The Rotherham NHS Foundation Trust

Ref No:

INFORMATION GOVERNANCE POLICY

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Name of originator/author:	**Scott Reid**
Name of responsible committee/individual:	**Information Governance Steering Group (Approved by the Corporate Health Informatics Steering Committee)**
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Target audience:	**All Staff**

Version	Date	Author	Status	Comment
1.0	18/01/05	S. Reid	Approved	Initial approved policy
1.1	22/02/06	S. Reid	Approved	Updates in line with review schedule
2.01	09/10/07	S. Reid	Draft	Re-formatted inline with new Trust policy template
2.02	10/10/07	S. Reid	Approved	Modified after discussion at IGSG meeting
3a	13/07/10	S. Reid	Draft	Re-formatted inline with new Trust policy template
3b	16/08/10	S. Reid	Draft	Revised to take account of comments from the IGSG
3c	05/10/10	S. Reid	Draft	Revised to take account of comments from the CHISC
3d	21/12/10	S. Reid	Approved	Revised to take account of comments from the PRG

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Appendices

The 10 Golden Rules of this Policy

1 The Trust regards all person identifiable data (PID) relating to patients as confidential.

2 Patients shall have ready access to information relating to their own health care, their options for treatment and their rights as patients – see the Health Records Policy.

3 For information requests from the public, see the Freedom of Information Policy and related Code of Practice.

4 Staff will undertake IG training on an annual basis (as required by the Trust). Line Managers must ensure staff undertake this training as required.

5 Non-confidential information on the Trust and its services shall be available to the public through a variety of media, in line with the Trust's Freedom of Information policy.

6 Wherever possible, information quality should be assured at the point of collection. All staff must therefore ensure data they are recording is accurate.

7 The Trust regards all person identifiable data (PID) relating to staff as confidential except where national policy on accountability and openness requires otherwise.

8 All staff will be familiar with and adhere to the related Trust documents listed in section 10 of this policy.

9 Managers are expected to take ownership of, and seek to improve, the quality of information within their services. This includes the development of local procedures for managing IG activities.

10 Data standards will be set through clear and consistent definition of data items, in accordance with national standards.

1 INTRODUCTION

1.1 Information is a vital asset, both in terms of the clinical management of individual patients and the efficient management of services and resources. It plays a key part in clinical governance, service planning and performance management.

1.2 It is therefore of paramount importance to ensure that information is efficiently managed, and that appropriate policies, procedures and management accountability provide a robust governance framework for information management.

1.3 Information Governance is an overarching framework which in currently includes the following initiatives or work areas.

- Data Protection Act 1998
- Freedom of Information Act 2000
- UK Re-use of Public Sector Information Regulations 2005
- Human Rights Act 1998
- The Confidentiality Code of Practice
- Information Security Management - BS7799
- Records Management: NHS Code of Practice
- Information Quality Assurance Programme

1.4 Information Governance has four fundamental aims:-

- To support the provision of high quality care by promoting the effective and appropriate use of information.
- To encourage responsible staff to work closely together, preventing duplication of effort and enabling more efficient use of resources.
- To develop support arrangements and provide staff with appropriate tools and support to enable them to discharge their responsibilities to consistently high standards.
- To enable organisations to understand their own performance and manage improvement in a systematic and effective way.

1.5 Principles

1.5.1 The Trust recognises the need for an appropriate balance between openness and confidentiality in the management and use of information.

1.5.2 The Trust supports the principles of corporate governance and understands its public accountability. However it places equal importance on the confidentiality of, and the security arrangements to safeguard, both personal information about patients and/or staff and commercially sensitive information.

1.5.3 The Trust also recognises the need to share patient information with other health organisations and other agencies in a controlled manner consistent with the interests of the patient and, in some circumstances, the public interest.

1.5.4 The Trust believes that accurate, timely and relevant information is essential to deliver the highest quality health care. As such it is the responsibility of all clinicians and managers to ensure and promote the quality of information and to actively use information in decision-making processes.

1.6 This policy covers all aspects of information within the organisation, including (but not limited to):

- Patient/Client/Service User information
- Staff related information
- Organisational information

2 PURPOSE

2.1 This policy covers all aspects of handling information, including (but not limited to):

- Structured record systems (paper & electronic)
- Transmission of information (fax, email, post & telephone)

2.2 The policy covers all information systems purchased, developed and managed by the organisation and any individual (directly employed or otherwise by the organisation) accessing information 'owned' by the organisation.

