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## DIRECTIONS

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### NATIONAL HEALTH SERVICE, ENGLAND

#### The Confidentiality and Disclosure of Information (General Medical Services, Personal Medical Services and Alternative Provider Medical Services) Directions 2013

The Secretary of State for Health, in exercise of the powers conferred by sections 98A, 272(7) and (8) and 273(1) of the National Health Service Act 2006(a), gives the following Directions.

##### Citation, commencement and application

1.—(1) These Directions may be cited as the Confidentiality and Disclosure of Information (General Medical Services, Personal Medical Services and Alternative Provider Medical Services) Directions 2013 and come into force on 1st April 2013.

(2) These Directions are given to the Board.

##### Interpretation

2.—(1) In these Regulations—

“the 2006 Act” means the National Health Service Act 2006;

“APMS contract” means arrangements made under section 83(2) of the 2006 Act for the provision of primary medical services(b);

“the Board” means the National Health Service Commissioning Board(c);

“the Code of Practice” means the document entitled “Confidentiality and Disclosure of Information: General Medical Services (GMS), Personal Medical Services (PMS) and Alternative Provider Medical Services (APMS) Code of Practice” dated April 2013(d);

“default contract” means a contract under article 13 of the General Medical Services Transitional and Consequential Provisions Order 2004(e);

“GMS contract” means a general medical services contract within the meaning of section 84 of the 2006 Act(f);

“GMS Contracts Regulations” means the National Health Service (General Medical Services Contracts) Regulations 2004(g);

“PMS agreement” means an agreement for primary medical services made under section 92 of the 2006 Act(h);

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- (a) 2006 c.41. Section 98A of the 2006 Act is inserted by section 49(1) of the Health and Social Care Act 2012 (c.7) (“the 2012 Act”). By virtue of section 271(1) of the 2006 Act, the powers conferred by these sections are exercisable by the Secretary of State only in relation to England.
- (b) Section 82(2) is amended by section 55(1) of, and paragraph 30 of Schedule 4 to, the 2012 Act.
- (c) The National Health Service Commissioning Board is established by Section 1H of the 2006 Act. Section 1H is inserted into the 2006 Act by section 9 of the 2012 Act.
- (d) A copy of this Code of Practice is available on the Department of Health’s website at <http://www.dh.gov.uk>.
- (e) S.I. 2004/433. A relevant amendment was made by S.I. 2004/865. See also S.I.2013/235, article 10.
- (f) Section 84 is amended by section 55(1) of, and paragraph 31 of Schedule 4 to, the 2012 Act.
- (g) S.I. 2004/291; relevant amendments are made by S.I. 2004/2694, 2005/893, 2007/3941, 2010/578, 2012/970 and 2013/363.
- (h) Section 92 is amended by section 55(1) of, and paragraph 36 of Schedule 4 to, the 2012 Act.

“PMS Agreements Regulations” means the National Health Service (Personal Medical Services Agreements) Regulations 2004(a); and

“Primary Care Trust” means the Primary Care Trust which was a party to an APMS Contract, a GMS Contract or a PMS Agreement immediately before the coming into force of section 34 (abolition of Primary Care Trusts) of the Health and Social Care Act 2012(b).

### **Compliance with the Code of Practice: Confidentiality and Disclosure of Information**

3. In exercising any function, or in enforcing any right or obligation, pursuant to—

- (a) a term of a GMS contract that gives effect to paragraph 77 (provision of information) or 81 (annual return and review) of Schedule 6(c) to the GMS Contracts Regulations;
- (b) a term of a PMS agreement that gives effect to paragraph 73 (provision of information) or 77 (annual return and review) of Schedule 5(d) to the PMS Agreement Regulations;
- (c) any equivalent terms to those specified in paragraph (a) in a default contract; or
- (d) any equivalent terms to those specified in paragraph (b) in an APMS contract,

the Board must, insofar as it is relevant to its exercise of that function, or the enforcement of that right or obligation, act in accordance with Section 1.1.1 to 1.2.2 (anonymised or aggregated patient information), Section 2.2 to 2.2.4 (confidential patient information), Section 3.2 to 3.2.3 (practice level data) and Section 4.2 and 4.2.1 (information about individual staff employed by or otherwise associated with the practice) of the Code of Practice.

