Sheffield
City Council

NHS
Sheffield Health
and Social Care
NHS Foundation Trust

Policy:

IMST 007 Data & Information Sharing

Executive or Associate Director lead	Executive Director of Finance & SIRO
Policy author/ lead	Assistant Deputy Director of IMS&T (Informatics and Architecture)
Feedback on implementation to	Assistant Deputy Director of IMS&T (Informatics and Architecture)

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Date for review	31/07/2020

Target audience	SHSC staff and people authorised to access the SHSC network

Keywords	Data, Sharing, GDPR, Safeguarding, Disclosure

Policy Version and advice on document history, availability and storage

New Policy for Data & Information Sharing Version1.2

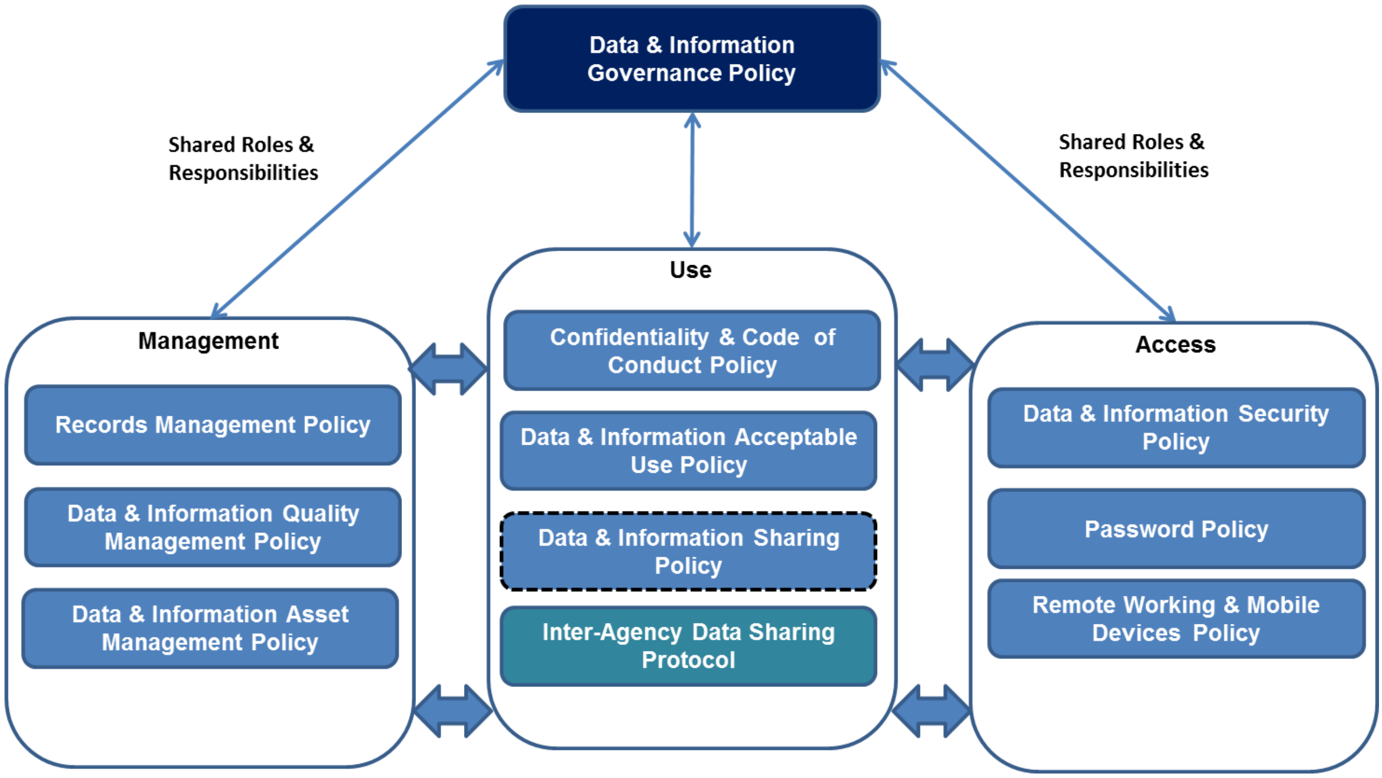
Includes and replaces Email Policy 2.3

Revised October 2019

Contents

Work Flow
Due to the complex and sensitive nature of data & information sharing, no workflow is available.

The Data & Information Governance Policy provides the overarching shared roles and responsibilities needed to satisfy complete trust Data, Information and System ownership and management.


Data & Information Governance Policy
Shared Roles & Responsibilities
Shared Roles & Responsibilities
Management
Records Management Policy
Data & Information Quality Management Policy
Data & Information Asset Management Policy
Use
Confidentiality & Code of Conduct Policy
Data & Information Acceptable Use Policy
Data & Information Sharing Policy
Inter-Agency Data Sharing Protocol
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Data & Information Security Policy
Password Policy
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1. Introduction

The objective of Data & Information Security is to protect the Trust's information assets from a wide range of threats, whether deliberate or accidental, internal or external, in order to ensure business continuity and minimise the impact of adverse events on service users, staff and the Trust. Information security is achieved through the implementation of controls and procedures that ensure the secure use of information and the identification and effective management of risk.

