**Information Sharing Agreement for**

**Direct Care**

Between:

Health and Social Care Organisations in *[insert]*

# **Background**

The safe, secure and legitimate handling of information is at the very core of health and social care.  As we move Health and Social Care into the 21st Century, the need to improve care underpinned by better information sharing is paramount.

Health and social care organisations are working in partnership to ensure local services are integrated and meet the needs of individuals within the local population. Health and social care professionals’ access to information at the right time, in the right place and within the right health and social care setting means that individuals are treated more safely and effectively.

Even though it is clearly in the best interests of the individual concerned to do so, any use or sharing of a person’s information has to be done in respect of their right to confidentiality and in a way that is lawful. Information should also meet standards to ensure it is of good quality and securely protected.

Each organisation involved in the Information Sharing Agreement is individually responsible for making sure their staff know how to handle confidential information andindividuals using their services are told how their information is being used and clearly understand that their information will be shared unless they object.

This Information Sharing Agreement sets out the common rules that binds the partner organisations involved in data sharing in [add area] for **direct care.**

To explain how this ISA should be developed for local needs as part of the Ripple programme we have developed our **Plain English Guide to Information Sharing** to accompany this template.The **guidance** provides supporting information to assist organisations to use this template for their own purpose and a glossary to explain words highlighted throughout the document.You are free to amend it to suit your particular needs.To note, this ISA does not cover the purpose of indirect care (e.g. research) although it is expected this will be addressed as part of the Ripple programme shortly.

To explain information sharing we have used a **Who, Where, What, Why, When and How** approach and have structured this Information Sharing Agreement in that way.

We want to give due credit to Joseph Waller director of XML Solutions, whose “[proposed consent model](http://www.xml-solutions.com/a-proposed-consent-model/)” of **implied, supplied, denied override**, we have deliberately reviewed, reused and hopefully improved.

[*comments have been inserted into the template as further guidance to assist local development*]

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**Approvals**

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| **Name** | **Organisation** | **Version** | **Date** |
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1. Purpose of the data sharing initiative

Information sharing between the health and social care partners in *[add area]*and signed up to this agreement is aimed at:

* Improving the care of individuals by ensuring health and social care professionals are provided with information they need to do their job safely and effectively;
* Ensuring the correct balance is achieved between our duty to care and our duty to share.
* Etc. *[add/amend as appropriate to your local area]*

# **Who** is involved in this Information Sharing Agreement?

The information we intend to share is about an **individual** who, in times of need seeks help from a **health or social care professional**.

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| The individual has certain rights concerning their personal information, including a right to access that information and a right to object to it being used in certain ways. Respecting the individual’s rights and expectations about confidentiality and telling them about how and why their personal information is used is a key principle of our information sharing agreement. |

“Who” includes whom the information is shared with.

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| For direct care, information will be shared between all of the health and social care professionals who work together in a multidisciplinary direct care team who plan, coordinate and provide care and treatment to the individual according to their needs.  It is also necessary to share information with staff who provide administrative and clerical support to help the direct care team to work effectively. |

The direct care team is made up of professional staff whose skills are necessary to provide the particular care the person needs according to their health condition and personal circumstances.

[*The direct care team may include a wide range of professionals not all of whom have direct contact with the individual, so it is important to explain here that as well as doctors, nurses, social workers, social care staff etc. the team also includes laboratory staffand administrative staff who provide support to help the team run efficiently etc.*]

Members of the team may be staff from one organisation (e.g. a GP Practice team) or from different organisations (e.g. community healthcare staff, hospital staff, social workers and carers).

These staff may work in public sector, non-public sector and 3rd sector (**voluntary**) organisations who work together to provide health and social care services.

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| Whoever is using information about a person, they are bound by laws, contracts and professional codes of conduct to use it responsibly, hold it securely and keep it confidential. |

A list of **who** is signed up to this Information Sharing Agreement can be found in Schedule 1.