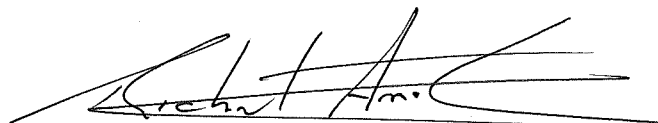
### **Transitional provision**

4. In a case where an APMS contract, default contract, GMS contract or a PMS agreement has been transferred to the Board in accordance with a property transfer scheme made under section 300 of the Health and Social Care Act 2012, the Board in exercising any functions, or enforcing any right or obligation in accordance with direction 3, may in respect of any act, omission, right or obligation that arose before 1st April 2013, have regard to the Confidentiality and Disclosure of Information: General Medical Services, Personal Medical Services and Alternative Provider Medical Services Directions 2005(e) as in force on 31st March 2013 in so far as it is necessary to ensure a just and expeditious outcome.

### **Revocation**

5. The Confidentiality and Disclosure of Information: General Medical Services, Personal Medical Services and Alternative Provider Medical Services Directions 2005 are revoked.

Signed by authority of the Secretary of State



Date: 27<sup>th</sup> March 2013

A member of the Senior Civil Service  
Department of Health

(a) S.I. 2004/627. Relevant amendments are S.I. 2004/2694, 2005/893, 2007/3491, 2010/578, 2012/970 and 2013/363.

(b) 2012 c.7.

(c) Paragraphs 77 and 81 of Schedule 6 were amended by S.I. 2004/2694 and 2013/363.

(d) Paragraphs 73 and 77 of Schedule 5 were amended by S.I. 2004/2694 and 2013/363.

(e) These Directions were signed on 24th March 2005 and published on [www.dh.gov.uk](http://www.dh.gov.uk).

*Confidentiality and Disclosure of Information*

**General Medical Services (GMS), Personal Medical Services (PMS),  
and Alternative Provider Medical Services (APMS) Code of Practice**

**April 2013**

## CONFIDENTIALITY AND DISCLOSURE OF INFORMATION: GMS, PMS AND APMS CODE OF PRACTICE

### Introduction

1. This Code of Practice sets out guidance on the confidentiality of information held by contractors – referred to collectively in this document as “contractors” – who provide General Medical Services (GMS), Personal Medical Services (PMS) and Alternative Provider Medical Services (APMS). Similarly, where the term “contract” or “contracts” is used in this document it refers to the contracts or agreements entered into by those who provide GMS, PMS and APMS (unless there is a specific reference to the contrary). It also sets out guidance on the provision of contractor-held information to the NHS Commissioning Board (“the Board”) and access by, and disclosure of, that information to the Board or a person authorised in writing by the Board.
2. This Code revises the Code issued in 2005 which was developed by the Department of Health in consultation with the General Practitioners’ Committee (GPC) of the British Medical Association, and other key stakeholders, including representatives from patient bodies. It takes account of the changes to the NHS which come into force in April 2013 and makes explicit existing legal and ethical obligations of confidentiality, placing them in the context of primary care contractual arrangements. It does not cover in detail all circumstances in which contractor-held information may be requested, but sets out principles of good practice for contractors of primary medical services and the Board when commissioning services from them. It also describes circumstances in which the Department of Health (DH) may request access to certain contractor-held information. The Board is required by Directions to comply with the provisions of this Code when exercising certain functions. The Board should normally seek actively to involve and engage Local Representative Committees in relation to the Code where there are any potential issues of contention or where contractors may require additional support.

### Legal Context

3. The NHS (General Medical Services Contracts) Regulations 2004, the NHS (Personal Medical Services Agreements) Regulations 2004 and the APMS Directions (referred to collectively in this document as “the regulations”) include provisions relating to patient records, the confidentiality of personal data, rights of access to, and the provision of, patient and practice information held by contractors. In particular, the regulations provide that GMS contracts, PMS agreements and APMS contracts must contain a term requiring contractors, at the Board’s written request, to produce to the Board, or a person authorised in writing by the Board; or allow access by the Board, or a person authorised in writing by the Board, to:-
  - (i) Information which is reasonably required by the Board for the purposes of, or in connection with the GMS Contract, PMS Agreement or APMS contract; and
  - (ii) Any other information which is reasonably required in connection with the Board’s functions.

Such requests are required to be made by the Board in accordance with the Directions.

