Trust Policy
Information Governance Department
Confidentiality Policy

Document Control

Author / Contact	Paul White, IG and CAM Manager	
Document Ref	GEN 6.71	
Document Impact Assessment	Yes Date: September 2017	
Version	V5	
Status		
Publication date		
Review date	May 2020	
Approval Recommended by	Information Governance Group	Date: 17th May 2018
Approved By (Executive)		
Distribution	Barnsley Hospital NHS Trust-intranet Please note that the Intranet version of this document is the only version that is maintained. Any printed copies must therefore be viewed as "uncontrolled" and as such, may not necessarily contain the latest updates and amendments	

Table of Contents

1. INTRODUCTION

1.1. A duty of confidentiality arises when one person discloses information to another in circumstances where it is reasonable to expect that information will be held in confidence (e.g. patient to clinician, commercial in confidence information disclosed in contract negotiations).

1.2. The purpose of this policy is to set out confidentiality requirements and consequent duties and provide a framework for Barnsley Hospital NHS Foundation Trust (BHNFT) to ensure compliance with all relevant legal obligations, standards and guidelines and professional codes of conduct.

1.3. The confidentiality of personal information of staff and patients will be achieved by the formal adoption of the DH publication 'Confidentiality: NHS Code of Practice' as the authoritative reference to be included in the BHNFT Confidentiality Policy and implemented throughout the Trust.

1.4. The confidentiality of non-personal information will be achieved by the implementation of relevant Trust policies (as detailed in Section 10).

2. OBJECTIVE

2.1. This policy sets out BHNFT's commitment to the confidentiality of information relating to patients, service users and all staff including volunteers, contractors and agency workers and its responsibilities with regard to the disclosure of such information.

2.2. All employees working in the NHS are bound by a legal duty of confidence to protect personal confidential data they may come into contact with during the course of their work.

2.3. The policy is also to protect staff by making them aware of the correct procedures for maintaining confidentiality of patient information so that they do not inadvertently breach any requirements of law or good practice.

2.4. The legal and best practice guidance informing the development of this policy includes:

- Common Law Duty of Confidence
- All contracts of employment with the Trust
- Data Protection Act 2018 and the General Data Protection Regulations
- Human Rights Act 1998
- Computer Misuse Act 1990
- Caldicott 2
- NHS Confidentiality Code of Practice
- Codes of Conduct for all Health Professionals

2.5 Under the Data Protection Act and the General Data Protection Regulations the Trust should ensure that the appropriate security measures are in place to safeguard patient information.

2.6 The Trust is held accountable, through clinical and information governance frameworks, specifically the Data Security and Protection Toolkit, for continuously improving confidentiality and security procedures governing access to and storage of personal information.

3. SCOPE OF POLICY

3.1. This policy applies to all employees of the Trust, in all locations, including the Non-Executive Directors, temporary employees, locums and contracted staff.

4. ROLES AND RESPONSIBILITES

4.1. **Chief Executive**

4.1.1. The Chief Executive has overall responsibility for Information Governance. As the Accounting Officer he is responsible for the management of the organisation and for ensuring appropriate mechanisms are in place to support service delivery and continuity.

4.2. **Data Protection Officer**

4.2.1. The implementation of, and compliance with, this policy is delegated to the Data Protection Officer (DPO) who will have responsibility for bringing data protection issues to the Trust Board.

4.3. **Roles of the IG Management Framework (IGMF)**

4.3.1. Other Key roles documented in the Trust Information Governance Management Framework include:

- Senior Information Risk Owner
- Caldicott Guardian
- Director of ICT
- Head of Information Governance and clinical Application Management
- Information Governance Specialist
- Information Asset Owner
- Information Asset Administrator

4.4. **Information Governance Group**

4.4.1. The Committee is responsible for ensuring that the Trust establishes monitors and maintains appropriate integrated systems, processes and reporting arrangements for the management of all aspects of information governance, data protection and confidentiality. It supports and drives the broader information governance agenda and provides the Governance Committees and the Board with assurance that effective information governance best practice mechanisms are in place within the Trust.

4.5. **Head of Health Records**

4.5.1. The Head of Health Records will oversee the management of health records in accordance with relevant Trust policies, and will ensure staff are provided with

training for their responsibilities for record keeping. The Head of Health Records will facilitate timely access to health records where a legitimate subject access request has been received.

4.6. **Managers**

4.6.1. Managers should ensure through appraisal and regular supervision that staff are aware of and comply with key policies and procedures relevant to their work.

4.7. **All Staff**

4.7.1. It is the responsibility of each member of Trust staff to familiarise themselves with, and follow the policies relevant to their role/work.