# **What** Information is being shared?

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| All information about an identifiable person and their physical and mental health and condition is confidential. Relevant information about the person and their current care needs will only be shared by the health and social care professionals who are involved in the provision of care and treatment to the individual (the “direct care team”)when it is:   * necessary for them to be able to do their job; and * with the person’s knowledge and agreement; and * in accordance with the conditions set out in law. |

“Relevant information” is information that may directly influence the health or social care professionals’ decision over what care is given to a patient or service user, and how that care should be given (*Independent Information Governance Review/Caldicott 2*).It is not necessary for everybody to know everything. Some information will be relevant to certain professional groups but completely irrelevant to others and therefore should not be shared.

Some information is particularly personal sensitive information (e.g. HIV status, sexual health; Human Fertilisation and Embryology) and its use is strictly controlled by law. The sharing of this type of information is excluded from this Information Sharing Agreement.

The presumption is that information will be shared to support an individual’s direct care unless they object.

Schedule 2 can be used to describe what information will be shared.

# **Why** is information shared?

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| Information is shared to support the **direct care** of patients |

The term ‘**direct care**’ means all activities that directly contribute to the diagnosis, care and treatment of the individual.

Individuals cannot be treated or cared for safely if health and social care professionals do not have access to information about them

Information is shared so that health and social care professionals in the direct care team can

* Design and implement a plan of care;
* Provide continuous quality care;
* Communicate with each other about the progress of the individual, developments, changes to the care plan
* Etc.[*add/amend for local purposes*]

# **When** is information shared?

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| The 7th Caldicott principle.  The duty to share information can be as important as the duty to protect confidentiality.  Health and social care professionals should have the confidence to share information in the best interests of their patient within the framework set out by these (Caldicott) principles. |

When the individual agrees to being treated it creates a direct care relationship between them and the health or social care professionals in the direct care team. This is known as a “legitimate relationship”.

Health and social care professionals have a duty of care to the individual. From October 2015 they will also have a legal duty to share information when:

* It will facilitate the provision of health and social care services to the individual; and
* It is in the individual’s best interest; and
* The individual has not objected.

The Health and Social Care (Safety and Quality) Act 2015 establishes this duty. It puts the 7thCaldicott principle onto a legal footing. The Act applies to any organisation commissioning or providing health and social care services. If an individual does not raise an objection, the direct care team can assume they have agreed to their information being shared when they agree to receive care and treatment. However, this is dependent upon fair processing information that tells people how their information is being used.

# **Where** information is shared

[*The setting where information will be shared, and the scope if it extends beyond local boundaries to regional and national level.*

*Information is shared in the location where the individual sees the health or social care professionals providing to receive direct care and treatment. This could be a range of care setting or the individual’s home.*

*Information may also be shared without the individual being present, for example in a laboratory where test results are being processed; or in an office where clerical or secretarial staff are performing administrative tasks to support the provision of direct care*].

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| Wherever information is shared, it will be kept secure and protected against being accessed by a person who is not authorised to see it to maintain confidentiality.  It will be safeguarded against unauthorised changes or alteration to protect its integrity; and  Information will be available to members of the direct care team at the point of clinical care when they require it. |

# **How** information is shared (the legal basis for sharing)

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| Information will be shared in accordance with the law and with respect for the rights and wishes of the individual whose personal confidential data it is.  All of the partner organisations involved are responsible for following the laws that control the use of confidential information i.e.   * The Common Law Duty of Confidence; * The Data Protection Act 1998 (DPA); and * The Human Rights Act 1998 (HRA) |

All organisations signed up to this Information Sharing Agreement are legally responsible for ensuring that they operate good information governance practice and have trained their staff so that information is appropriately managed, of high quality, kept secure and the individual’s rights are respected.

They are also legally responsible for ensuring people using their services understand that their personal information will be shared for direct care unless they have objected. This is known as “fair processing”.