2.3 There are four key interlinked strands to the information governance policy:

- **Openness**

- Non-confidential information on the Trust and its services shall be available to the public through a variety of media, in line with the Trust's Freedom of Information policy.
- The Trust will establish and maintain policies to ensure compliance with the Freedom of Information Act.
- The Trust will undertake or commission annual assessments and audits of its policies and arrangements for openness.

- Patients shall have ready access to information relating to their own health care, their options for treatment and their rights as patients.
- The Trust will have clear procedures and arrangements for liaison with the press and broadcasting media.
- The Trust will have clear procedures and arrangements for handling queries from patients and the public.

➢ **Legal Compliance**

- The Trust regards all identifiable personal information relating to patients as confidential.
- The Trust regards all identifiable personal information relating to staff as confidential except where national policy on accountability and openness requires otherwise
- The Trust will establish and maintain policies to ensure compliance with the Data Protection Act, Human Rights Act and the common law confidentiality.
- The Trust will establish and maintain policies for the controlled and appropriate sharing of patient information with other agencies, taking account of relevant legislation (e.g. Health and Social Care Act, Crime and Disorder Act, Protection of Children Act).
- The Trust will undertake or commission annual assessments and audits of its compliance with legal requirements.

➢ **Information Security**

- The Trust will establish and maintain policies for the effective and secure management of its information assets and resources.
- The Trust will undertake or commission annual assessments and audits of its information and IT security arrangements.
- The Trust will promote effective confidentiality and security practice to its staff through policies, procedures and training.
- The Trust will establish and maintain incident reporting procedures and will monitor and investigate all reported instances of actual or potential breaches of confidentiality and security.

➢ **Information Quality Assurance**

- The Trust will establish and maintain policies and procedures for information quality assurance and the effective management of records.
- The Trust will undertake or commission annual assessments and audits of its information quality and records management arrangements.

- Managers are expected to take ownership of, and seek to improve, the quality of information within their services.
- Wherever possible, information quality should be assured at the point of collection.
- Data standards will be set through clear and consistent definition of data items, in accordance with national standards.
- The Trust will promote information quality and effective records management through policies, procedures/user manuals and training.

3 DUTIES

3.1 Duties within the Organisation

3.1.1 The **Chief Executive** has overall responsibility for the maintenance and implementation of the policy.

3.1.2 The **Information Governance Steering Group (IGSG)**, led by the **SIRO** (Chief Financial Officer), has delegated responsibility for the maintenance and implementation of this policy and the Information Governance agenda.

3.1.3 The **SIRO** will have lead responsibility to ensure organisational information risk is properly identified, managed and that appropriate assurance mechanisms exist. This will entail:

- Leading and fostering a culture that values, protects and uses information for the success of the organisation and benefit of its customers
- Owning the organisation's overall information risk policy and risk assessment processes and ensuring they are implemented consistently by Information Asset Owners
- Advising the Chief Executive or relevant accounting officer on the information risk aspects of the statement on internal controls
- Owning the organisation's information incident management framework

3.1.4 The **Head of Information** will act as the lead officer for the IGSG and will maintain IG related policies.

3.1.5 The **Information Governance & Security Manager** will act as the central IG resource for the Trust, and will support the IGSG in its activities.

3.1.6 **Heads of Departments / Line Managers** are responsible for the implementation of the policy within their business or clinical area, and for adherence to it by their staff. This will include performing a local induction including IG awareness, ensuring staff complete the IG Training Tool annually (as required by the Trust), and include in job descriptions any appropriate IG responsibilities (namely confidentiality and data quality).

3.1.7 Local procedures will be developed by appropriate **Heads of Departments** which will document specific processes for managing IG activities (e.g. data quality, records management, and information security). These will detail procedures for staff at a local level to ensure all IG activities are clearly documented and monitored.

3.1.8 Key information assets will have a designated **Information Asset Owner** (IAO). An IAO will be identified by the Information Governance Manager in conjunction with the senior member of staff within the relevant area. They will take the lead on managing the asset, managing risk and controlling access. Further details on the IAO role can be found at: http://www.connectingforhealth.nhs.uk/systemsandservices/infogov/security/risk/iaojd.doc

The IAO will document, understand and monitor:

- What information assets are held, and for what purposes
- How information is created, amended or added to over time
- Who has access to the information and why

3.1.9 **Heads of Departments** will also be responsible for providing appropriate information for the completion of the IG Toolkit.