4.7.2. All Trust staff, whether clinical or administrative, has responsibility for the safety and proper management of the information they process, and for the prompt reporting of any Information Governance incident using the Datix incident recording system.

4.7.3. All staff must complete their Data Security Awareness refresher training annually.

5. POLICY PRINCIPLES

5.1. No employee shall breach their legal duty of confidentiality, allow others to do so, or attempt to breach any of the Trust's security systems or controls in order to do so.

5.2. All information about patients must be treated as confidential and only be used for the purposes for which it was given i.e. to provide care, or for local clinical audit of that care. The duty of confidentiality is owed to all patients and endures beyond the individual's death.

5.3. Information necessary to provide care or treatment for an individual patient should be shared on a 'need to know basis', i.e. with others in the healthcare team for that episode of care.

5.4. As it is impractical to obtain consent every time information needs to be shared, patients must be informed and understand that some information may be made available to other members of the team involved in the delivery of their care.

5.5. Disclosure of information outside the team that will have personal consequences for patients must be with the explicit consent of the patient.

5.6. If the patient withholds consent, or if consent cannot be obtained for whatever reason, disclosures may be made only where there is a legal basis for doing so.

5.7. Further details on the disclosure of information and consent practices can be found in the Trust Confidentiality Code of Conduct.

6. APPLICATION OF THE CODE OF CONFIDENTIALITY

6.1. General guidance for all persons listed in the scope of this policy, in order to comply with relevant legislation and professional guidelines and ethics, is contained in the Trust Confidentiality Code of Conduct available on the Trust Policy Warehouse.

6.2. Principles of confidentiality will be communicated to staff via induction, mandatory training and Trust communication mechanisms.

7. KEEPING PATIENTS INFORMED

7.1. The Trust will ensure that patients are informed of the proposed uses of their personal information through the Trust Privacy Notice, patient information leaflets, patient awareness sessions and external communications (e.g. social media).

7.2. The Trust will ensure that staff and volunteers are informed of the importance of providing good Data Quality standards through the Data Quality policy and mandatory training.

7.3. The Trust will regularly:

- review the use of patient information
- ensure that all new uses of information are brought to the attention of affected patients
- update communication materials if necessary

8. BREACH OF THIS POLICY

8.1. Failure to manage personal confidential data securely places the Trust at risk of breaching data protection legislation, NHS Caldicott Guidelines and Trust policy. All Trust staff has responsibility for the security and proper management of the personal confidential data and other confidential information they process.

8.2. Failure to comply with the terms of this and associated policies may lead to disciplinary action and / or legal proceedings against the individuals concerned.

9. INCIDENT REPORTING

9.1. All information governance incidents, including actual and suspected breaches of confidentiality and information security, must be recorded on Datix in line with the Trust Incident Management Policy.

9.2. The Trust must notify the Information Commissioner and in some cases the Department of Health of a breach of personal confidential data within 72 hours. If the breach is likely to result in a high risk of adversely affecting individuals' rights and freedoms, organisations must also inform those individuals without undue delay.

10. ASSOCIATED POLICIES AND GUIDANCE

10.1. All Information Governance Policies and associated policies such as Health Records is accessible to all staff via the Trusts Policy Warehouse: http://systems/pt/default.aspx

11. TRAINING AND RESOURCES

11.1. Information on confidentiality, points of contact for advice and training will be included in the Trusts Induction Booklet and Corporate Induction presentation.

11.2. Staff will be made aware of this policy via line management.

11.3. The confidentiality policy and NHS Code of Practice will be available to all staff via the Trust policy warehouse.

11.4. References to this policy will be included in mandatory and induction training sessions, and form the basis of IG principles for related education and training sessions.

12. MONITORING AND AUDIT

Minimum requirement to be monitored	Process for monitoring e.g. audit	Responsible individual/ group/ committee	Frequency of monitoring	Responsible individual/ group/ committee for review of results	Responsible individual/ group/ committee for development of action plan	Responsible individual/group / committee for monitoring of action plan and Implementation
Confidentiality Incidents	Datix System	Head of IG and CAM	Daily	IG Group	IG Specialist	Head of IG and CAM

13. EQUALITY AND DIVERSITY

13.1. Trust is committed to an environment that promotes equality and embraces diversity in its performance as an employer and service provider. It will adhere to legal and performance requirements and will mainstream equality and diversity principles through its policies, procedures and processes. This policy should be implemented with due regard to this commitment.

13.2. To ensure that the implementation of this policy does not have an adverse impact in response to the requirements of the Equality Act 2010 this policy has been screened for relevance during the policy development process and a full equality impact analysis conducted where necessary prior to consultation. The Trust will take remedial action when necessary to address any unexpected or unwarranted disparities and monitor practice to ensure that this policy is fairly implemented.

