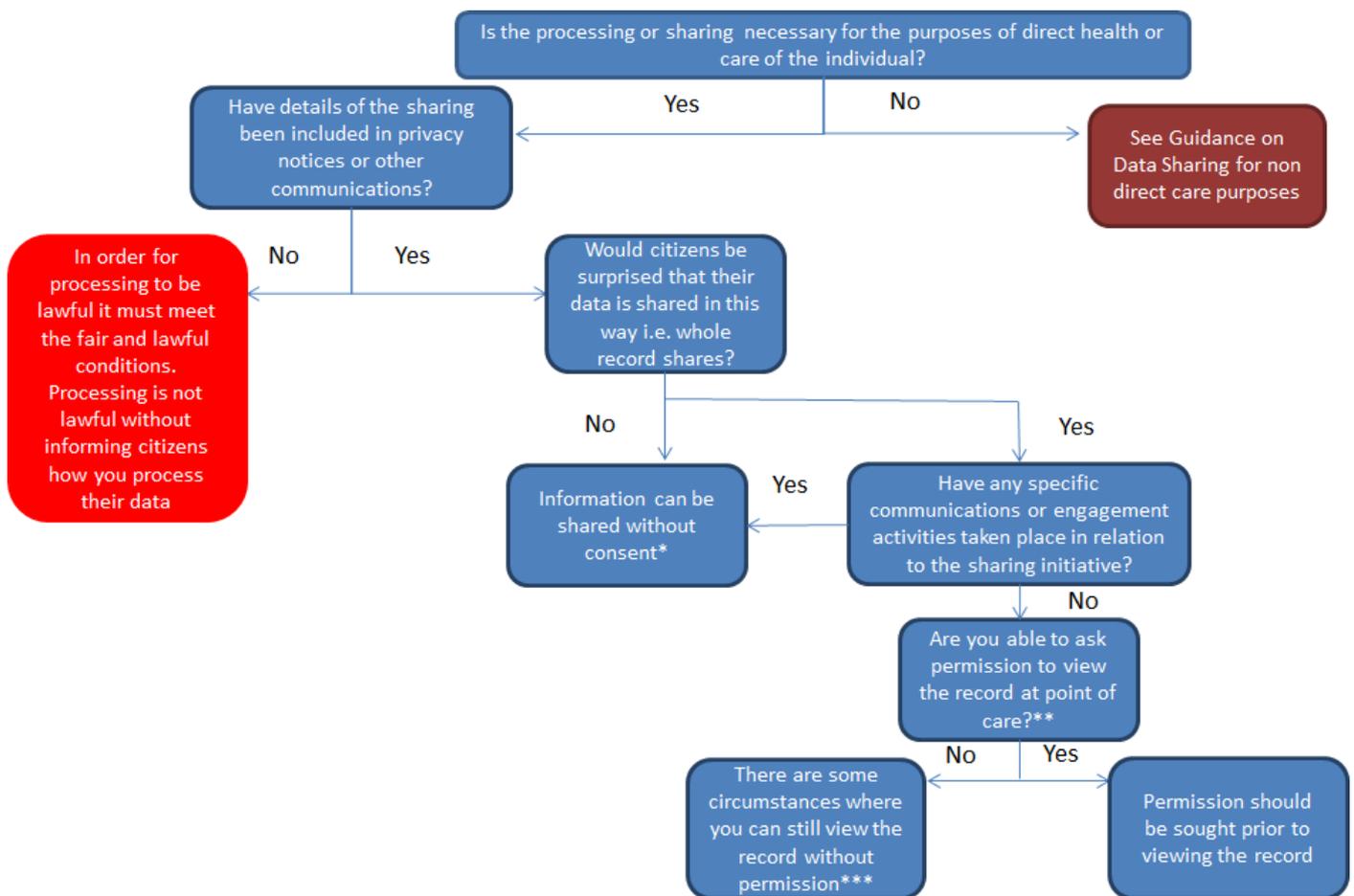


Title: Nottinghamshire Record Sharing Principles- Sharing for Direct Patient Care	
Date of Issue: June 2018	Guide No.: 2018/001
Endorsed by: Nottinghamshire Health and Care Information Governance Specialists	Approved Date: 14 June 2018
Replaces/Supersedes Guide No: 2016/001	Distribution: All Connected Nottinghamshire organisations
<p>Scope: To provide a framework of principles to support the sharing of information across Nottinghamshire health and care providers to support direct patient care. It is recognised that this will need to be expanded upon to include other care providers outside of healthcare in the future and will need regular review as technology develops and learning occurs. Some key principles have been identified which should enable all health and care providers to take a consistent approach to sharing information.</p>	
<p>Principles:</p> <ol style="list-style-type: none"> 1. Sharing information with care professionals involved in the patient's direct care is essential to providing high quality care. Information can be shared where supported by the legal and professional duty to share information to facilitate direct care. Under Data Protection legislation a legal basis for sharing special category health and care data for the purposes of providing health and social care for an individual is where it <i>"is necessary for the purposes of preventive or occupational medicine, for the assessment of the working capacity of the employee, medical diagnosis, the provision of health or social care or treatment or the management of health or social care systems and services on the basis of Union or Member State law or pursuant to contract with a health professional and subject to the conditions and safeguard"</i> NOT consent, however there is still an obligation to satisfy the requirements of the common law duty of confidentiality by informing citizens about how their information is shared. Sharing information must be undertaken to enable safe care to be delivered and there is a valid legal basis to do so without obtaining consent. 2. It is recognised that patients or citizens may occasionally raise objections to sharing information for direct care. In these situations, it is important that these concerns are handled by sufficiently senior staff and that their mental capacity for these decisions is assessed, including a detailed discussion of the potential safety risks involved with not sharing information. These cases need to be handled on a case-by-case basis, with reference to relevant professional guidance. There may be occasions when it is justified to share information for direct care in the face of explicit refusal to do so (for instance, in certain safeguarding situations). The organisation's Caldicott Guardian can be consulted if there is any doubt in this regard. 3. Where whole records are shared due to lack of access-control functionality in the system capabilities, those accessing the record are under a legal, contractual and moral duty to only access the information they need to undertake a specific task or function and comply with Caldicott principles and their professional code of conduct. 4. Wherever possible asking the patient for their consent to view their <u>whole</u> record is the best option and thus this should be the first consideration. 5. With sufficient communication to citizens (for example through privacy notices), implied consent is valid to make the patient's information available in order to deliver their care needs. 6. The users of the information or data must have a legitimate relationship with the patient i.e. they are part of a team providing direct care to the patient and are bound by the duty of confidentiality. 7. The users must be either 'registered or regulated professionals' or, in the case of administrative and support staff, be directly supervised by registered or regulated professionals as part of the wider care team, as per Caldicott2 Review recommendations. 8. Communication is essential if relying on implied consent, as in the absence of affirmative action from the patient, any data sharing must be informed. The test is whether the patient, if asked, would be 'surprised' by the data sharing and people who may be accessing their information. There are a number of conditions that would mean that implied consent could be used such as viewing the record due to receiving a referral prior to seeing the patient to establish its appropriateness. 	

