Policy:

IMST 011 - Confidentiality Code of Conduct

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Policy Owner	Data Protection Officer
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Document Type	Policy
Document Version Number	v5
Date of Approval By PGG	30/01/2023
Date of Ratification	18/04/2023
Ratified By	ARC
Date of Issue	12/02/2020
Date for Review	02/2026

Summary of policy
This policy provides guidance on the use of confidential personal information within the Trust.

Target audience	All SHSC staff, volunteers, contract staff and people working on behalf of the Trust.

Keywords	Confidentiality, Security, Disclosure, Consent

Storage & Version Control

Version 5 of this policy is stored and available through the SHSC intranet/internet.. This version of the policy supersedes the previous version (V4 02/2020). Any copies of the previous policy held separately should be destroyed and replaced with this version.

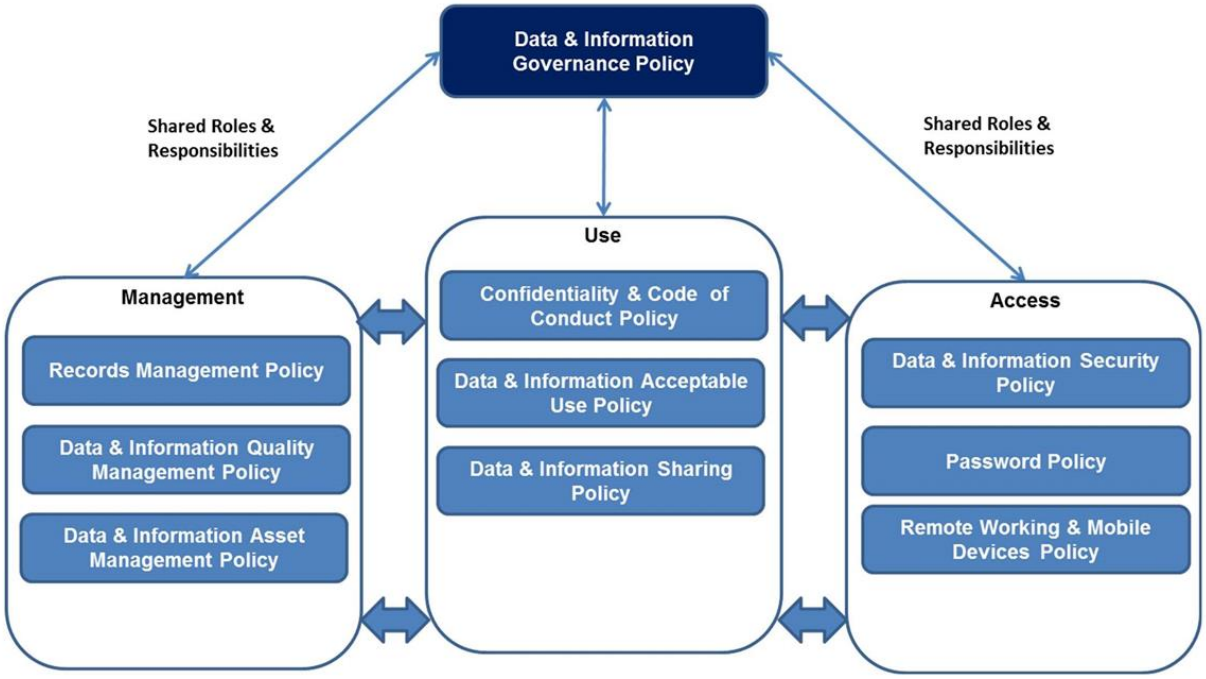
Version Control and Amendment Log

Version No.	Type of Change	Date	Description of change(s)
1.0	Original policy approved by Information Governance Committee	09/2007	New policy approved along with other Information Governance policies developed by city-wide information governance group and after consultation with and agreement by staff-side.
1.0	Policy re-formatted and approved by Information Governance Committee	03/2008	
2.0	Policy revised and approved	04/2009	Organisation name changes, clarification of scope, addition of advance statements, additional guidance on taking records off Trust premises
2.1	Policy revised	02/2015	Minor updates
2.1	Policy approved by Information Governance Steering Group	04/2015	
3.0	Ratified and issued	09/2016	Ratified by EDG
4.0	Updated for change in regulations	12/2019	Updated for references to GDPR/DPA 2018, DSPT. Section on consent revised, fax guidance removed.
5	Updated for organisational change	01/2023	Minor updates to reflect organisational change

Contents

Flowchart

This policy is part of a suite of information governance policies which provide guidance on the use, processing and security of personal information within the Trust.



1 Introduction

This Code of Conduct has been developed as a guide for staff and others working on Sheffield Health and Social Care NHS Foundation Trust (SHSC) business to the required standards of good practice in relation to providing a confidential service.

In delivering effective treatment and care, SHSC processes (obtains, holds, uses and discloses) confidential information. Confidential information may be:

- Information about named individuals (including service users, members of staff or other third parties)
- Information about SHSC or other health or social care organisations (such as financial or risk records)

Keeping information confidential is not the same as keeping it secret. It is essential that relevant confidential information is available to those who have a need to know it in order to do their work.