4. This Code does not detail each specific provision with the regulations that deal with obligations on a contractor to provide specific information or reports to the Board or other bodies, for example –
  - (i) the requirement to send clinical reports to the Board where services are provided to non-registered patients (see, for example, Schedule 6, paragraph 7 of the GMS Contracts Regulations);
  - (ii) notifications of deaths (see, for example, Schedule 6, paragraph 87, of the GMS Contract Regulations).

#### Scope of this Code

5. This Code applies to contractors and to the Board, to all staff employed by the practice and [the Board] for the purposes of the contract, and individuals involved in work under the contract who are otherwise associated with the practice (for example, locum GPs). It covers the Board's access to, or requests for disclosure of, contractor held information. This includes information to support payments under the Quality and Outcomes Framework (QOF) in relation to GMS.
6. Four categories of information are covered in this Code:-
  - (i) Anonymised or aggregated patient information;
  - (ii) Confidential practice information;
  - (iii) Practice level information;
  - (iv) Information about individual staff employed by the practice for the purposes of the contract, and individuals involved in work under the contract who are otherwise associated with the practice (e.g. locum GPs).
7. In dealing with disclosure of information, contractors, the Board and the other bodies referred to in this document should have regard to other publications issued to support implementation of the GMS Contract, PMS and APMS, and to:-
  - (i) The "NHS Code of Practice on Confidentiality" (Department of Health, November 2003), available at [http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_4069253](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4069253) ;
  - (ii) Guidance Notes on Section 251 of the National Health Service Act 2006 for those wishing to use patient identifiable information for an acceptable purpose as defined by the Act, available at: <http://www.hra.nhs.uk/hra-confidentiality-advisory-group/>
  - (iii) Any guidance in relation to the processing of information published by the Board under Section 23, paragraph 13S of the Health and Social Care Act 2012, and to the Code of Practice on Confidential Information published by the Health and

Social Care Information Centre under Section 263 of the Health and Social Care Act 2012.

8. Although they are not explicitly covered by this Code, Annex A outlines the position in relation to:
- (i) Local Healthwatch
  - (ii) Care Quality Commission
  - (iii) NHS Protect
  - (iv) NHS Internal Audit
  - (v) Social Services Departments
  - (vi) National Clinical Assessment Service (NCAS); and
  - (vii) Researchers

#### **General Principles**

9. Patient information held by contractors is generally held under legal and ethical obligations of confidentiality. Patients seeking treatment entrust sensitive information to those who provide their healthcare. They do so in confidence, and have the legitimate expectation that their privacy will be respected, and that their health records will be used by the health service to support their healthcare. Information that can identify individual patients must not be used or disclosed for purposes other than healthcare without the individual's explicit consent, or some other legal basis, such as a robust public interest or legal justification for doing so.
10. However, the provision of care and treatment does require information to be shared appropriately amongst those that provide that care. In addition, data (which will in most cases be anonymised or aggregated) is required to support the wider functioning of the NHS, including the management of healthcare services. When the Board requires access to information, they should explain to practices the precise purpose for which access is required and who will gain access. Generally, patients who present for care are assumed to consent to the required information sharing between clinicians for the purpose of their individual healthcare needs, and those in the NHS to whom they are accountable. Ensuring that patients understand how such information may be shared underpins this assumption and is therefore extremely important. Where appropriate, clinical and non-clinical staff may need to discuss consent issues with patients and check patient understanding. This is covered in more detail in the NHS Code of Practice on Confidentiality.
11. Practice information should only be held, used or shared appropriately and with good reason. Where information identifies individuals, it is likely to be subject to Data Protection Act provisions. Where those individuals are patients, there will be obligations of

confidentiality and privacy. Even where there are no apparent legal restrictions on disclosing or permitting access to information, care should be taken to ensure that its use will not result in detriment, whether to individuals, to practices or the wider NHS, unless there is a robust public interest in disclosing information, or a legal basis, such as a request under the Freedom of Information Act or disclosure in accordance with the Data Protection Act.

