period of 13 weeks or more since he/she was 14 and has left care after 16 but is still under 21. It does not include children who have received respite care or if the young person has returned home	statutory duty. Most likely to be Health Services but could be by any agency (GP registration)	24A to 24D
Children's Services	Because Children's Services has lost contact with an eligible care leave and has to take reasonable steps to locate them	Any agency who has this information, most likely Health	Children Act 1989 Section 23 and Section 24, as amended by Children (Leaving Care) Act 2000 sections 24, 24A to 24D

General Functions, Powers and Duties (Implied Statutory Powers)

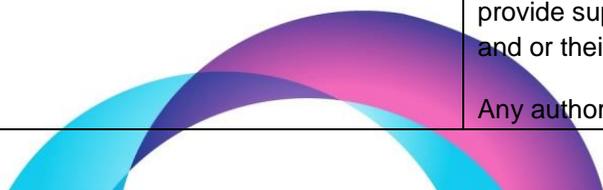
To use implied statutory powers, stronger justification is required to demonstrate that it is necessary to share sensitive data without explicit consent

Agency	Why do you want to share/request information?	From whom do you wish to share/request information?	Legal basis to share/request information
Any Local Authority Department	Because the department has a statutory duty to carry out a particular function, e.g. filling in the Pupil Level Annual School Census by the LEA	Other agencies (including voluntary agencies) that hold relevant information to enable the LA department to carry out its statutory duty. Without the information they	Section 111 of the Local Government Act 1972, give LA's the power to do anything which is calculated to facilitate, or is conducive or incidental to the discharge of any of their

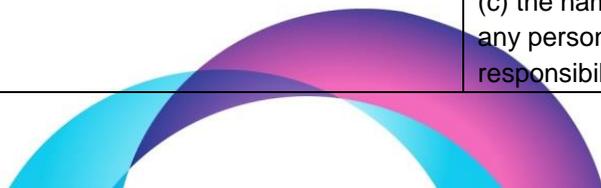
		would not be able to carry out the particular function	functions”
Any Local authority Department	Because the local authority considers that with the information it can: (a) promote or improve the economic well-being in their area (b) promote or improve the social well-being of their area (c) promote or improve the environmental well-being of their area	Any other agency who holds relevant information	Section 2 of the Local Government Act 2000, which gives the LA “a power to do anything they consider is likely to achieve any one or more of the objectives” as set out in column 2. So long as there are no restrictions or prohibitions or limitations in other enactments, i.e. must be compatible with the requirements of the Data Protection Act and Human Rights Act and Common Law Duty of Confidence
Any Health Service within NHS	To provide a comprehensive health service in England and Wales to improve the physical and mental health of the population and to prevent and diagnose and treat illness	Other NHS practitioners working within the Health Service and practitioners from other agencies e.g. social care, who are carrying out health service functions that would otherwise be carried out by the NHS	National Health Service Act 1977, Section 2
Any Health Service within NHS and Local Authority	In order for Health to exercise their Health Service functions and for the LA to exercise its functions in order to secure and advance the health and welfare of the people of England and Wales	Other NHS practitioners working within the Health Service and practitioners from other agencies e.g. social care, who are carrying out health service functions that would otherwise be carried out by the NHS	National Health Service Act 1977, Section 22
Any Local Authority; any Local Education Authority; any Local Housing Authority; Any Health	Because is felt that a child or young person or family is in need of services to safeguard and promote	Other agencies within this partnership who are involved with the child, young person or family and	Children’s Act 1989. Part III: • Section 17 (1) (provision of service)