Confidential information should only be used for the purpose(s) it was provided for unless there are exceptional circumstances.

This code sets out the principles for handling confidential information and explains what this means in practice. It is based on the NHS Confidentiality Code of Practice published by the Department of Health in 2003.

2 Scope

This code of conduct applies to all SHSC employees and non-Trust employees who work within SHSC or under contract to it. This includes, but is not limited to, all staff, whether directly employed, seconded, on honorary contracts, permanent or temporary, also agency staff, non-executive directors, students on placement and people working in a voluntary capacity.

For convenience, the term ‘staff’ is used in this document to refer to all those to whom the code of conduct applies.

The Code relates to the requirements that must be met in order to provide service users, staff and others with a confidential service. It is based around the four main requirements of the Confidentiality Model which is at the heart of the NHS Confidentiality Code of Practice.

Although the Model and its requirements were written primarily for the handling of service user information, the Model’s four requirements apply to the handling of all personal information including staff, service user and carer information. The requirements in relation to confidential information are:

- Protect - look after personal information
- Inform - ensure that individuals are made aware of how the information they provide is used
- Provide choice - allow individuals to decide whether their information can be disclosed or used in particular ways when the purpose is not for direct care.
- Improve - always look for better ways to protect, inform and provide choice

The principles in section 7 are a synthesis of this model with the addition of accepted good practice.

The duty of confidentiality for all staff arises out of common law, legal obligations, staff employment contracts and professional obligations. This duty continues after the staff member no longer works for or has an association with SHSC.

Any breaches of this code including unauthorised breaches of confidentiality, inappropriate access to or use of personal health data or abuse of computer systems will be treated as a disciplinary offence, which may result in the staff member's employment, or association, with the Trust being terminated. It may also have consequences for professional registration and possibly result in legal proceedings.

If you have concerns regarding any aspect of SHSC's business, there are internal mechanisms in place by which you can raise these issues to gain redress in a constructive and practical way. Such mechanisms include line management advice and support, complaints mechanism, grievance procedure, Chief Executive or Non-Executive Director guidance. In particular your attention is drawn to the Trust's Speaking Up – Freedom to Speak Up: Raising Concerns (Whistleblowing) Policy.

3 Purpose

The purpose of this code of conduct is to protect service users and staff from the misuse of their information and to ensure that confidential information is handled in a lawful and appropriate manner by:

- Defining what is meant by the phrase "confidential information"
- Informing you of your responsibilities in relation to such information
- Informing you of the correct procedures for dealing with confidential information so that you do not inadvertently breach confidentiality
- Providing sources of further information

4 Definitions

Caldicott Guardian:
The role of the Caldicott Guardian resulted from the 1997 Review of Patient Identifiable Information, chaired by Dame Fiona Caldicott. Central to the recommendations of the review was the appointment in each NHS organisation of a Guardian of person-based clinical information to oversee the arrangements for the use and sharing of that information. The Guardian is usually a clinician at Trust Board level who acts as the conscience of the organisation, leading improvements in the way the Trust handles confidential patient identifiable information.

Caldicott Function:
Staff, skills and other resources available to support the Caldicott Guardian carry out the responsibilities of the role.

Safe Haven Procedures:
In this context a safe haven is a location or system within the Trust where arrangements and procedures are in place to ensure person-identifiable information can be held, received and communicated securely.

Informed Explicit Consent:
Consent, freely given, usually verbally or in writing, when the individual understands why their information is needed, who it will be shared with, what options are available to them with regard to their information and the consequences of those options.

Under the UK General Data Protection Regulation (UK GDPR) and the Data Protection Act 2018, if consent is used as the legal basis for processing this must involve a clear affirmative action (an opt-in). Most of SHSC processing does not rely on consent as the legal basis.

5 Detail of the policy

This policy provides guidance on the holding, use and sharing of confidential personal information within the Trust, including information about service users, carers and staff, plus sources of advice and further guidance.

6 Duties

All managers are responsible for ensuring their staff are aware of this Code of Conduct and their individual responsibilities for it, and that they are equipped to fulfil those responsibilities. This will include covering the Code in corporate and local induction programmes and by identifying and meeting specific or generic training needs through personal development plans.

The Trust has a duty of care to make all reasonable adjustments for staff with disabilities. In cases where staff have disabilities that impact on their ability to fulfil their responsibilities under this Code it is the responsibility of the line manager to assess the situation and ensure appropriate adjustments are put in place.

All staff are expected to adhere to this Code of Conduct. Staff must ensure that they are aware of the requirements and standards of behaviour that apply.

All staff are responsible for reporting all breaches of confidentiality, and near misses, in accordance with the Trust's Incident Management Policy and Procedure. Advice on using the Trust's incident reporting process should be obtained from line managers in the first instance. Further advice can be obtained from the Trust's Risk Department.