9. Where an individual lacks the capacity to understand about information sharing and give consent to sharing information to support their care consent should be sought from their guardian where possible. When you are unable to obtain consent and it is in the best interests of the patient information should be accessed in order to safely treat the individual. The assessment of capacity should be made and documented in line with organisational policies.
10. Often there is no one size fits all model that can be realistically implemented in a timely fashion without detracting from the best possible care for the patient. Registered or regulated professionals should consider when undertaking information sharing present guidance; the 7 Caldicott Principles, the ICO Data Sharing Code of Practice/Checklist, NHS Digital Guide to Confidentiality, IGA guidance and their own ethical guidelines.
11. The Health and Social Care (Safety & Quality) Act 2015 introduces a new legal duty requiring health and adult social care organisations to share information where this will facilitate care for an individual.

Flow diagram for assessing information sharing for direct health and care



*You will still need to ensure that the other principles of data protection legislation are met

** Records can be made available to view using implied consent

***There are some conditions which mean you don't need to ask consent such as in the public interest, safeguarding or vital interests

Type of Sharing	Data Protection Legal Basis	Duty of Confidentiality	Approach
Sharing in the course of day to day activities (i.e. referrals, ToC, ad hoc sharing between agencies)	6(1)(e) public interest or public duty 9(2)(h) allows processing for the provision of healthcare (direct care) or the management of healthcare systems (invoice validation, commissioner reporting, quality audits – essentially, mandated activity).	Data can be shared under implied consent as the patient would reasonably expect this type of sharing to happen.	No consent required
Electronic sharing of whole records (i.e. eDSM)	6(1)(e) public interest or public duty 9(2)(h) allows processing for the provision of healthcare (direct care) or the management of healthcare systems (invoice validation, commissioner reporting, quality audits – essentially, mandated activity).	Record can be shared out using implied consent, however where possible permission to view should be obtained at point of care, as they patient may not reasonably expect their whole record to be shared and the 'no surprises' rule should be considered. Records may be viewed where permission is not possible and it is in the vital interests of the patient to do so.	Implied share out and permission to view where possible should be obtained.
Systematic sharing of data through an integration engine or repository (i.e. MIG, Portal)	6(1)(e) public interest or public duty 9(2)(h) allows processing for the provision of healthcare (direct care) or the management of healthcare systems (invoice validation, commissioner reporting, quality audits – essentially, mandated activity).	Record can be shared out using implied consent, however where possible permission to view should be obtained at point of care, as they patient may not reasonably expect their whole record to be shared and the 'no surprises' rule should be considered. Records may be viewed where permission is not possible and it is in the vital interests of the patient to do so.	Implied share out and permission to view where possible should be obtained.
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