12. The standards and constraints that apply to the holding, using and sharing of information are important components of NHS Information Governance. This Code of Practice reflects the NHS Information Governance principles and key standards in relation to the disclosure of, or access to, information. The NHS Information Governance toolkit is available at <https://nww.igt.connectingforhealth.nhs.uk/> The key governance principles are that:-

- (i) Contractors should provide a confidential and secure service for patients;
- (ii) Information should only be disclosed or shared by contractors when it is lawful to do so;
- (iii) Information should be disclosed or otherwise shared by contractors on a “need to know” basis;
- (iv) Where the Board needs to obtain information from contractors, the minimum necessary information should be determined and the disclosure limited accordingly;
- (v) Where, exceptionally, there is a need for the Board to seek access to or to obtain information beyond that generally required for their day to day business, and where access to patient identifiable information is necessary (see paragraph 30-32), the process of obtaining such information will be open to audit and appropriate scrutiny – such as by NHS auditors, or Caldicott Guardians;
- (vi) Where data is required that identifies an individual patient, the patient’s consent may be necessary, depending on the circumstances and purpose for which the data is required (see paragraphs 30-32).

13. Even though sharing information for healthcare purposes will be lawful within GMS,PMS or APMS, personal medical records should only be accessed within practices on a “need to know” basis, for example, by:-

- (i) GPs, who will usually have access to the complete clinical record;
- (ii) Other health professionals employed by the contractor or other organisations such as the Board or mental health trusts. In some situations, only a summary of clinical information may be required that relates to a particular aspect of patient care;
- (iii) Contractor staff with responsibility for the management of patient records, including security and the transfer and updating of records;

- (iv) Health professionals employed by local authorities – e.g. in Care Trusts.

#### **Providing a Secure and Confidential Service**

14. This Code requires that all disclosures of information follow the principles of limiting disclosure to the minimum necessary, keeping patients informed and seeking consent where appropriate, disclosing information for defined purposes only, and only permitting access to information on a need to know basis. This provides for a procedural hierarchy, i.e.

- (i) Where anonymised information will satisfy a purpose, disclosure should be limited to anonymised information as far as is practicable;
- (ii) Where anonymised information will not suffice or is impracticable, the patient's consent may be necessary, depending on the circumstances and purpose for which the data is required (see paragraphs 30-32). Where such consent is sought or is not required, the reasons for disclosure must be demonstrated and recorded, and there must be a clear audit trail, available for scrutiny by bodies such as NHS Audit and Caldicott Guardians (see paragraph 32).

15. All NHS organisations are expected to meet [or have improvement plans that in time will enable them to meet,] appropriate confidentiality and security standards as outlined in the NHS Code of Practice on Confidentiality. These standards were established by the Department of Health in collaboration with the General Medical Council, the British Medical Association and the Office of the Information Commissioner and have been endorsed by those bodies. Contractors who are actively engaged with the NHS Information Governance work programme, will already be working to, or be working towards, appropriate confidentiality and security standards.

16. The key elements of information governance that contractors should have regard to are:

- (i) Procedures should be in place to ensure that contractors, staff and volunteers are aware of their responsibilities regarding confidentiality and security;
- (ii) Employment contracts should include specific requirements relating to the confidentiality of personal patient information, linked to disciplinary procedures;
- (iii) Patient information should be recorded accurately and consistently;
- (iv) Patient information should be kept private;
- (v) Patient information should be kept physically secure;
- (vi) Information should only be used and disclosed with appropriate care;
- (vii) Patients should be informed, in general terms, how their information may be used, who will have access to it and the organisations it may be disclosed to.

17. Contractors are required by virtue of their Contract to nominate a person with responsibility for practices and procedures relating to the confidentiality of personal data held by the contractor. This reflects an existing requirement that applies to all other NHS bodies, where



roles such as 'Caldicott Guardian' or 'Caldicott Lead' are common. In primary care, this responsibility might be delegated to an appropriate member of the practice, though clinicians will need to be involved where decisions about the disclosure of confidential clinical information need to be made. Contractors should also have regard to the need for security of personal data.

18. Contractors providing essential services or their equivalents must ensure that their Patient Leaflet contains details of who has access to patient information (including information from which the identity of the individuals can be ascertained) and the patient's rights in relation to the disclosure of such information. The leaflet should refer to the possibility of anonymised or patient-identifiable information being disclosed for the purpose of the provision of care and treatment and the management of healthcare services within the NHS. Patients should also be informed of their rights under the Data Protection Act, including any procedures for complaint or objection. Contractors may also want their leaflet to identify who should be the point of contact for those who have concerns about confidentiality issues. Practices may wish to refer to this Code of Practice in their Leaflet, and where a copy can be obtained.