If there is anything within this Code of Conduct that you do not understand, you should contact your line manager in the first instance, or the Information Governance Manager or the Data Protection Officer for further information.

The Trust's Data & Information Governance Group has authority delegated by the Audit & Risk Committee to provide direction to and oversee implementation of this Code of Conduct, including arrangements to test compliance with the Code and implementation of necessary actions arising from internal or external compliance checks. It will ensure that the Code of Conduct is reviewed periodically. The Data & Information Governance Group is accountable to the Audit & Risk Committee.

7 Procedure

This section sets out the principles for handling confidential information and explains what this means in practice. The topics covered are listed below.

7.8 Capacity to consent
7.9 Consent of children and young people
7.10 Only disclose information without consent for legitimate reasons
7.11 Follow the relevant SHSC procedure when disclosing information without consent
7.12 Disclosing information to the police
7.13 Check list of points that must be considered before disclosing confidential information
7.14 Access to records
7.15 Keep information secure
7.16 Report incidents and near misses in line with SHSC policy
7.17 Do not hold confidential information on portable devices without authorisation
7.18 Improve standards of practice wherever possible
7.19 Use confidential information in accordance with SHSC policies
7.20 Apply policy in areas within your work area

Principle	**What this means in practice**
7.1 What is confidential information?	Confidential information may be information about identifiable individuals including, but not limited to, service users, carers, members of staff or other third parties. It may also be organisational information about SHSC or any other health or social care organisation. It is not necessary for the name of the individual to be known for the information to be identifiable. For example, it may be possible to identify an individual when a number of data items are put together such as post code, ethnicity and medical condition. Information about deceased people is still classed as confidential. Confidential information may be in a variety of forms including but not limited to electronic, paper, digital or audio format, such as records, note books, message books, x-rays, photographs, audio or video recordings, voicemail etc, or it may be knowledge gained from overheard conversations or seeing someone attend a clinic appointment. Examples of confidential information SHSC holds include: • Personal demographic details of service users and staff • Contact details of service users and staff • Medical details of service users and staff • Ethnicity of service users and staff • Bank and salary details of staff • Results of DBS (formerly CRB) checks • Organisational financial information • Waiting list data Information that has been placed in the public domain, except as a result of a breach of confidentiality, is not classed as confidential.

7.2 Who has a duty of confidentiality?	All SHSC employees and non-Trust employees who work within SHSC or under contract to it have a duty to maintain the confidentiality of information gained during their employment or association with the Trust. This includes, but is not limited to, all staff, whether directly employed, seconded, on honorary contracts, permanent or temporary, also agency staff, non executive directors, students on placement and people working in a voluntary capacity. For convenience, the term 'staff' is used in this document to refer to all those to whom the code of conduct applies. Anyone may come into contact with confidential information in the course of their duties. For example: • You may have direct access to confidential information if you are authorised to access information held in staff or service user records • You may have confidential information passed to you in connection with your work • You may become aware of information as a result of breaches of confidentiality. You are obliged to maintain the confidentiality of this information. This duty continues after you no longer work for or have an association with SHSC.
7.3 Why is confidentiality important?	Confidentiality is important to protect the privacy of all individuals (staff, service users and carers) whose information we hold. Both staff and service users provide us with confidential information about themselves. They have a legitimate expectation that we will respect their privacy and treat their information appropriately. In a service delivery setting, it is important to maintain the trust of service users. Service users entrust us with, or allow us to gather, confidential information relating to their health and other matters as a part of their seeking treatment. We use this information to assess their needs and deliver appropriate treatment and care. It is essential that clinicians/practitioners have all relevant information to hand. If service users do not trust us with their information they may withhold vital information or not seek treatment. Trust is also important in managing health and safety, and risk. Staff or service users may want to pass on information about other individuals for example, to report poor practice. Staff should be aware of the appropriate procedures, which should be followed in such cases. (In some circumstances, service users may lack the competence to extend this trust or may be unconscious, but this does not diminish the duty of confidence). It is essential if the trust of staff and service users is to be retained, and legal requirements are to be met, that the NHS provides, and is seen to provide, a confidential service.

7.4 Inform service users and staff	At their first contact with the organisation/ service/member of staff you should: • Explain to service users/carers/staff why we collect information, how it might be used and who it might be shared with. • Make it clear to individuals what your role is and the circumstances under which confidential information may have to be shared. This gives them the opportunity to limit the information they provide. • Explain to service users in particular that the information they give may be recorded, may need to be shared in order to provide them with care and may be used to support clinical audit and other work to monitor the quality of care provided. • Explain to individuals their general rights (see section 6.6 below). • Consider if individuals would be surprised to learn that their information is being used in a particular way. If they would be, they are not being effectively informed. Staff should consider the following options in order to inform service users effectively: • Is it clear to service users when information is recorded or health records accessed? • Is it clear to service users when staff are or will be sharing information with others? • Are service users aware of the choices available to them in respect of how their information may be used or shared? • Check that service users have no concerns or queries about how their information is used or shared • Answer any queries personally or direct the service user to others who can answer their questions or to other sources of information • Respect the rights of service users and help them in exercising their right to have access to their health records
7.5 Record information accurately, consistently and in a timely manner	• Record information in accordance with SHSC policy and service-specific procedures. • You have a duty to maintain proper records. (This is vital to the provision of care and the running of the Trust). • If records are inaccurate, future decisions may be wrong and may result in harm to a service user or member of staff. • If information is recorded inconsistently, then records will be harder to interpret, resulting in delays and possible errors.