<p>Authority</p>	<p>the welfare of a child or young person. Section 17 of Children’s Act states a child is in need if:</p> <p>(a) He/she is unlikely to achieve or maintain, or to have the opportunity of achieving or maintaining a reasonable standard of health or development without the provision for him/her of services by a local authority under this part</p> <p>(b) His/her health or development is likely to be significantly impaired, or further impaired, without the provision for him/her of such services</p> <p>(c) He/she is disabled. “Family” includes any person who has parental responsibility for the child and any other person with whom he/she has been living</p>	<p>with any other agency that may provide the appropriate services (including voluntary agencies)</p>	<p>This places a general duty on every LA “to safeguard and promote the welfare of children within their area who are in need and so far as is consistent with that duty, to promote the upbringing of such children by their families, by providing a range and level of services appropriate to those children’s needs”</p> <ul style="list-style-type: none"> • Section 27 (1)(2) and (3) (other agencies acting on behalf of the LA) • Section 17(5) (voluntary agencies) Section 17(10) and (11) (definition of a child in need) Section 2 Local Government Act 2000
<p>Health Service</p>	<p>A child or young person has physical or mental health problems which require extra services</p>	<p>Any agency that can provide appropriate health services (that could be voluntary agency providing a health service)</p>	<p>National Health Service Act 1977, Section 1</p>
<p>Children’s Services</p>	<p>Because it is felt that another organisation could assist them to provide support for children in need and or their families.</p> <p>Any authority to whom such a</p>	<p>Other local authorities, any local education authority, any local housing authority, any health authority</p>	<p>Children Act 1989, Section 27</p>

Local Competition Dispute Resolution Process v.1.0 June 2014



	request is made has duty to cooperate provided that the request is not incompatible with the performance of its own obligations or unduly prejudice the performance of their own functions		
Children's Services	Record involvement of agency with child or young person, investigate suitable service provision to improve the well being of children so far as relating to: (a) physical and mental health and emotional well being; (b) protection from harm and neglect; (c) education, training and recreation; (d) the contribution made by them to society; (e) social and economic well-being	Districts, Police, Probation, Youth Offending Team, any health authority, local education authority, schools, probation board, Youth Offending Team providers under section 114 Learning and Skills Act 2000; the governor of a prison or secure training centre in England (or, in the case of a contracted out prison or secure training centre, its director); the British Transport Police Authority; a person registered in England for child minding or the provision of day care; a registered social landlord; a voluntary organisation	Children's Act 2004, Section 10 & 11
Children's Services	A Database: (a) name, address, gender, DoB (b) a number identifying him/her (c) the name and contact details of any person with parental responsibility who has care of	Districts, Police, Probation, YOT, any health authority, local education authority, probation board, YOT providers under section 114 Learning and Skills Act 2000	Children's Act 2004 Section 12 (1,2,3,4)



	<p>him/her at any time</p> <p>(d) details of any education being received by him /her</p> <p>(e) the name and contact details of any person providing primary medical services in relation to him/her under Part 1 of the NHS Act 1977 (c.49)</p> <p>(f) the name and contact details of any person providing to him/her services of which description as the SoS regulations specify</p> <p>(g) information as to the existence of any cause for concern in relation to him/her</p> <p>Information of such description, not including medical records or other personal records, as the SoS regulations specify</p>		
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HEALTH SERVICE

General functions/powers/duties

Section/Regulation	Description
Section 1 National Health Service Act 1977	<p>“1(1) It is the Secretary of State’s duty to continue the promotion in England and Wales of a comprehensive health service designed to secure improvement:</p> <p style="padding-left: 40px;">a) In the physical and mental health of the people of those countries, and b) In the prevention, diagnosis and treatment of illness,</p> <p>And for that purpose to provide the effective provision of services in accordance with this Act”</p>
Section 31 Health Act 1999	This section allows the Secretary of State to make regulations in connection with enabling the NHS bodies and local authorities to enter into prescribed arrangements in relation to prescribed functions on the NHS bodies and prescribed health-related functions of local authorities
NHS Bodies and Local Authorities Partnership Arrangements Regulations 2000 (S.I.2000/617)	These regulations are made under s31 Health Act 1999 and allow NHS bodies and local authorities to enter into partnership arrangements in relation to the exercise of any NHS functions if the partnership arrangements are likely to lead to an improvement in the way in which those functions are exercised.
Adoption Agencies Regulations 1983 (S.I. 1983/1964)	Regulation 6(5) obliges the adoption agency to consult its medical adviser in relation to arrangements for access to and disclosures of health information which is required or permitted by virtue of regulation 15
NHS (General Ophthalmic Services) Regulations 1986 (S.I. 1986/975)	This requires opticians to keep records and imposes an obligation to disclose to the PCT or the Secretary of State on request
Section 47 Children Act 1989	<p>S47(9) provides,</p> <p>“Where a local authority are conducting enquiries under this section, it shall be the duty of any person mentioned in subsection</p>