2. Scope

The scope of this document is to outline the Trust's policy for Data & Information Security for all data, information and system management and protection.

This policy applies to all staff and services within the Sheffield Health & Social Care FT (SHSC), including private contractors, volunteers and temporary staff and to those organisations where we provide commissioned services.

Shared governance and compliance areas for data and information include:

- NHS Digital & England Guidance
- Data Security & Protection Toolkit
- Cyber-Security Best Practices
- Information Technology Service Management
- General Data Protection Regulation
- Caldicott Principles
- Data & Information Quality Management
- ISO27001 Information Security Management Systems

The policy supports the Trusts needs to continually improve, protect and manage all digital, data and information assets according to legislation and best practice through a collaborative approach.

Systems

All manual and electronic information systems owned, operated or managed by the Trust, including networks and application systems, whether or not such systems are installed or used on Trust premises.

Other systems brought onto Trust premises including, but not limited to, those of contractors and third party suppliers, which are used for Trust business.

Users

All users of Trust information and/or systems including Trust employees and non-Trust employees who have been authorised to access and use such information and/or systems.

Data & Information

All information collected or accessed in relation to any Trust activity whether by Trust employees or individuals and organisations under a contractual relationship with the Trust.

All information stored on facilities owned or managed by the Trust or on behalf of the Trust.

All such data & information belongs to the Trust unless proven otherwise.

3. Definitions

Personal Information

Personal information is information which can identify a person – in which the person is the focus of the information and which links that individual to details which would be regarded as private e.g. name and private address, name and home telephone number etc.

Sensitive personal information

Sensitive personal information is where the personal information contains details of that person's:

- Health or physical condition
- Sexual life
- Ethnic origin
- Religious beliefs
- Political views
- Criminal convictions

For this type of information even more stringent measures should be employed to ensure that the data remains secure.

Safe Haven

The term safe haven is a location (or in some cases a piece of equipment) situated on Trust premises where arrangements and procedures are in place to ensure person-indefinable information can be held, received and communicated securely.

General Data Protection Regulation (GDPR)

A new regulation for increased data protection and privacy for individuals, giving regulatory authority greater powers to take action against businesses that breach the new laws. As a Trust we all play a part in continually protecting, securing and ensuring data is appropriately used, stored and processed correctly and in accordance with GDPR & IGTK compliance.

4. Purpose

This document is a statement of the approach and intentions of the SHSC to fulfil its statutory and organisational responsibilities. It will enable management and staff to make correct decisions, work effectively and comply with relevant legislation and the organisations aims and objectives.

Information sharing is a vital component of an effective health and social care system. Local organisations are increasingly working together. To work together effectively organisations need to be able to share data about the services they provide and the people to whom they provide these services.

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.

5. Duties

The strategy combines traditional Information Asset (IAO / IAA), data governance, data quality and (ITSM) system management roles and responsibilities into a single accountable shared Business Information Management framework.

Role		Responsibility	Description
Chief Information Officer	CIO	Director IMST	Responsible for the Information Technology that supports the overarching strategies of the Trust.
Chief Clinical Information Officer	CCIO	Director Medical	Providing a vital voice for clinical strategy, allowing new IT and Data & Information products to help improve the provision of healthcare.
Senior Information Risk Owner	SIRO	Director Finance	Owns the Trust's information risk policy and risk assessment process.
Caldicott Guardian	CG	Director Nursing	Responsible for protecting the confidentiality of patient and service user information and enabling the appropriate level of information sharing.
Data Protection Officer	DPO		Supporting Trust - wide Data & Information governance in accordance to GDPR, NHS Digital & England and Data Security & Protection Toolkit.
Clinical Information Officer	CLIO		Supporting the Chief Clinical Information Officer and trust wide clinical initiatives for increased data and information usage and opportunities, supported by data and information governance framework.
Cyber Security Officer	CSO		Supporting the Trust to continuously assess, implement and manage Trust wide cyber-security, and removing identified vulnerabilities with support from all technical and business managers and users.
Data & Information Asset Owners	DIAO	Directorate	Senior representatives of the directorates closely aligned to major stores of organisational data, information and systems.
Data & Information Asset Managers	DIAM	Service Managers	Primary administrative and management responsibilities for segments of data primarily associated with their functional area.
Data & Information Asset Supervisors	DIAS	Supervisors / Team Leaders	Supervisors have responsibility for the day-to-day maintenance and protection of data & information when they are

			affected by the processes that they manage.
Data & Information Asset Users	DIAU	All Users	Responsibility lies with all staff to make sure that all policies and security measures are adhered to.
Data & Information Asset Stewards	DIAS	IMST & Suppliers	Trust and third party IMST enabling and supporting secure & compliant data and information technical implementation, governance and guidance throughout the Trust and in accordance to trust policy, national guidelines and regulations.

Each Data and Information role has clear responsibilities for data, information and system management within their respective service domains and role accountability, supported by natural hierarchy escalation and incident management.