7.6 Understand and respect the rights of individuals in relation to their information	Under the Data Protection Act 2018 and UK GDPR, individuals have certain rights about the way information about them is used. These include the right to:
	
	• To be informed about the collection and use of their personal data.
	• Have a copy of information that is recorded about them (a subject access request) and to have any part of it they do not understand explained (or authorise someone else to request access on their behalf)
	  ○ Access to some or all of the information may be refused where it would cause serious harm to the data subject or anyone else (any health information should be reviewed by an appropriate health professional prior to disclosure)
	  ○ Access to information that identifies another person will be refused unless s/he has consented to the disclosure (this does not apply if the information is about a professional involved in the care of the individual and relates to their care)
	  ○ The request must be answered within one month
	• Object to processing of their data or, in certain circumstances, have information about them erased.
	  ○ The right to erasure depends on the legal basis used for processing. Most SHSC processing depends on the 'Public function' basis so data subjects do not have an automatic right to have their data deleted
	
	• Have inaccurate information rectified or destroyed. (In cases of dispute, the individual will be allowed to place a note on the record disputing SHSC's version of events).
	• Not to be subject to automated decision making or profiling without human intervention

7.7 Obtain consent to share information where necessary	• Information can be shared for direct patient care without consent although data subjects should be informed of the uses their information will be put to. • Information can also be shared without consent where the Trust has a legal obligation, or to protect the vital interests of the data subject or another person, or for the prevention or detection of serious crime. • Where information is shared for other purposes data subjects should be given the choice of whether their information is shared or not. In these cases the consent of the data subject needs to be informed and explicit – • i.e. the individual understands why their information is needed, who it will be shared with and the possible consequences of them agreeing or not to the proposed use, and it requires a positive action to opt-in. • Service users are able opt out of their confidential patient information being used for research and planning via the National Data Opt-Out – see www.nhs.uk/your- nhs-data-matters/ • Where a third party requests access to records and has provided written consent of the individual, you should

	check that the consent is informed. • In certain circumstances, if a service user wishes to prohibit the disclosure of information to other health or social care professionals it may mean that the care that can be provided is limited or, in rare circumstances, cannot be provided at all. Clinicians cannot treat service users safely, nor provide continuity of care, without having relevant information about a service user's condition or medical history. • You must inform service users if their wishes about disclosure have implications for the provision of care or treatment. • Where a service user has been informed about the proposed uses and disclosures of their information and has agreed, then further consent is not required for each specific disclosure associated with that purpose. • Lack of consent should not prevent the sharing of information where there are concerns about the welfare of an individual.
7.8 Capacity to consent to sharing information	• Where the individual does not have the capacity to consent, the responsibility for deciding the appropriate course of action lies with the agency giving care or, for service users who have planned ahead, the person with an appropriate and properly registered power of attorney. • Where the agency giving care is responsible for decisions about information sharing, these must be made in the best interests of the service user taking into consideration any previously expressed views of the service user. The service user's views may have been recorded in an Advance Statement although they are not legally binding. It is good practice to encourage patients to complete an Advance Statement whilst they still have the capacity to do so. • In accordance with the Mental Capacity Act 2005 (MCA), the agency, where appropriate, should consult other people, especially: anyone previously named by the service user as someone who should be consulted, carers, close relatives or friends of the patient, any attorney appointed under the MCA, the views of an appointed independent mental capacity advocate (IMCA), any deputy appointed by the Court of Protection to make decisions for the service user.
7.9 Consent of children and young people	• Young people aged 13 or over are able give their own consent for processing their information. • In the case of children and young people under the age of 13, consent is usually required from a person with parental responsibility (who is usually the mother or father or someone who holds a court order giving them parental responsibility). • People with parental responsibility can authorise other people to make decisions about their children including the sharing of information.