	(11) to assist them with those enquiries (in particular by providing relevant information and advice) if called upon by the authority to do so”
Section 85 Children Act 1989	
Section 47 National Health Service and Community Care Act 1990	This section concerns the assessment of needs for community care. It provides that when a local authority is assessing need and it appears that there may be a need for health or housing provision, the local authority shall notify the PCT, Health Authority or local housing authority an invite them to assist, to such extent as is reasonable in the circumstances, in the making of the assessment
NHS (General Dental Services) regulations 1992 (S.I. 1992/661) Schedule 1 Para 25	These regulations place an obligation on dentists to keep records and to disclose to a PCT, the Secretary of State, the Dental Practice Board or a dental officer on request
Section 31 Health Action 1999	S31(3)(g) provides that regulations may make provisions as to the sharing of information between NHS bodes and local authorities
Section 60 Health and Social Care Act 2001	This allows for the SoS to make regulations in respect of the processing of prescribed patient information for medical purposes if he considers it necessary or expedient: a) In the interests of improving patient care, or b) In the public interest
Heath Service (Control of Patient Information) Regulations 2002 (S.I. 2002/1438)	These regulations are made under 260 of the Health and Social Care Act 2001 and provide circumstances when confidential patient information may be processed for medical purposes



Appendix 3

Process for Authorising Information Sharing

1. Complete Information Sharing Protocol or obtain a copy of the Information Sharing Protocol if already written by another organisation
2. Send copy of Information Sharing Protocol along with details of the method in which information is to be shared to the Information Governance Team
3. Information Governance Team review protocol and liaise with Caldicott Guardian as to whether protocol is acceptable.
4. Information Governance Team notifies originator if Protocol has been agreed and originator arranges for protocol to be signed.
5. Copy of signed Protocol sent back to Information Governance Team.
6. Information Sharing can take place.

Appendix 4 - HVCCG Equality & Quality Inclusion Analysis Form

Equality Analysis - Equality Impact Assessment Screening Form

Very occasionally it will be clear that some proposals will not impact on the protected equality groups and health inequalities groups.

Where you can show that there is no impact, positive or negative, on any of the groups please complete this form and include it with any reports/papers used to make a decision on the proposal.

Name of policy / service	Information Sharing Policy
What is it that is being proposed?	This Information Sharing Policy and accompanying set of procedures, detail the obligations and commitments, that staff must follow at all times, to ensure that legislation is not breached, and that patients/clients/families/carers/staff/employees confidentiality is maintained at all times.
What are the intended outcome(s) of the proposal	That all staff are aware of the process to follow if sharing information.
Explain why you think a full Equality Impact Assessment is not needed	This is a process document to help staff to share information appropriately and safely, the content of the information is covered in other policies.
On what evidence/information have you based your decision?	That this is guidance to staff to ensure that they share information using the correct tools under the correct legislation.
How will you monitor the impact of policy or service?	Via reported data breaches or near misses.
How will you report your findings?	Via the Risk Group meetings/ the SIRO and IG Toolkit (if a level 2 data breach)

Having considered the proposal and sufficient evidence to reach a reasonable decision on actual and/or likely current and/or future impact I have decided that a full Equality Impact Assessment is not required.

Assessors Name and Job title	Ruth Boughton – IG Manager Paul Curry - Equality & Diversity Manager
Date	2 nd May 2017