3.1.10 **All Staff** are responsible for adhering to this policy, and related Trust policies (see section 11). All staff will also complete the IG Training Tool annually as per requirements which will be communicated via IG briefings.

3.2 Consultation and Communication with Stakeholders

The **Information Governance Steering Group** will lead on and develop the policy. It will approve minor changes to the policy.

3.3 Approval of the policy

The policy will be approved by the **Corporate Health Informatics Steering Committee (CHISC)**.

3.4 Ratification of the policy

3.4.1 Ratification is via the **Trust Policy Ratification Group**.

4 DEFINITIONS AND ABBREVIATIONS

- **Departmental Intranet Administrator** – The individual who has responsibility for maintaining the department's Intranet site and can load documents onto the document management system. A listing of Departmental Intranet Administrators can be found on the contacts system on the Intranet or via the Webmaster.
- **Document Management System** – A tool residing on the Trust Intranet that allows for the storage of documents intended to be accessed by all staff.
- **CHISC** – Corporate Health Informatics Steering Committee.
- **IGSG** – The Information Governance Steering group is the body responsible for ensuring the Trust complies with information governance requirements and legislation. The contact for this group is the Head of Information.
- **IGTT** – IG Training Tool. A national web-based IG training tool for all NHS staff.

  http://www.igte-learning.connectingforhealth.nhs.uk/igte/index.cfm
- **IGTK** – IG Toolkit. The annual audit of IG capability for all Healthcare providers.

  https://nww.igt.connectingforhealth.nhs.uk/
- **SIRO** – The Senior Information Risk Owner is an Executive Director (Chief Financial Officer) who takes overall ownership of the Trust's Information Risk Policy, act as champion for information risk on the Board and provide written advice to the Accounting Officer on the content of the Organisation's Statement of Internal Control in regard to information risk.

5 EQUALITY IMPACT ASSESSMENT

5.1 The Trust aims to design and implement services, policies and measures that meet the diverse needs of our service, population and workforce, ensuring that none are placed at a disadvantage over others.

5.2 A completed copy of the Equality Impact Assessment tool is attached as **Appendix 1**.

6 REVIEW AND REVISION ARRANGEMENTS

6.1 The policy will be reviewed by the **IGSG** within the timescales listed on the coversheet.

6.2 The **Head of Information**, as the Author of this policy will be the lead officer for ensuring the policy is reviewed and approved according to the method identified.

6.3 Significant changes to the policy will be submitted to the **CHISC**.

7 PROCEDURAL INFORMATION

IG issues will be dealt with as detailed in the relevant Codes of Practice.

8 DISSEMINATION AND IMPLEMENTATION

8.1 Dissemination

8.1.1 The policy will be added to the Trust document management system located on the Intranet site. **The Head of Information** is responsible for this task.

8.1.2 The current version of the policy will be stored as "**Latest**" on the document management system and will be the document users find when initiating a search.

8.1.3 Previous versions will remain on the document management system and be marked as "**Previous**". These will not be visible to users when initiating a search, but retrievable by Departmental Intranet Administrators.

8.1.4 A **Departmental Intranet Administrator** shall be contacted to retrieve a superseded policy from the document management system if required.

8.1.5 The policy will be communicated to staff.

As a minimum:

8.1.5.1 An electronic version of the policy document will be emailed to all **Heads of Departments/Ward Managers/Matrons/Clinical Directors** by the **Head of Information**.

8.1.5.2 **Heads of Departments/Ward Managers/Matrons/Clinical Directors** by the **Caldicott Coordinator** must ensure that new policy documents are communicated to all relevant staff and that arrangements for training and support are identified. A record of how this communication has taken place should be available for audit purposes.

8.1.5.3 The approval of the policy will be printed in relevant **CEO Bulletin** or equivalent document.

8.1.5.4 The **Head of Information** will load the policy on the Document Management System.

8.2 Implementation plan including training

8.2.1 Implementation is detailed in the IG Communications plan.

9 MONITORING COMPLIANCE

9.1 Monitoring Compliance With and the Effectiveness of Procedural Documents

9.1.1 This policy will be monitored through the development and implementation of a series of Information Governance Action plans and the annual IG Toolkit submission.