7.10 Only disclose information without consent for legitimate reasons	• There are circumstances when it is necessary to share information even though the individual has not consented.
	• These circumstances are the exception rather than the rule.
	• Information can be shared without the consent of the person whom the information is about when:
	  ○ It is in the public interest to do so
	  ○ It is required by law
	
	Examples of sharing information in the public interest include:
	• Where a child is believed to be at risk of harm (Children Act 1989)
	• Where there is a risk of harm to anyone, including the data subject
	• Where information is required for the prevention, detection or prosecution of a serious crime
	
	Examples of sharing information where it is required by law include:
	
	• If the individual gives information about suspected terrorism (Anti-terrorism, Crime & Security Act 2001 and Terrorism Act 2000)
	• Notification of certain infectious diseases
	• Where it is required by court order
	• Under the Mental Health Act 1983 where a service user objects to their 'nearest relative' being consulted re:
	  - An application for Treatment Order (Section 3) is being considered
	  - An application for assessment and treatment (Section 2) in relation to the service user has been made
	  - Under the Mental Health Act (Patients in the Community) Act 1995 where the service user is known to have the propensity to violent or dangerous behaviour
	• Domestic Violence, Crime and Victims Act 2004 gives victims of specified sexual or violent offences the right to be informed of certain decisions if the offender becomes subject to provisions under the MHA 1983.
	
	Confidential information that is disclosed without consent must follow the appropriate process

7.11 Follow the relevant SHSC procedure when disclosing information without consent	• If it is felt necessary to share information where consent is withheld the individual should be informed of this decision (unless it would prejudice the investigation of a crime or would put the individual at risk of harm). It may be appropriate to give the individual an opportunity to disclose the information him/herself. • If it is not possible to obtain the consent of the individual, or it is not desirable, then the decision whether to share information should be taken at an appropriate level within the organisation. • The authority to disclose information may vary within different parts of SHSC and may depend on the reason for/circumstances of disclosure. It may lie with the Caldicott Guardian/Caldicott function, or professional lead such as the Clinical Director or other senior manager. • You should ask your line manager for the procedure you should follow or obtain advice from the information gGovernance ead. • It is a requirement of SHSC that the reasons for the final decision (either to share or not to share) should be recorded. • It is important where information is shared without consent that the member of staff documents what information was released and when, to whom it was disclosed, and why it was felt justified. • All non-consented disclosures must be reported to the Caldicott Guardian and information governance lead.
7.12 Disclosing information to the police	• Requests for personal information should be in writing. If requests are submitted by e-mail they should be from a genuine police e-mail address. • The request for information should specify why it is required. (See section 6.10 for legitimate reasons for disclosing information without consent). • If it is not possible for the applicant to specify why the information is required (for example, because it would prejudice the investigation of a crime) then the request should be signed by a senior officer (chief inspector or above). • Information should only be disclosed with the proper authority (See section 6.11 and 6.13.4). • Disclosures to the police may be very sensitive. Consider if special arrangements need to be put in place to facilitate disclosure, for example, nominate a member of staff to deal with the request. • Where police produce a consent form for the records they wish to access, a member of staff should check with the data subject that the consent is informed.

7.13 Check-list of points that must be considered before disclosing confidential information	The purpose of these questions is to help you decide the appropriate action to take if you are asked to disclose confidential information about a service user, carer or member of staff. They are not sequential or definitive but are intended as a guide to good practice. • Have I verified the applicant's identity? • Is there a legitimate reason for disclosing the information? • Is the information requested adequate, relevant and not excessive for the purpose? • Do I have the authority to disclose the information? • What is the most appropriate method of disclosing the information? • Who do I need to inform that I have disclosed confidential information? • What do I need to record about the request and disclosure/non-disclosure?
7.13.1 Verifying identity	You must ensure that you can confirm the identity of the person and/or legitimacy of the organisation requesting information. *Requests in person* If you are not familiar with the individual then you can ask for some photo ID. *Telephone requests* You can verify identity in the following ways: *Request from another agency* Telephone the individual back via the main switchboard of their organisation. If you do not know the telephone number (for example, because it is an agency that you are not familiar with), then you should independently verify the number via the agency's official website or a telephone directory/directory enquiry service, that is, don't accept the number as given by the applicant. Unless there is a local procedure in place that states otherwise, you should ask for the request to be put in writing. All requests from the police should be put in writing. *Written requests* Written requests from organisations (for example, a solicitor or substance misuse agency) must be on headed notepaper. The address should be independently verified (that is, you should not accept an address/fax number given to you for an organisation that you are unfamiliar with). The identity of the applicant should be verified for all written requests.

7.13.2 Legitimate reasons for disclosing information	• Disclosure is required law, for example, by statute or court order. • There is an overriding public interest in disclosing the information. • Disclosure of the information is required for the purposes of providing direct care to service users. • The service user/staff member who is the subject of the data wishes the information to be disclosed.
7.13.3 Disclosing information that is adequate, relevant and not excessive for the purpose	Consider: • What does the recipient hope to achieve by the disclosure?(That is, what is the purpose of disclosing information?) • What is the minimum amount of information you can share to achieve that purpose? • Who does the information need to be shared with?
7.13.4 Authority to disclose information – consented and non-consented disclosures including routine bulk transfers of patient identifiable data (PID)	Confidential personal or SHSC information may only be disclosed with the proper authority and must be protected against improper disclosure at all times. Authority to disclose may be obtained from the data subject or from the designated individual in the Trust. **Authority from the service user/staff member** The service user/staff member has given authorisation for the disclosure of his/her information. **Appropriate authority from within SHSC** Disclosures of information that breach confidentiality should be authorised by the Caldicott Guardian/Caldicott function or by a designated senior manager/professional lead such as a clinical director where there are local departmental procedures in place. (Advice can be obtained from the information governance lead). All non-consented disclosures should be reported to the Caldicott Guardian. All bulk transfers of PID must be subject to a Data Protection Impact Assessment and approved before they can commence.