All staff who use Trust information systems (including manual systems as well as electronic ones) plus other authorised users of systems are required to adhere to this policy.

6 Process

6.1 Information Disclosure

The circumstances under which information is requested will vary between routine sharing, one off requests, individual requests and request for bulk data. If the circumstances are not covered within this document and you require clarity whether to disclose or not, please contact the Data Protection Officer & Informatics and Information Systems team.

In all circumstances, disclosures of personal information must be documented to record what information was disclosed, to whom it was disclosed and how it was disclosed. Information to be disclosed must be disclosed securely, in accordance with the Trust Safe Haven Procedure for transferring information.

The rules for sharing and disclosure were changed by the introduction of the General Data Protection Regulation (GDPR) which came into effect in May 2018, enacted by the Data Protection Act 2018.

Where an organisation holds inaccurate personal data and has shared that with another organisation, the holder will have to advise the other organisation so that it can correct its own records.

6.2 Information Sharing

In all circumstances, sharing of personal information must be documented to record what information was disclosed, to whom it was disclosed and how it was disclosed.

Agreement and approval of information sharing will follow Trust Information Sharing protocol, assessing rules, laws, principles and standards adopted by partner agencies and the completion of Data Protection Impact Assessments.

6.3 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:

- What is the purpose of sharing personal information?
- Who will be a party to the sharing?
- What types of information are proposed to be shared?
- What is the basis for sharing e.g. consent/legal basis
- How will the information be shared?

In order for the SHSC to meet its legal obligations, and to achieve compliance with the standards stipulated within the Data Security & Protection Toolkit, the Trust has 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.

6.4 Information Sharing Protocols

Information sharing protocols should, at least, document the following:

- the purpose of the data sharing;
- recipients and the circumstances in which they will have access;
- the data to be shared;
- data security;
- individuals rights – procedures for dealing with subject access requests, complaints etc;
- termination of the sharing agreement;

All information sharing protocols will be developed in accordance with the statutory Data Sharing Code of Practice issued by the Information Commissioner’s Office.

SHSC is a signatory to the Inter-Agency Information Sharing Protocol administered by The Health Informatics Service. This sets out principles for sharing of person-identifiable data between a wide range of agencies including Health, local authorities, police and other public sector and independent organisations.

Specific Information Sharing Agreements will be developed with partner organisations as necessary to cover individual data flows.

6.5 Data Minimisation

Data protection legislation and national guidance require that when sharing information the amount of person-identifiable data should be limited to what is necessary to achieve the intended purpose and excessive or irrelevant data should not be included.

Anonymised data should be used instead of identifiable data where it is sufficient to meet the purpose. Similarly, pseudonymised data should be used in preference to identifiable data where anonymised data is not sufficient but identifiable data is not necessary (pseudonymisation is a process that means that personal data cannot be attributed to specific data subjects without reference to additional information which is held separately).

6.6 Sharing for non–care purposes

The purposes for sharing need to be defined and limited, and additional requirements such as recorded informed consent or evidence of support under section 251 of the NHS Act 2006 are necessary.

De-identified data should still be used within a secure environment with staff access on a need to know basis. This is reflected in the Caldicott Principles. This principle applies to the use of PCD for secondary or non-direct care purposes.

With other organisations, eg research or other secondary use organisations, the protocols will need to address both the basic information governance standards that should apply and the additional ones associated with the secondary uses in question – i.e. purpose, constraints on re-use of information, retention periods and destruction policies.

Where person-identifiable data is released for non-care purposes on the basis of a section 251 approval, it must be checked against the National Data Opt-Out system and data subjects who have declined to have their information shared for non-care purposes must be removed before the data is released.

See https://digital.nhs.uk/services/national-data-opt-out for further details.

6.7 Safeguarding

Where health professionals have concerns about a child, young person or adult 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/children, young person(s) or adult(s) at risk must guide decision-making at all times.

Further guidance can be found in the Department of Health Information Sharing advice for practitioners providing safeguarding services to children, young people, parents and carers.

6.8 Sharing and disclosure 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.

There is no legal definition as to what constitutes a ‘serious crime’. In the Police and Criminal Evidence Act 19845 a ‘serious arrestable offence’ is an offence that has caused or has the potential to cause:

a) Serious harm to the security of the state or to public order
b) Serious interference with the administration of justice or with the investigation of offences or of a particular offence
c) The death of any person
d) Serious injury to any person
e) Substantial financial gain to any person; and
f) Serious financial loss to any person

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.

Where the police or other ‘competent authorities’ request information for the purposes of prevention or detection of crime; apprehension or prosecution of offenders or other law enforcement processing they should specify the information needed with sufficient explanation of the matter being investigated to allow the Trust to judge whether breaching service user confidentiality is justified. South Yorkshire Police have a specific form for submitting requests, as do most other police forces, so these should be used wherever possible. If the police or other requester supply a consent form signed by the data subject the Trust may check with the data subject if there is any doubt that the data subject understands the consequences of the request.