## Fair processing

A fundamental requirement underpinning this Information Sharing Agreement is that all organisations operate within the “**fair processing**” principles. This is where the health and care organisations involved communicate as widely as they reasonably can to tell people how information about them will be used and shared between health and social care professionals when it is “**fair and lawful**” to do so.

*[Fair processing information must reflect the content of this Information Sharing Agreement and in particular should clearly list the organisations involved in the data sharing initiative].*

[*Fair processing requires the individual to understand how their information is being used, who it is being shared with, what is being shared for and why. They also need to understand that they have a right to ask that certain information about them is not shared and what they need to do if they wish to exercise that right*]

*[Health and social care professionals can share personal information about an individual with confidence if:*

1. *the individual has been informed through fair processing information; and*
2. *has not raised an objection.]*

[*This section should be used to describe the fair processing arrangements supporting the Information Sharing Agreement*].

## The consent framework

### Implied

To support integration of services, information needs to be shared between health and social care professionals more widely so people can do their jobs as effectively as possible to improve care. In the majority of cases, consent to information sharing for direct care is simply **implied** as part of the individual’s consent to receive care and treatment as long as they have been provided with fair processing information to explain this and they do not object.

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| Unless informed otherwise, the general assumption is that people are happy for their information to be shared for a direct care purpose. |

[*Explain to what extend your information sharing will be relying on implied consent]*

### Supplied

A health or social care professional may decide to make a verbal or written request to ask the individual for permission to share their personal confidential information. For example, they may wish to share information with a professional who is not a current member of the direct care team or from a health or social care provider who is not mentioned in the fair processing information.

The individual can respond by either agreeing to **supply** consent to share their information (which is by far the most common response)or, **deny**consent for the information sharing request (which is only done occasionally, but is technically explained as a refusal or **objection** to share information).

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| Where it is necessary to get permission (because there is no other legal basis to use personal confidential data for a specific purpose), but it has not been **supplied** or it has been **denied,** then you cannot use or share information for that purpose. |

*[Provide local examples of when permission to share will be requested or state if not applicable with rationale]*

### Denied

The **NHS Constitution** states that an individual has the right to **object** to information about them being shared in a form that might identify them and in general to have reasonable objections to this sharing upheld. This is a broad statement that reflects the more complex legal framework:

* The common law duty of confidence, which provides a right of choice through its basis of consent;
* The Data Protection Act 1998, which provides a right to object to, or stop the use of personal data;
* The Human Rights Act 1998, which provides a right to a private life including the right to have medical information kept private and confidential and self-determination over such private information.

*[On rare occasions an individual may express a concern or object to information about them being shared for direct care. If this happens, a relevant health or care professional should make it clear to the individual that their decision may compromise their ability to provide safe and adequate care. Alternative options should be discussed and agreed with them. Explain those local procedures in this section]*.

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| An individual’s objection is managed by their registered GP Practice who are responsible for allocating a clinical code appropriate to the objection request to the GP Record. |

The right to object and how an individual registers an objection should be included in the fair processing information published by all partner organisations.

[*A Patient Consent and Objections Management policy should be developed to support this Information Sharing Agreement to ensure all partners are dealing with individual choices consistently.]*

### Override

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| The NHS Constitution sets out the individual’s right to object to their personal confidential information being used and shared and provides a commitment that an individual’s decision will be respected unless there is a legal reason to override it. |

If a patient lacks the capacity to make a decision, the health or social care professional can **override** the requirement for consent and access or share confidential information they believe is required to provide essential care and treatment and in the person’s best interest. This is also known as “breaking the glass”.