7.13.5 Appropriate methods of communicating confidential information	The most appropriate method of communicating information will depend on a number of factors including the sensitivity of the information, its destination and the urgency of the request. Information should be transferred effectively, that is, it should reach its destination in a timely manner, and confidentially. As a general rule, you should inform the intended recipient if you are sending them confidential information so that they can inform you if they have received it or not. **By post** • Ensure you have an up to date address for the intended recipient (authorised staff have access to the National Spine/Summary Care Record which may be used to check service user details). • Confidential information should marked 'Private and confidential: for the addressee only' • Confidential information sent in both the internal and
	external post should be in sealed envelopes or packaging • Depending on the sensitivity of the information and where it is being sent to, information may be double or single wrapped, and delivered by hand/recorded delivery/ normal post/internal post - but not in a transit envelope (either sealed or unsealed) • Confidential information sent/transferred on a CD rom/floppy disc/memory stick must be encrypted. **By fax** Fax machines are being phased out within the NHS in favour of more secure methods of transfer. **By telephone** Ensure you know the identity of the caller before giving out information. (See 'verifying identity' above). Do not leave confidential information on voicemail. **By e-mail** Confidential information should not be shared by e-mail unless it is part of a process agreed and authorised by the information governance lead/Caldicott function. See the Data & Information Sharing policy for details of how confidential information can be sent by e-mail securely.

7.13.6 Informing appropriate individuals that confidential information has been disclosed	**The service user/staff member** 1. Even where there are grounds for disclosing confidential information without consent it is good practice to ask permission to do so (but see point 4 below). 2. Where a service user/staff member has disclosed information that you feel needs to be disclosed to a third party, it may be appropriate to give the service user/staff member an opportunity to disclose this information him/herself first. You should follow this up later, by an agreed date with the individual, to ensure the information has been disclosed. 3. If it is decided that it is necessary to disclose information even though the service user/staff member has specifically withheld their consent, it is good practice to inform him/her of your intention. 4. The service user/staff member should not be asked for permission to release information or told that information about them has been disclosed without their consent if it would prejudice the investigation of a crime or would put any individual at risk of harm. **Other health and social care professionals** It is important to identify and inform any individuals who need to be made aware that confidential service user/staff member information has been disclosed. This is particularly important where information has been disclosed without consent.
7.13.7 Recording information about disclosures	All relevant information about disclosures must be recorded in the service user's notes/staff personal file. This includes: • The name of the person and agency making the request • The method of the request (telephone, in writing, e-mail etc) • The purpose of the request • Whether information was disclosed or not • Who the information was disclosed to and by what method • Reasons for disclosure or non-disclosure • If there was service user/staff member consent to the disclosure or not • Who has been informed of the disclosure

7.14 Access to records	• The Data Protection Act 2018 gives individuals a general right of access to view or receive a copy of information that is held about them. An individual can apply for access to his/her own information or authorise someone else to apply for access to this information on his/her behalf. Responses must be made within one month. Requests can be submitted to any point within the Trust and may be verbal as well as written - contact the Access to Records team if a request is received. • Requests to access the health records of deceased people can be made under the Access to Health Records Act 1990. Under this Act, the patient's personal representative or anyone with a claim arising from the death can request access to their records.

7.15 Keep information Secure	Personal information should be held, used and shared securely and confidentially and in line with SHSC policies.
	
	For example:
	
	Confidentiality in public places
	• Be aware of the difficulties of maintaining confidentiality in open plan offices
	• Do not discuss confidential information in public areas where it may be overheard, for example:
	  ○ In corridors
	  ○ In reception areas
	  ○ When using mobile phones
	• Do not record confidential information where it may be accessed by unauthorised people – for example, on white boards, electronic dashboards, in paper files that are not locked away etc.
	
	Access to information
	• Do not browse electronic systems or records
	• Do not access information which you do not have a need to know
	• Save information on a secure server where available
	• Ensure information stored in a shared drive is accessible only to those with a need to know
	• Consider how PC screens are positioned - can confidential information be seen by anyone who does not have a need to know
	• Do not leave confidential information unattended, for example, do not leave information out on your desk or information systems logged on when you are not present
	• Share information on a need-to-know basis
	