Where disclosure is justified it should be limited to the minimum necessary to meet the need and patients should be informed of the disclosure unless it would defeat the purpose of the investigation, allow a potential criminal to escape or put staff or others at risk.

6.9 Prevent Duty

There is specific guidance in the Counter-Terrorism and Security Act 2015 for specified authorities in England and Wales on the duty to have due regard to the need to prevent people from being drawn into terrorism.

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/445977/3799_Revised_Prevent_Duty_Guidance__England_Wales_V2-Interactive.pdf

There is specific guidance on the sharing of information and information governance for NHS organisations specifically for Prevent, a copy is referenced below.

https://www.england.nhs.uk/wp-content/uploads/2017/09/information-sharing-information-governance-prevent.pdf

6.10 Process for Sharing

When considering a new project or process which will involve sharing of information between parties, a Data Protection Impact Assessment will capture the information required to determine if and how the sharing may take place.

The Data Protection Impact Assessment (DPIA) template can be requested from the Informatics & Information Team.

6.11 Restrictions on Information sharing

It is also important to ascertain whether there are express statutory restrictions on the data sharing activity proposed, or any restrictions which may be implied by the existence of other statutory, common law or other provisions.

6.12 Physical Transfer

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 Digital 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 Trust can ensure the information is secured in transit.

6.13 Protection of information sent by email/electronically

There are a number of considerations when sharing information electronically:

- What are the implications of the information being released into the public domain?
- Does the information contain personal information about patients or staff and/or in such a way as the identity of the data subject could be guessed by looking at the information contained?
- Does the information need to be sent by email?
- Is there a need to stipulate that the information must not be forwarded on?
- Is there a need to anonymise the information contained?

If information does need to be shared and email is considered the most appropriate method, any identifiable information should only be sent via secure, encrypted email services. The main email service for the NHS is NHS.net, as this provides a guarantee that the information contained will be safe in transit.

Confidential or sensitive information, including information about service users and staff, must not be sent outside the Trust by unencrypted e-mail.

Do not send confidential information via e-mail unless it is absolutely necessary. Use anonymised information whenever possible and where it is necessary to include person identifiable information use the minimum necessary.

Where it is necessary to send person identifiable information from a SHSC e-mail address (ending in @shsc.nhs.uk) the text "[encrypt]" must be included in the subject line. The square brackets are part of the mandatory text. Any such messages will then be encrypted if they pass outside the boundaries of the SHSC network. The recipient will then be required to register with a secure website to generate a password which will allow the encrypted message and any future encrypted messages from the Trust to be opened. Messages sent by replying to an encrypted e-mail will also be encrypted. A password will not be required to open messages sent within the Trust or the City Council network but the "[encrypt]" text must still be included to protect the message should it be forwarded outside the network. A guide on using this encryption facility is available on the Intranet.

Sheffield City Council has its own policy on how confidential information may be sent via email (move line below to this line)
– check with the intended recipient before sending.

Messages sent from NHSmail e-mail addresses (ending in @nhs.net) are encrypted during transmission to other NHSmail addresses and to certain other public sector addresses belonging to linked networks.

GCSX (*.gcsx.gov.uk) GSI (*.gsi.gov.uk)
SCN (*scn.gov.uk) CJX (*.police.uk or .pnn.police.uk)
CJSM (*cjsm.net) GSE (*.gse.gov.uk)
MoD (*.mod.uk) GSX (*.gsx.gov.uk)

Some public sector organisations insist on the use of NHSmail addresses for the transfer of person identifiable information – the IT Department can advise on how to get an NHSmail account.

To provide added protection when sending information within the Trust it can be attached to the e-mail as a password-protected document. When using this method make sure that the password is given to the recipient separately, not included in the same message.

Confidential or sensitive Trust information must not be processed on non-NHS devices without authorisation from the IT Department. Where members of staff process information under:

Bring Your Own Device (BYOD) arrangements the device must be protected in line with Trust requirements which include the facility to wipe information remotely if the device is lost.

Any computer that is used for work purposes must be protected by up to date, approved antivirus software. (Advice about anti-virus software can be obtained from the IT Help Desk).

6.14 Referrals by E-mail

E-mails sent from NHSmail addresses to SHSC addresses are not encrypted in transit so where SHSC services wish to accept referrals by e-mail they must adopt and publicise a generic NHSmail address for the receipt of confidential referral details from other secure e-mail accounts. In such cases, a standard operating procedure (SOP) must be developed to ensure that the e-mails are processed promptly and are not dependent on a single member of staff.

6.15 E-mail correspondence with Service Users or Carers

SHSC has no control over access to the service user's PC. E-mails will be encrypted as long as the text "[encrypt]" is included in the subject line as described above but the recipient is responsible for who has access to their PC and what they do with the password generated by the encryption software. They are also responsible for the secure storage and eventual disposal of any e-mails they receive, whether in electronic or printed format.

If service users request communication via unencrypted e-mail they must be made aware of and accept the higher risk of unauthorised access to messages. By default e-mails sent to service users should be encrypted.