A health or social care professional can also **override** a person’s objection in the following situations:

* By law doctors have to share information with Public Health when a patient with a “notifiable disease” is identified.  This helps to control the spread of infection and protects the public.
* Information should be shared when it is necessary to protect a child or vulnerable adult from harm.
* Various regulatory bodies have statutory powers to access patients’ records as part of their duties to investigate complaints, accidents or a health or social care professionals’ fitness to practise.
* Where a judge issues a court order for the disclosure of information; or
* There is a significant public interest in the sharing of information that is greater than the combined public interest in the provision of confidential services and the individual’s right to confidentiality. For example, the public interest would support the sharing of information about an individual who is not medically fit to drive but refuses to stop, or to protect another individual against a direct risk to their health. This has to be considered on a case by case basis.
* Etc*. [add local arrangements here]*

## Data Protection

Organisations must process information in accordance with the principles of the Data Protection Act 1998.

The first principle requires information that identifies a person, whether on its own or when matched to other data, to be used (processed) fairly and lawfully and meet a condition set out in Schedule 2. When that data includes “sensitive personal data” i.e. information about the individual’s mental or physical health or condition or racial or ethnic origin (or other categories listed in section 2 of the Act), then a condition in both Schedule 2 and Schedule 3 has to be met.

Organisations should state the Schedule 2 and Schedule 3 conditions they are relying on to ensure their use of personal data complies with the Data Protection Act here in this section.

# Information Governance

**To support fair and lawful information sharing, all organisations agree to have in place:**

1. Fair processing information, which is provided to individuals to tell them how their information is used; what information is shared; who it is shared with; why; when and includes their rights to access that information, their right to object and who to contact.
2. Staff who are properly trained so they understand their duty to share information; the issues that can arise if they do not take proper care of personal confidential information and what they are expected to do to when:

* Sharing it with other members of the direct care team;
* They need to ask an individual for permission to share their data;
* They need to transfer personal data securely;
* An individual objects to the ways their personal data is being used or shared;
* They are asked to share it with someone outside the health care team for an in-direct care purpose;
* They can share information without an individual’s consent or override their objection.

1. Staff training should take place at induction and before they have access to personal data and repeated on an annual basis or sooner if necessary to take account of new developments, changes in policy or the law.
2. Access to personal data is managed, audited and controlled so that it is restricted to authorised personnel providing direct care and treatment to individuals and on a basis of need to know in order to be able to do their job.
3. Written clauses in employment contracts ensure staff maintain confidentiality and operate in accordance with the organisation’s policies and procedures and, Human Resources procedures are in place to ensure the reliability of staff and activate disciplinary procedures for non-compliance issues.
4. Good standards of information governance practice evidenced by meeting or exceeding the Department of Health’s Information Governance Toolkit standards required of their organisation.
5. Technical security standards and organisational procedures in place that protect personal confidential data from the harm that would be caused by its unauthorised disclosure, loss, damage or destruction.
6. Procedures to ensure the rights of individuals are met such as responding to subject access requests, ensuring data accuracy and correcting errors, handling objections, concerns and complaints.

# Signatories

[*This ISA should be signed by a senior member of the organisation such as the Chief Executive, Caldicott Guardian, Chief Technical Officer, Director, Senior Responsible Owner, Senior Information Risk Owner, or someone with similar responsibilities. The person who signs the contract will be ultimately responsible for ensuring that the terms are met and that personal data is only processed and used within the limits of this agreement*.]

On behalf of the organisation I agree that personal information about individuals who use our health and care services will be used and shared in accordance with this Information Sharing Agreement.

I acknowledge that this Information Sharing Agreement does not provide the legal basis for the organisation to use and share information.

The organisation is responsible for making sure all staff handle confidential personal information for direct care purposes when it is fair and lawful to do so.

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| **Name** |  | |
| **Position** |  | |
| **Organisation** |  | |
| **Signature** |  | **Date:**  dd/mm/yyyy |

# Schedule 1 - List of organisations signed up to this Information Sharing Agreement.

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|  | **Contact** | | |
| **Organisation** | **Name** | **Email address** | **Telephone** |
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# Schedule 2 – Data sharing specification

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| **Who** | | **What** | **Why** | **When** | **Where** | **How** |
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