	Information security
	• Lock information away when not in use
	• Information not stored on a server, for example, confidential information held on a PC or laptop hard drive must be encrypted and must be backed up

	regularly, kept in a secure place and transferred to a server as soon as possible • Information must only be stored on such portable devices in accordance with SHSC policy (see section 7.17) • Do not introduce unauthorised software onto your PC or laptop • Use up to date anti-virus software (generally managed centrally by IT Dept.) • Virus check memory sticks etc. before introducing them onto your PC **Records taken Away from Trust Premises** • Any staff taking confidential information away from Trust premises must risk-assess the need for adequate security. This requirement is set out in the Remote Working and Mobile Devices Policy, which includes: o Confidential information, whether manual or electronic, must be protected by adequate security, for example, it must be :- o Kept out of sight, for example, in the locked boot of the car when transported; o Not left unattended, for example, not left in the car boot overnight or when the car is parked up and left during visits etc.; o Locked away when not being used; o Kept secure and guarded from theft, unauthorised access and adverse environmental events when taken home.
	See also the section regarding the need for assessing the potential risk before working on confidential information at home. Send personal information appropriately (see 7.13.5) • By post – in a sealed envelope marked 'Private and confidential: for the addressee only' • By portable media – confidential information must be encrypted to the appropriate standard and transferred appropriately • By telephone – ensure you know the identity of the caller before giving out information • E-mail – confidential information should not be shared by e-mail unless it is part of an authorised process • Don't leave confidential messages on voicemail **Confidential waste** Confidential information may be stored in a number of formats such as paper records, information in notepads/message books, CDs/DVDs, hard drive of computers etc. All such information and devices storing such information must be disposed of appropriately and in line with SHSC policy, for example, use of 'confidential waste'

	boxes, shredding, destruction of hard drives by IT Dept. etc. **Passwords** Use passwords to access electronic systems in line with the Trust Password policy, for example, in deciding what the password should be, how often it is changed, not sharing passwords, locking workstations, password-protecting documents etc. In particular: **Do not share passwords with others** • Change your password at regular intervals • Do no re-use old passwords • Do not write your passwords down in an obvious place • Avoid using short passwords or using names or words that are associated with you, for example, children's or pets' names • Use a combination of numbers and letters
7.16 Report incidents and near misses in line with SHSC policy	Report security incidents such as theft or unauthorised disclosure, including near misses, in line with SHSC policy.
7.17 Do not hold confidential information on portable devices without authorisation	• Confidential information must only be stored on mobile devices such as laptops, memory sticks or mobile phones in line with Trust policy and those devices must be encrypted. • Working on confidential information at home also requires authorisation as above. (See section 7.15 regarding records taken away from Trust premises, and the separate Mobile Working and Remote Devices Policy).
7.18 Improve standards of practice wherever possible	It is not possible to achieve best practice overnight but we must work towards continuous improvement. In order to work towards achieving best practice staff must: • Be aware of the issues surrounding confidentiality, and seek training, support and advice as necessary in order to deal with them effectively • Feedback comments or suggestions to managers on systems, procedures or working practices that give a cause for concern or could be improved • Report breaches, suspected breaches and near misses

7.19 Use confidential information in accordance with SHSC policies	Be aware of all relevant SHSC policies and procedures. These are available on the intranet/JARVIS. Before any new processing of personal information can begin, or significant changes to existing processing are made, a Data Protection Impact Assessment (DPIA) should be completed – contact the Data Protection Officer for more details.
7.20 Apply policy within your work area	• Inform the staff you manage of their responsibilities in relation to SHSC information governance policies • Ensure these are adhered to or action is taken to address non-compliance

8 Development, Consultation and Approval

The original policy was developed by the SCT Information Department jointly with the Sheffield PCT Information Governance Group in order to establish a common approach to Information Governance across the city.

The policy was revised in light of national guidance issued in early 2008.

The draft policy was presented to and approved by the SCT Information Governance Committee.

It was submitted to the JCF and agreed by Staff Side The policy was approved by the EDG.

The policy was revised and submitted to the Information Governance Steering Group in October 2010

The policy was revised and submitted to the Information Governance Steering Group in February 2015 and approved in April 2015

The policy was re-formatted in line with Trust requirements and submitted to EDG for approval in September 2016

The policy was reviewed and updated to reflect legislative change and monitoring requirements, and re-formatted in line with Trust requirements in December 2019

The policy was revised and minor changes made to reflect organizational changes in January 2023.

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 Code of Conduct	Review as part of the Data Security & Protection Toolkit assessment	Data & Information Governance Group	Annual	Data & Information Governance Group	Data & Information Governance Group	Data & Information Governance Group

Policy documents should be reviewed every three years or earlier where legislation dictates or practices change. The policy review date is February 2026.

10 Implementation Plan

Action / Task	**Responsible Person**	**Deadline**	**Progress update**
Upload new policy onto intranet and remove old version	Corporate Governance	03/2023	
Ensure staff are aware of this policy	SHSC Team managers	Ongoing	

11 Dissemination, Storage and Archiving (Control)

This policy will be achieved through induction processes (corporate and local), the provision of training and day-to-day management of individuals.

The policy will be made available to all staff via the SHSC intranet/website.

Changes to this policy will be made by the SHSC Data Protection Officer at the request of or approved by the Data & Information Governance Group (DIGG).