13.3. This policy and procedure can be made available in alternative formats on request including large print, Braille, moon, audio, and different languages. To arrange this please refer to the Trust translation and interpretation policy in the first instance.

13.4. The Trust will endeavour to make reasonable adjustments to accommodate any employee/patient with particular equality and diversity requirements in implementing this policy and procedure. This may include accessibility of meeting/appointment venues, providing translation, arranging an interpreter to attend

appointments/meetings, extending policy timeframes to enable translation to be undertaken, or assistance with formulating any written statements.

14. RECORDING AND MONITORING OF EQUALITY AND DIVERSITY

14.1. The Trust understands the business case for equality and diversity and will make sure that this is translated into practice. Accordingly, all policies and procedures will be monitored to ensure their effectiveness.

14.2. Monitoring information will be collated, analysed and published on an annual basis as part Equality Delivery System. The monitoring will cover the nine protected characteristics and will meet statutory duties under the Equality Act 2010. Where adverse impact is identified through the monitoring process the Trust will investigate and take corrective action to mitigate and prevent any negative impact.

14.3. The information collected for monitoring and reporting purposes will be treated as confidential and it will not be used for any other purpose.

EQUALITY IMPACT ASSESSMENT TEMPLATE
INITIAL ASSESSMENT STAGE 1 (part 1)

Department:	IG & CAM	**Division:**	Corporate
Title of Person(s) completing this form:	Head of IG & CAM	**New or Existing Policy/Service**	Existing
Title of Policy/Service/Strategy being assessed:	Confidentiality Policy	**Implementation Date:**	01/8/17
What is the main purpose (aims/objectives) of this policy/service?	The purpose of this policy is to set out confidentiality requirements and consequent duties and provide a framework for Barnsley Hospital NHS Foundation Trust (BHNFT) to ensure compliance with all relevant legal obligations, standards and guidelines and professional codes of conduct.		

Will patients, carers, the public or staff be affected by this service? Please tick as appropriate.		Yes	No	If staff, how many individuals/which groups of staff are likely to be affected? All staff.
	Patients		X	
	Carers		X	
	Public		X	
	Staff	X		

Have patients, carers, the public or staff been involved in the development of this service? Please tick as appropriate.				If yes, who did you engage with? Please state below: Information Governance Committee with Clinical, Operational and Corporate staff representation.
	Patients		X	
	Carers		X	
	Public		X	
	Staff	X		

What consultation method(s) did you use?	

DATA COLLECTION AND CONSULTATION

1a In relation to this service/policy/procedure – Do you currently record/have any of the following patient data?

Protected Characteristic	Indicate yes or No	If Yes – State where Recorded
Age	**No**	
Sex	**No**	
Ethnicity	**No**	
Religion or Belief	**No**	
Disability	**No**	
Sexual Orientation	**No**	
Gender Re-assignment	**No**	
Marriage & Civil Partnership	**No**	
Pregnancy & Maternity	**No**	
Carer Status	**No**	

Please indicate Yes or No

Equality Impact Assessment Stage 1 PART 2

What does this data tell you about each of the above protected characteristics? Are there any trends/inequalities?

Not Applicable

What other evidence have you considered? Such as a 'Process Map' of your service (assessment of patient's journey through service) / analysis of complaints/ analysis of patient satisfaction surveys and feedback from focus groups/consultations/national & local statistics and audits etc.

Not Applicable

Equality Impact Assessment Stage 1 PART 3

ACCESS TO SERVICES

What are your standard methods of communication with service users?

Please tick as appropriate.

Communication Methods	Yes	No
Face to Face Verbal Communication	X	
Telephone	X	
Printed Information (E.g. leaflets/posters)	X	
Written Correspondence		X
E-mail	X	

Other (Please specify)		**X**

If you provide written correspondence is a statement included at the bottom of the letter acknowledging that other formats can be made available on request?
Please tick as appropriate.

Yes	No
	X

Are your staff aware how to access Interpreter and translation services?

Interpreter & Translation Services	Yes	No
Telephone Interpreters (Other Languages)	X	
Face to Face Interpreters (Other Languages)	X	
British Sign Language Interpreters	X	
Information/Letters translated into audio/braille/larger print/other languages?	X	

ACCESS
Please tick as appropriate

Is the building where the service is located wheelchair accessible?	Yes	No
Does the reception area have a hearing loop system?		X
Does the building where the service is located have a unisex wheelchair accessible 'disabled toilet?	X	
Does the building have car parking space reserved for Blue Badge holders?	X	
Does the building have any additional facilities for disabled people such as a wheelchair, hoist, specialist bath etc?	X	
Does the building/hospital sire where the service is provided have access to prayer and faith resources?	X	