## **Section 1 - Anonymised or aggregated patient information**

- 1.1.1. Wherever practicable, patient data disclosed for purposes other than the patient's care should be anonymised. Anonymised or statistical information is not confidential and may be used with relatively few constraints. Anonymised information is information that does not identify an individual. Anonymisation requires the removal of name, address, full postcode, date of birth, NHS number and local patient identifiable codes, and any other detail or combination of details that might support identification. Aggregated information is statistical information, which, if care is taken with respect to rare conditions etc, will also provide anonymity for patients.
- 1.1.2. In certain circumstances, contractors may need to anonymise patient records prior to disclosure. It will usually be for the person passing on the data to ensure that it is passed on in a non-identifiable form, wherever that is practical. The Board and contractors should aim to work together to develop the capacity to generate anonymised and aggregated information. In particular, the upgrading of practice IT equipment will provide opportunities to improve this capacity.
- 1.1.3. There are circumstances where it will not be practicable for anonymised information to be generated in order to satisfy the purposes of third parties. This may be because there is limited capacity to anonymise information by a contractor, or where the contractor is unable to anonymise data with a reasonable degree of ease – for example because it would involve substantial additional work, or because the purpose to be satisfied requires examination of original records. Where any of these apply, care must be taken to ensure that disclosure of information is lawful.

### **1.2. The Board**

1.2.1 The Board requires access to anonymised patient information for a range of purposes in order to fulfil their statutory responsibilities to provide primary care services and discharge their wider functions. Where the Board requires access, they should explain to practices the precise purpose for which access is needed and who will gain access. These circumstances include:-

- (i) Strategic planning;
- (ii) Financial management;
- (iii) Public health;
- (iv) Workforce planning;
- (v) To check that payments under the Quality and Outcomes Framework (QOF) are, or have been, accurate, complete and correct;

- (vi) To carry out an annual review of the contractor's performance, including patient experience, against the QOF;
- (vii) Clinical audit purposes;
- (viii) Internal audit;
- (ix) To deter, prevent and detect fraud;
- (x) Where the Board has concerns about a contractor's compliance with its contract.

1.2.2 A person acting on behalf of the Board must, if requested, produce written authorisation to the contractor in order to see or access information held by the contractor.

### **1.3 Department of Health**

1.3.1 Anonymised or aggregated information may also be requested for certain purposes by the Department of Health.

1.3.2 Under paragraph 77 of Schedule 6 to the NHS (GMS Contracts) Regulations 2004 or its PMS/APMS equivalents, a contractor is only required to provide information to the Board or a person authorised in writing by the Board. There may be occasions where the information needs of the Department of Health can be met more effectively by asking a contractor directly for anonymised or aggregated information. Failure to comply with a request for information from the Department may not be a breach of contract. However, in deciding how to respond, contractors should bear in mind that the same request for information may later be made by the Board in accordance with the terms of the contract and this Code.

1.3.3 The Department of Health may request information deriving from practices in order to support the Department's work. These data, such as the Attribution Dataset for resource allocation, will usually be requested via the Board.

## Section 2 - Confidential Patient Information

### 2.1 General

2.1.1 By definition, confidential patient information is that which can identify individual patients and if information that was gathered in circumstances where it is reasonable for the patient to expect his/her confidences to be respected.

### 2.2. The Board

2.2.1 The circumstances in which the Board, or persons authorised by the Board, may need to access and obtain information that identifies individual patients should be limited. A decision to disclose such information to the Board will be a matter for the contractor. However, a contractor may risk being in breach of its contract if it refuses to produce information which the Board reasonably requires and which it has requested in accordance with the relevant requirements of this Code. The circumstances in which, in the view of the Department, patient identifiable information would generally be reasonably required by the Board and could lawfully be disclosed by the practice would include:-

- (i) Where the practice is unable to anonymise data that is needed to support the wider functioning of the NHS, including the management of healthcare services, such as the QOF annual review process. For example, this may be where the practice does not possess an IT system which can ensure complete anonymisation, or where it is not practicable to anonymise paper records – such as where this would require substantial additional work on the part of the practice, or where the practice cannot guarantee to erase all identifying information. The practice should make a judgement in the context of each request for information as to whether or not anonymisation is practicable. Where anonymisation is not practicable, data may be released to the Board in patient identifiable form (but see paragraph 2.12);
- (ii) Where the Board is investigating and assuring the quality and provision of clinical care, for example, in relation to a written complaint made by, or on behalf of, a patient (whether living or dead);
- (iii) Where it is needed in relation to the management of the contract or agreement, for example, where remedial action, or termination of the contract/agreement is being considered (e.g. because of poor record keeping);
- (iv) Where the Board considers there is a serious risk to patient health or safety;
- (v) Investigation of suspected fraud or any other potential criminal activity;