9.1.2 Local IG audits will be carried out in association with the IG Department to monitor local practices.

10 REFERENCES

This Policy has been produced in accordance with the following documents:

IG Toolkit Guidance
https://nww.igt.connectingforhealth.nhs.uk/

IG Training Tool
http://www.igte-learning.connectingforhealth.nhs.uk/igte/index.cfm

11 ASSOCIATED DOCUMENTATION

Documents available on Trust Intranet

- IT Security & Acceptable Use Policy
- Freedom of Information & Environmental Information Regulations Policy
- Freedom of Information Code of Practice – Requests for Information
- Freedom of Information Code of Practice – Requests for Environmental Information
- Rotherham Joint Agency Overarching Information Sharing Protocol
- Data Quality Policy
- Registration Authority Policy
- Fax Policy
- Safe Haven Policy
- Use and Protection of Patient Information Policy (Confidentiality Code of Conduct)
- Data Protection Policy
- Health Records Policy
- Corporate Records Management Policy

Appendix 1

Policy Title: Information Governance Policy

EQUALITY IMPACT ASSESSMENT (EIA) INITIAL SCREENING TOOL

Document Name: Corporate (Non-Clinical) Records Management Policy Date/Period of Document: 2 year review cycle

Lead Officer: Scott Reid, Head of Information Directorate: Finance Reviewing Officers: John Francis

❑ Function	x Policy	❑ Procedure	❑ Strategy	❑ Joint Document, with who?

Describe the main aim, objectives and intended outcomes of the above:
To ensure robust record management practices are in place to manage non-clinical records and that national legislation and guidance is followed.

*You must assess **each** of the 7 areas separately and consider how your policy may affect people's human rights.*

1. Assessment of possible adverse impact against any minority group

	How could the policy have a **significant** negative impact on equality in relation to each area?	**Response** Yes	**Response** No	**If yes, please state why and the evidence used in your assessment**
1	Age?		x	
2	Gender (Male, Female and Transgender)?		x	
3	Disability (Learning Difficulties/Physical or Sensory Disability)?		x	
4	Race or Ethnicity?		x	
5	Religious, Spiritual Belief?		x	
6	Sexual Orientation?		x	
7	Socio-economic groups?		x	

You need to ask yourself:

- Will the policy create any **problems** or **barriers** to any community of group? **Yes/No**
- Will any group be **excluded** because of the policy? **Yes/No**
- Will the policy have a negative impact on **community relations**? **Yes/No**

If the answer to any of these questions is Yes, you must complete a full Equality Impact Assessment

2. Positive impact:

	Could the policy have a **significant** positive impact on equality by reducing inequalities that already exist? Explain how will it meet our duty to:	**Response** Yes	**Response** No	**If yes, please state why and the evidence used in your assessment**
1	Promote **equal opportunities**		x	
2	Get rid of **discrimination**		x	
3	Get rid of **harassment**		x	
4	Promote **good community relations**		x	
5	Promote **positive attitudes** towards disabled people		x	
6	Encourage **participation** by disabled people		x	
7	Consider **more favourable treatment** of disabled people		x	
8	Promote and protect **human rights**		x	

3. Summary

On the basis of the information/evidence/consideration so far, do you believe that the policy will have a positive or negative adverse impact on equality?

Positive	*Please rate, by circling, the level of impact*					**Negative**
HIGH	**MEDIUM**	**LOW**	**NIL**	**LOW**	**MEDIUM**	**HIGH**

Date assessment completed:30.07.10	Is a full equality impact assessment required? ❑ Yes (documentation on the intranet)	x No

WEBSITE SUMMARY FORM

Please ensure that you complete this form for publishing on our website

DETAILS OF COMPLETED EQUALITY IMPACT ASSESSMENT	KEY FINDINGS	FUTURE ACTIONS	TIMESCALES
Directorate **Finance** **Name of Function or Policy** INFORMATION GOVERNANCE POLICY **Brief description of aims of the Policy/Function** To establish and maintain policies and procedures for Information Governance assurance and the effective management of records. **Status of Function or Policy (i.e. new, changing, existing)** **Revised policy** **Name of Lead Officer Completing the Assessment** **IG Manager** **Date of Assessment** **30.07.10**	No areas identified that will have either a positive or negative impact on equality.		

We are required to publicise the results of all Equality Impact Assessments, could you please forward a copy of your completed screening tool and website summary form to webmaster@rothgen.nhs.uk for uploading on the intranet/internet.