Version	Date added to intranet	Date added to internet	Date of inclusion in Connect	Any other promotion/ dissemination (include dates)
1.0	03/2008	03/2008		
2.0	04/2009	04/2009		
3.2	09/2016	09/2016		
4.0	02/2020	02/2020		
5.0				

12 Training and Other Resource Implications

Departmental managers are responsible for ensuring that their staff are aware of and comply with this policy.

13 Links to Other Policies, Standards (Associated Documents)

The main references in compiling this Code are :

- Access to Health Records Act 1990;
- Common Law Duty of Confidence;
- Computer Misuse Act 1990;
- UK General Data Protection Regulation (UK GDPR)
- Data Protection Act 2018;
- Freedom of Information Act 2000;
- Health and Social Care Act 2012;
- Human Rights Act 1998;
- Mental Capacity Act 2005;
- Mental Health Act 1983;
- Caldicott Review of Patient Identifiable Information 1997;
- Information: To share or not to share? The Information Governance Review 2013;
- Confidentiality: NHS Code of Practice 2003;
- NHS Information Governance Requirements;
- Professional Codes of Conduct;
- Guide to Confidentiality in Health and Social Care - Treating confidential information with respect. HSCIC, 2013;

SHSC Policies:

- Records Management Policy
- Data & Information Sharing Policy
- Remote Working & Mobile Devices Policy
- Password Policy
- Data & Information Security Policy
- Speaking Up – Freedom to speak up: Raising concerns (whistleblowing) policy

- Incident Management Policy and Procedure (Including Serious Incidents)

14 Contact Details

Title	***Name***	***Phone***	***Email***
Caldicott Guardian	Mike Hunter	2664838	Mike.hunter@shsc.nhs.uk
Chief Clinical Information Officer	Raihan Talukdar	2718057	Raihan.talukdar@shsc.nhs.uk
Information Governance Manager	Katie Hunter	2716723	Katie.hunter@shsc.nhs.uk
Data Protection Officer	John Wolstenholme	3050749	John.wolstenholme@shsc.nhs.uk

Appendix A

Equality Impact Assessment Process and Record for Written Policies

Stage 1 – **Relevance** - Is the policy potentially relevant to equality i.e. will this policy potentially impact on staff, patients or the public? This should be considered as part of the Case of Need for new policies.

NO – No further action is required – please sign and date the following statement. **I confirm that this policy does not impact on staff, patients or the public.**	***I confirm that this policy does not impact on staff, patients or the public.*** Name/Date: J Wolstenholme, 23 Jan 2023	**YES,** Go to **Stage 2**

Stage 2 Policy Screening and Drafting Policy - 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 and Flow Chart.

Stage 3 – **Policy Revision** - Make amendments to the policy or identify any remedial action required and record any action planned in the policy implementation plan section

SCREENING RECORD	Does any aspect of this policy 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			
Marriage or Civil Partnership			

Please delete as appropriate: - Policy Amended / Action Identified (see Implementation Plan) / no changes made.

Impact Assessment Completed by:
Name /Date

Appendix B

Review/New Policy Checklist

This checklist to be used as part of the development or review of a policy and presented to the Policy Governance Group (PGG) with the revised policy.

		Tick to confirm
	Engagement	
1.	Is the Executive Lead sighted on the development/review of the policy?	✓
2.	Is the local Policy Champion member sighted on the development/review of the policy?	✓
	Development and Consultation	
3.	If the policy is a new policy, has the development of the policy been approved through the Case for Need approval process?	N/A
4.	Is there evidence of consultation with all relevant services, partners and other relevant bodies?	✓
5.	Has the policy been discussed and agreed by the local governance groups?	✓
6.	Have any relevant recommendations from Internal Audit or other relevant bodies been taken into account in preparing the policy?	✓
	Template Compliance	
7.	Has the version control/storage section been updated?	✓
8.	Is the policy title clear and unambiguous?	✓
9.	Is the policy in Arial font 12?	✓
10.	Have page numbers been inserted?	✓
11.	Has the policy been quality checked for spelling errors, links, accuracy?	✓
	Policy Content	
12.	Is the purpose of the policy clear?	✓
13.	Does the policy comply with requirements of the CQC or other relevant bodies? (where appropriate)	✓
14.	Does the policy reflect changes as a result of lessons identified from incidents, complaints, near misses, etc.?	✓
15.	Where appropriate, does the policy contain a list of definitions of terms used?	✓
16.	Does the policy include any references to other associated policies and key documents?	✓
17.	Has the EIA Form been completed (Appendix 1)?	✓
	Dissemination, Implementation, Review and Audit Compliance	
18.	Does the dissemination plan identify how the policy will be implemented?	✓
19.	Does the dissemination plan include the necessary training/support to ensure compliance?	✓
20.	Is there a plan to i. review ii. audit compliance with the document?	✓
21.	Is the review date identified, and is it appropriate and justifiable?	✓