2.2.2 In cases where patient identifiable information is required, it will, in some circumstances, be necessary to obtain the consent of the individual concerned to disclosure. This will depend upon the circumstances of the case. For example, consent will not be necessary to comply with the Data Protection Act or common law duties of confidentiality where the practice is unable to anonymise data and the Board reasonably requires access to that data for

- Checking legal entitlement to payments; or

- The management of healthcare services – provided that those accessing that data are bound by a duty of confidentiality not to disclose information.

2.2.3 Where the Board requires access to a particular patient record for the purposes of the QOF and the practice can demonstrate that disclosure of that particular record would:

- (a) be unlawful for a reason not relating to data protection or the common law of duty of confidentiality e.g. because of a court order or another statutory requirement;
- (b) involve the disclosure of personal data relating to third parties without their consent and which cannot be removed with a reasonable degree of ease; or
- (c) a patient has explicitly requested non-disclosure of particularly sensitive aspects of their records which cannot be removed from the material to be disclosed with a reasonable degree of ease,
- (d) conflict with the expressed preferences of the patient concerned

the practice should explain its reasons for non-disclosure to the Board and ask the Board to select a different record. The Board should normally accede to such requests, unless the purpose for which the information is required would thereby be defeated. If this is the case, the issue of consent to disclosure should be further considered.

2.2.4 Where the patient's consent is not sought to disclose identifiable information, the reasons why must be documented and there must be a clear audit trail. The NHS Code of Practice on Confidentiality provides further guidance about access to and disclosure of patient-identifiable information. Where a practice is making a disclosure on the basis that it is justified in the public interest (e.g. to prevent abuse or serious harm to others) and that the public good which would be achieved by disclosure outweighs the obligation of confidentiality to the individual patient concerned, such a disclosure should be proportionate and limited to relevant details. Contractors should be prepared to justify such disclosures to a court or regulatory bodies.

## **2.3 Department of Health**

2.3.1 It is not, in general, necessary for the Department to see individual patient level data. However, the Department collates patient data at postcode level in the Attribution Data Set (see Annex B). Whilst not containing readily identifiable individual level data, it includes sufficient detail to allow data about individuals to be deduced. The Department therefore has in place effective security and management protocols to safeguard patient privacy during data processing. All of the outputs are of aggregated data. The Department is involved in development work using the GP practice code and data on deceased patients but all data is anonymised and then aggregated.

## **Section 3 - Practice Level Data**

### **3.1 General**

3.1.1 Contractors need to access their own practice-level data for specific purposes. This includes data to assist planning, develop and evaluate the delivery of services, and to measure delivery against national and local organisational and clinical benchmarks. For contractors taking part in the national QOF, this data will be used to calculate likely income, and so contribute to financial planning. Contractors may also wish to share their quality data with other practices, or with the Local Representative Committee (LRC).

### **3.2 The Board**

3.2.1 The Board will need to see relevant QOF practice data in-year on a monthly basis to enable them to oversee practice development, including expenditure against projections. Such data will be available via the Quality Management and Analysis System (QMAS) or, upon the closure of QMAS, the Calculating Quality Reporting Service (known as CQRS) which will provide monthly reports on each contractor's performance against the QOF to the Board. The Board will also require access to end-year data (the Achievement Report) for example, for planning purposes, and to confirm payments to be made to the contractor under the QOF.

3.2.2 In all cases, it will be necessary for the Board to be able to identify, from practice-level data, contractors within a particular [geographical] area. This will enable the Board, as part of its statutory functions, to identify where it may be necessary to request further appropriate and relevant information from contractors, as well as enabling it to identify any contractor which may be experiencing difficulties and to arrange for it to receive appropriate support. It will not usually be necessary for in-year contractor identifiable data to be disclosed outside the Board unless the contractor agrees, there is a robust public interest to do so, or it is covered by a formal publication scheme or is otherwise in accordance with the law – for example under the Freedom of Information Act.