6.16 Privacy Impact Assessment

Before entering into any data sharing arrangement, it is good practice to carry out a Privacy Impact Assessment. This will help to assess the benefits that the information sharing might bring to particular individuals or society more widely. It will also help to assess any risks or potential negative effects, such as an erosion of personal privacy, or the likelihood of damage, distress or embarrassment being caused to individuals.

As well as harm to individuals, staff should consider potential harm to the organisation's reputation which may arise if information is shared inappropriately, or not shared when it should be.

Any new information assets and data flows that arise out of a new project or procurement where the Trust is the data controller or receives personal, confidential, and sensitive or business sensitive information will need to be recorded on the Data & Information Asset Register.

6.17 Reporting Incidents and Weaknesses

An Information Incident is an event that could compromise the confidentiality of information (if it is lost or could be viewed by or given to unauthorised persons), the integrity of the data (if it could be inaccurate or content could have been changed) or the availability of the information (access).

Examples of information incidents are:

- Potential and suspected disclosure of NHS information to unauthorised individuals.
- Loss or theft (attempted or actual) of paper records, data or IT equipment on which data is stored.
- Disruption to systems and business processes.
- Attempts to gain unauthorised access to computer systems, e.g. hacking.
- Records altered or deleted without authorisation by the data "owner".
- Virus or other malicious malware attacks (suspected or actual).
- "Blagging" offence where information is obtained by deception.
- Breaches of physical security e.g. forcing of doors or windows into secure rooms or filing cabinets containing NHS sensitive or other UK Government information left unlocked in an accessible area.
- Leaving a desktop or laptop unattended when logged-in to a user account without locking the screen to stop others accessing information.
- Human error such as emailing data by mistake.
- Covert or unauthorised recording of meetings and presentations.
- Damage or loss of information and information processing equipment due to theft, fires, floods, failure of equipment or power surges.
- Deliberate leaking of information.
- Insider fraud.[1]
- Smartcard or application misuse.
- Smartcard theft.
- Non-compliance of local or national RA policy.
- Any unauthorised access of HSCIC applications.
- Any unauthorised alteration of patient data.

The Trust handles considerable amounts of patient data and this can be sensitive. An information incident involving sensitive data, especially patient confidential information, is considered to be a data/information breach and must be reported.

[1] Where any incidents involving suspected fraud are identified, the Trust's Fraud, Bribery and Corruption Policy should be followed and advice sought from the Local Counter Fraud Specialist (robert.purseglove@nhs.net).

All information management and technology security incidents and weaknesses must be reported via Trust incident reporting procedures (see Trust Incident Reporting Policy).

Incidents that present an immediate risk to the Trust should be escalated through local supervisor & manager, IT Helpdesk & Data Protection Officer.

SIRO & Data & Information Governance Group Reporting

The Data Protection Officer will keep SIRO & DIGB informed of the information incidents and status by means of regular reports and immediate escalation where an immediate risk is identified.

7. Dissemination, storage and archiving (Control)

This policy replaces version 1.5 Information Security Policy. The policy is to be made available on the Trust intranet and available to all staff.

8. Training and other resource implications

Information Governance training is mandatory for all staff on induction and on a yearly basis.

The Information Governance Team will work with the Learning Development team and managers to ensure that appropriate additional training is available to support staff.

The Information Governance team will work the Senior Information Risk Owner, Data & Information Managers and other appropriate managers and teams to maintain continued awareness of confidentiality and security issues to both the organisation and staff through staff emails, newsletters, intranet etc.

9. Audit, monitoring and review

This section should describe how the implementation and impact of the policy will be monitored and audited. It should include timescales and frequency of audits.

If the policy is required to meet a particular standard, it must say how and when compliance with the standard will be audited.

Monitoring Compliance Template						
Minimum Requirement	Process for Monitoring	Responsible Individual/ group/committee	Frequency of Monitoring	Review of Results process (e.g. who does this?)	Responsible Individual/group/ committee for action plan development	Responsible Individual/group/ committee for action plan monitoring and implementation
Compliance with this policy in terms of use of the Internet and related systems	Review in light of any incidents, staff requests and suggestions	Information Manager; Head of Informatics and Information Systems; IT Dept.	Annual	Data & Information Governance Board	Information Manager; Head of Informatics and Information Systems; IT Dept.	Data & Information Governance Board

Policy documents should be reviewed every three years or earlier where legislation dictates or practices change. The policy review date should be written here - 31/07/2020.