EQUALITY IMPACT ASSESSMENT – STAGE 1 (PART 4)

Protected Characteristic	Positive Impact High Low None	Negative Impact High Low None	Reason/comments for positive Impact Why it could benefit any/all of the protected characteristics	Reason/Comments for Negative Impact Why it could disadvantage any/all of the protected characteristics	Resource Implication Yes / No
Men	None	None			
Women	None	None			
Younger People (17 – 25) and Children	None	None			
Older people (60+)	None	None			
Race or Ethnicity	None	None			

Learning Disabilities	**None**	**None**			
Hearing impairment	**None**	**None**			
Visual impairment	**None**	**None**			
Physical Disability	**None**	**None**			
Mental Health Need	**None**	**None**			
Gay/Lesbian/Bisexual	**None**	**None**			
Trans	**None**	**None**			
Faith Groups (please specify)	**None**	**None**			
Marriage & Civil Partnership	**None**	**None**			
Pregnancy & Maternity	**None**	**None**			
Carer Status	**None**	**None**			
Other Group (please specify)	**None**	**None**			
Applies to ALL Groups	**None**	**None**			

INITIAL ASSESSMENT (PART 5)

Have you identified any issues that you consider could have an adverse (negative) impact on people from the following protected groups?

Title of Service/Policy being assessed:	Confidentiality Policy
Assessment Date:	**25/09/2017**

IF 'NO IMPACT' IS IDENTIFIED Action: No further documentation is required.

IF 'HIGH YES IMPACT' IS IDENTIFIED Action: Full Equality Impact Assessment Stage 2 Form must be completed.

(a) In relation to each group, are there any areas where you are unsure about the impact and more information is needed?

No

(b) How are you going to gather this information?

(c) Following completion of the Stage 1 Assessment, is Stage 2 (a Full Assessment) necessary? NO

Assessment Completed By: Katie Hunter **Date Completed: 25/09/17**

Line Manager Tom Davidson Date

Head of Department …… Date……..

When is the next review? Please note review should be immediately on any amendments to your policy/procedure/strategy/service.

1 Year	**2 year**	**3Year X**

Is the service/policy aimed at a specific group of users?	No – All staff

ST AG

E 2 – FULL ASSESSMENT & IMPROVEMENT PLAN

MUST be completed if any negative issues have been identified at stage 1

Protected Characteristic	What adverse (negative) impacts were identified in Stage 1 and which groups were affected?	What changes or actions do you recommend to improve the service to eradicate or minimise the negative impacts on the specific groups identified?	Lead	Time-scale
Men Younger People (17-25) and Children Older People (50+) Race or Ethnicity Learning Disability Hearing Impairment Visual Impairment Physical Disability Mental Health Need Gay/Lesbian/Bisexual Transgender Faith Groups (please specify) Marriage & Civil Partnership Pregnancy & Maternity Carers Other Group (please specify) Applies to ALL Groups				

How will actions and proposals be monitored to ensure their success? Which Committee will you report to? (i.e. Divisional DQEC / Governance Meeting).	Information Governance Group
Who will be responsible for monitoring these actions?	Lead of each action.

Appendix 2
Caldicott Principles

The Caldicott Standards are based on the Data Protection Act 2018 principles and again are set out in the form of Principles

The Caldicott Guardian for the Trust is the Medical Director.

Principle 1: **Justify the Purpose**
Every proposed use or transfer of patient-identifiable
Information within or from an organisation should be clearly defined and scrutinised, with continuing uses regularly reviewed by an appropriate Guardian.

Principle 2: **Don't use Patient-Identifiable Information unless it is absolutely necessary**
Patient-identifiable information items should not be used unless there is no alternative

Principle 3: **Use the minimum necessary Patient-Identifiable Information**
Where use of patient-identifiable information is considered to be essential, each individual item of information should be justified with the aim of reducing identifiability

Principle 4: **Access to Patient-Identifiable Information should be on a strict need-to-know basis**
Only those individuals who need access to patient-identifiable information should have access to it, and they should only have access to the information items that they need to see

Principle 5: **Everyone should be aware of their responsibilities**
Action should be taken to ensure that those handling patient-identifiable information – both clinical and non-clinical staff – are aware of their responsibilities and obligations to respect patient confidentiality

Principle 6: **Understand and Comply with the Law**
Every use of patient-identifiable information must be lawful. Someone in each organisation should be responsible for ensuring that the organisation complies with legal requirements

Appendix 3

Version	Date	Comments	Author
5	17/05/2018	Discussion at the Information Governance Group	Head of IG and CAM

Review Process Prior to Ratification:

Name of Group/Department/Committee	Date
Information Governance Group	17/05/18
Clinical Effectiveness Group	06/06/18
Quality and Governance Group	20/06/18