10. Implementation plan

The implementation plan should be presented as an action plan and include clear actions, lead roles, resources needed and timescales. The Director of Corporate Governance team can provide advice on formats for action plans however; an example layout for the plan is shown below:

Action / Task	**Responsible Person**	**Deadline**	**Progress update**
Upload to Intranet	Corporate Affairs	TBC	26/11/2019
Distribute communications	Corporate Affairs	TBC	05/12/2019
Provide training and awareness	IMST	TBC	
Review against progress and operational need	DIGB	TBC	

11. Links to other policies, standards and legislation (associated documents)

The Trust and its employees, including non-Trust employees authorised to access Trust information and systems, are obliged to comply with the following legislation and requirements:

- Common Law Duty of Confidentiality
- Data Protection Act 2018/GDPR
- Computer Misuse Act 1990
- Freedom of Information Act 2000
- Regulation of Investigatory Powers Act 2000
- Copyright, Designs and Patents Act 1998
- NHS Code of Connection
- Confidentiality: NHS Code of Practice
- Records Management: NHS Code of Practice
- Fraud, Bribery and Corruption Policy

And any relevant guidance related to the following:

- Information Quality Assurance
- Information Security
- Information Governance Management

12. Contact details

The document should give names, job titles and contact details for any staff who may need to be contacted in the course of using the policy (sample table layout below). This should also be a list of staff who could advise regarding policy implementation.

Title	***Name***	***Phone***	***Email***
Senior Information Risk Owner (SIRO)	Phillip Easthope	0114 3050765	Phillip.easthope@shsc.nhs.uk
Assistant Deputy Director of IMS&T	Ben Sewell	0114 2711144	Ben.sewell@shsc.nhs.uk
Data Protection Officer	John Wolstenholme	0114 3050749	John.wolstenholme@shsc.nhs.uk

13. References

The document should include key references for the evidence base, and relevant legislation or government policy.

- The Data Protection Act (2018)
- General Data Protection Regulation (GDPR)
- The Freedom of Information Act (2000)
- Environmental Information Regulations (2004)
- European Directive 2003/4/EC
- Access to Health Records Act (1990)
- Human Rights Act (1998)
- Crime and Disorder Act (1998)
- Criminal Procedures and Investigations Act (1996)

- Regulatory and Investigatory Powers Act (2000)
- ICO Framework Code of Practice for Sharing Personal Information
- (2007)
- Children Act (2004)
- Working together to Safeguard Children (2006)
- NHS Act (2006)
- Multi-Agency Public Protection Arrangements (MAPPA)
- Mental Capacity Act 2005 and Code of Practice (2007)
- Information Sharing Guidance for Practitioners and Managers
- (2008)
- Confidentiality NHS Code of Practice (2003)
- Confidentiality Guidance for Doctors (GMC 2009)
- Confidentiality and Disclosure of Health Information Toolkit (BMA
- 2008)
- The NMC Code of Professional Conduct: Standards for Conduct,
- Performance and Ethics (NMC 2004)
- No Secrets: Guidance on developing and implementing multiagency policies and procedures to protect vulnerable adults from abuse.
- Data Protection and Sharing – Guidance for Emergency Planners and Responders (HMG 2007)
- Data Sharing Review Report (Thomas and Walport 2008)
- Health and Social Care Act (2012)
- Caldicott Guidance (2010)
- To Share or Not to Share – The Information Governance Review (2013)
- Computer Misuse Act 1990
- Department of Health, Records Management: NHS Code of Practice (2006)
- NHS Connecting for Health
- NHS Information Governance, Guidance on Legal and Professional Obligations (Department of Health, 2007)
- Inter-Agency Information Sharing Protocol (co-ordinated by The Health Informatics Service)

Appendix A – Version Control and Amendment Log

Version No.	Type of Change	Date	Description of change(s)
1	New policy	March 2018	New policy created aligning to the Data & Information Governance Strategy
1.1	Amended and approved	May 2018	Minor amendments and approval by Data & Information Governance Board (DIGB)
1.2	Revision	Apr – Oct 2019	Updates for legislative and monitoring changes and contact details. Inclusion of Data Minimisation, reference to the Inter-Agency Information Sharing Protocol and the National Data Opt-Out.

Appendix B – Dissemination Record

Version	Date on website (intranet and internet)	Date of “all SHSC staff” email	Any other promotion/ dissemination (include dates)
1.1	August 2018		

Appendix C – Stage One Equality Impact Assessment Form

Equality Impact Assessment Process for Policies Developed Under the Policy on Policies

Stage 1 – Complete draft policy

Stage 2 – **Relevance** - Is the policy potentially relevant to equality i.e. will this policy potentially impact on staff, patients or the public? If **NO** – No further action required – please sign and date the following statement. If **YES –** proceed to stage 3

This policy does not impact on staff, patients or the public (insert name and date) No. J Wolstenholme, 21 Oct 2019

Stage 3 – **Policy Screening** - Public authorities are legally required to have 'due regard' to eliminating discrimination , advancing equal opportunity and fostering good relations , in relation to people who share certain 'protected characteristics' and those that do not. The following table should be used to consider this and inform changes to the policy (indicate yes/no/ don't know and note reasons). Please see the SHSC Guidance on equality impact assessment for examples and detailed advice. This is available by logging-on to the Intranet first and then following this link https://nww.xct.nhs.uk/widget.php?wdg=wdg_general_info&page=464

	Does any aspect of this policy actually or potentially discriminate against this group?	**Can equality of opportunity for this group be improved through this policy or changes to this policy?**	**Can this policy be amended so that it works to enhance relations between people in this group and people not in this group?**
AGE			
DISABILITY			
GENDER REASSIGNMENT			
PREGNANCY AND MATERNITY			
RACE			
RELIGION OR BELIEF			
SEX			
SEXUAL ORIENTATION			

Stage 4 – **Policy Revision** - Make amendments to the policy or identify any remedial action required (action should be noted in the policy implementation plan section)
Please delete as appropriate: Policy Amended / Action Identified / no changes made.

Impact Assessment Completed by (insert name and date)

Appendix D - Human Rights Act Assessment Form and Flowchart

You need to be confident that no aspect of this policy breaches a person's Human Rights. You can assume that if a policy is directly based on a law or national policy it will not therefore breach Human Rights.

If the policy or any procedures in the policy, are based on a local decision which impact on individuals, then you will need to make sure their human rights are not breached. To do this, you will need to refer to the more detailed guidance that is available on the SHSC web site
http://www.justice.gov.uk/downloads/human-rights/act-studyguide.pdf
(relevant sections numbers are referenced in grey boxes on diagram) and work through the flow chart on the next page.

1. **Is your policy based on and in line with the current law (including case law) or policy?**

✓ **Yes. No further action needed.**

□ **No. Work through the flow diagram over the page and then answer questions 2 and 3 below.**

2. **On completion of flow diagram – is further action needed?**

□ **No, no further action needed.**

□ **Yes, go to question 3**

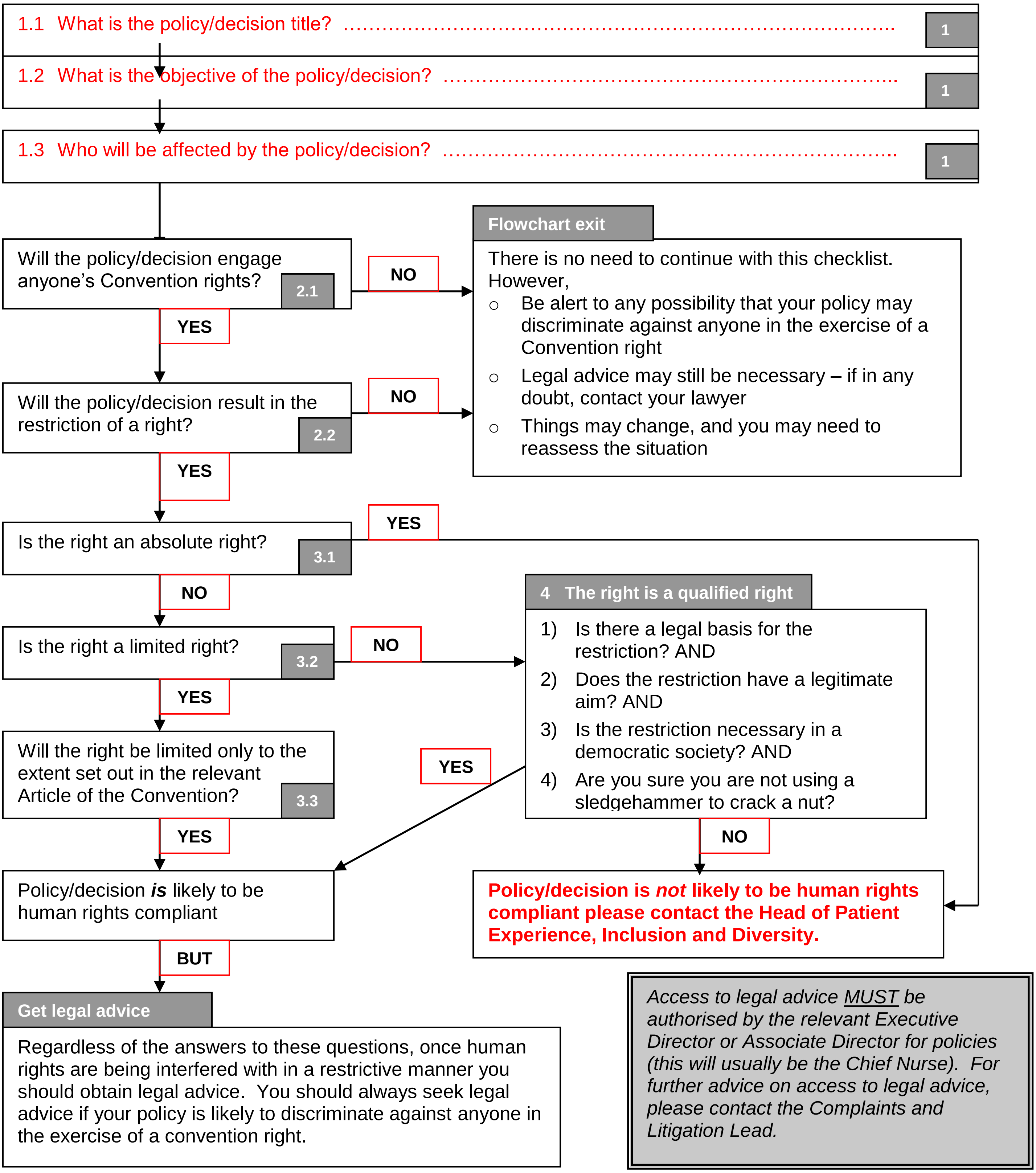
3. **Complete the table below to provide details of the actions required**

Action required	By what date	Responsible Person

Human Rights Assessment Flow Chart

Complete text answers in boxes 1.1 – 1.3 and highlight your path through the flowchart by filling the YES/NO boxes red (do this by clicking on the YES/NO text boxes and then from the Format menu on the toolbar, choose ‘Format Text Box’ and choose red from the Fill colour option).

Once the flowchart is completed, return to the previous page to complete the Human Rights Act Assessment Form.



1.1 What is the policy/decision title? …………………………………………………………………….. 1

1.2 What is the objective of the policy/decision? ………………………………………………………….. 1

1.3 Who will be affected by the policy/decision? ………………………………………………………….. 1

Will the policy/decision engage anyone’s Convention rights? 2.1

Will the policy/decision result in the restriction of a right? 2.2

Is the right an absolute right? 3.1

Is the right a limited right? 3.2

Will the right be limited only to the extent set out in the relevant Article of the Convention? 3.3

Policy/decision ***is*** likely to be human rights compliant

Flowchart exit

There is no need to continue with this checklist. However,

- Be alert to any possibility that your policy may discriminate against anyone in the exercise of a Convention right
- Legal advice may still be necessary – if in any doubt, contact your lawyer
- Things may change, and you may need to reassess the situation

4 The right is a qualified right

1) Is there a legal basis for the restriction? AND
2) Does the restriction have a legitimate aim? AND
3) Is the restriction necessary in a democratic society? AND
4) Are you sure you are not using a sledgehammer to crack a nut?

Policy/decision is *not* likely to be human rights compliant please contact the Head of Patient Experience, Inclusion and Diversity.

Get legal advice

Regardless of the answers to these questions, once human rights are being interfered with in a restrictive manner you should obtain legal advice. You should always seek legal advice if your policy is likely to discriminate against anyone in the exercise of a convention right.

Access to legal advice MUST be authorised by the relevant Executive Director or Associate Director for policies (this will usually be the Chief Nurse). For further advice on access to legal advice, please contact the Complaints and Litigation Lead.

Appendix E – Development, Consultation and Verification

This policy was developed as part of a major review of Information Governance policies in 2018 to meet the requirements of legislative change (introduction of the General Data Protection Regulation (GDPR) and Data Protection Act 2018) and the migration from the Information Governance Toolkit to the Data Security & Protection Toolkit which takes account of the National Data Guardian's data security standards.

It incorporates and replaces the previous e-mail policy.

The policies were approved by the Data & Information Governance Board in May 2018.

This policy was updated in October 2018 to update references and contact details for submission to the November 2019 Data & Information Governance Board.

Appendix F –Policies Checklist

Please use this as a checklist for policy completion. The style and format of policies should follow the Policy template which can be downloaded on the intranet (also shown at Appendix G within the Policy).

1. Cover sheet ☒

All policies must have a cover sheet which includes:

- The Trust name and logo ☒
- The title of the policy (in large font size as detailed in the template) ☒
- Executive or Associate Director lead for the policy ☒
- The policy author and lead ☒
- The implementation lead (to receive feedback on the implementation) ☒
- Date of initial draft policy ☒
- Date of consultation ☒
- Date of verification ☒
- Date of ratification ☒
- Date of issue ☒
- Ratifying body ☒
- Date for review ☒
- Target audience ☒
- Document type ☒
- Document status ☒
- Keywords ☒
- Policy version and advice on availability and storage ☒

2. Contents page

3. Flowchart ☒

4. Introduction ☒

5. Scope ☒

6. Definitions ☒

7. Purpose ☒

8. Duties ☒

9. Process ☒

10. Dissemination, storage and archiving (control) ☒

11. Training and other resource implications ☒

12. Audit, monitoring and review ☒

This section should describe how the implementation and impact of the policy will be monitored and audited and when it will be reviewed. It should include timescales and frequency of audits. It must include the monitoring template as shown in the policy template (example below).

Monitoring Compliance Template						
Minimum Requirement	Process for Monitoring	Responsible Individual/ group/ committee	Frequency of Monitoring	Review of Results process (e.g. who does this?)	Responsible Individual/group/ committee for action plan development	Responsible Individual/group/ committee for action plan monitoring and implementation
A) Describe which aspect this is monitoring?	e.g. Review, audit	e.g. Education & Training Steering Group	e.g. Annual	e.g. Quality Assurance Committee	e.g. Education & Training Steering Group	e.g. Quality Assurance Committee

13. Implementation plan ☒

14. Links to other policies (associated documents) ☒

15. Contact details ☒

16. References ☒

17. Version control and amendment log (Appendix A) ☒

18. Dissemination Record (Appendix B) ☒

19. Equality Impact Assessment Form (Appendix C) ☒

20. Human Rights Act Assessment Checklist (Appendix D) ☒

21. Policy development and consultation process (Appendix E) ☒

22. Policy Checklist (Appendix F) ☒