3.2.3 The Board and contractors will agree between them arrangements for the annual contract review and visit, and the annual QOF review and visit. Where practicable, both reviews may be combined. Following either review, or as a result of issues which arise in-year, the Board may require additional information, possibly combined with further visits by the Board or a person, or persons, acting on its behalf.

## **Section 4 - Information about individual staff employed by or otherwise associated with the practice**

### **4.1 General**

4.1.1 It is also important for contractors to consider the handling of personal data about their staff. Handling of such data is covered by provisions in the Data Protection Act 1998 and the Human Rights Act.

### **4.2 The Board**

4.2.1 The Board may require data on staff employed by or associated with contractors for certain purposes. These include – for workforce planning purposes, and where necessary, to seek evidence that staff employed by contractors are suitably trained and qualified.

### **4.3 Department of Health**

4.3.1 The Department needs access to individual level data for statistical purposes, e.g. to:-

- Inform workforce planning policy;
- Form a realistic view on the size of the workforce, taking into account staff who work in more than one place;
- Allow retention, recruitment and other flows to be measured.

4.3.2 Wherever possible, anonymised data will be used in accordance with the principles outlined in Sections 1.1 to 1.3. Tax returns received by the HMRC are used as the source of the data. To meet confidentiality and disclosure obligations, the analysis is conducted by HMRC. Once the analysis has been completed, HMRC provides the Department with only aggregated results. Anything which could allow GPs to be identified is withheld from the Department. Where, exceptionally, data which could identify individuals is required, the Department will ensure that any request for disclosure complies with the Data Protection Act.

4.3.3 Where data are collected for statistical purposes, they will not be used to inform decisions relating to any individual. In addition, the individually identifiable data will not be disclosed to any third party except in certain limited circumstances where the Department, as data controller, has firm written assurances that the data will be used only for statistical or research purposes, as defined in section 33 of the Data Protection Act.

### **Local Healthwatch**

Local Healthwatch monitors and reviews health services from the patients' perspective and will ensure that patients' views are fed into local decision-making processes. Local Healthwatch have an additional responsibility to help the Board discharge its duty to involve and consult the public and to monitor how this duty is carried out. Local Healthwatch has a statutory right to request information to help them carry out their functions and this information must be provided subject to the limitations set out in the regulations. Examples of the kind of information that Local Healthwatch might request includes evidence of public involvement in decision-making processes, data on trends in complaints and details about proposed changes to the way services are delivered.

### **Care Quality Commission (CQC)**

The Care Quality Commission has produced a Code of Practice on confidential personal information that sets out the practice CQC will follow in obtaining, handling, using and disclosing confidential personal information. The Code of Practice can be found at: [http://www.cqc.org.uk/sites/default/files/media/documents/20121105\\_code\\_of\\_practice\\_on\\_cpi.pdf](http://www.cqc.org.uk/sites/default/files/media/documents/20121105_code_of_practice_on_cpi.pdf)

[Required by the Health and Social Care Act 2008]

### **National Clinical Assessment Service (NCAS)**

The purpose of NCAS is to protect patients by helping the NHS to address concerns about doctors. The NCAS provides advice to the Board about local handling of cases and about good local procedures for managing GPs whose performance gives cause for concern. They also undertake assessments of a doctor's performance to clarify concerns and make recommendations for how concerns may be addressed. Where a doctor undergoes an assessment by the NCAS the Board will need to arrange for the casework manager to access a sample of patients records for the purpose of examining the quality of records kept by the doctor, and the quality of care provided, as evidenced in the records.

### **NHS Protect**

NHS Protect has responsibility for reducing NHS losses to fraud and corruption to an absolute minimum. Through a network of accredited Local Counter Fraud Specialists, NHS Protect discharges its day-to-day responsibility to prevent and detect fraud in the NHS. The Board also has responsibility for countering fraud in the NHS under Secretary of State Directions. Examples of the kind of information NHS Protect might request include non-clinical individual patient data such as name and address, where there are grounds for believing that claims have been made for a service not provided. Data is gathered to assist in exercises carried out to assess the level of risk to NHS funds in a particular service area and to reassess the impact on



these levels of fraud after counter fraud measures have been introduced. Data would also be sought to assist in investigation of alleged frauds against the NHS.

### **NHS Internal Audit**

NHS internal auditors have powers through the NHS bodies' Standing Financial Instructions, which provide them with access to all records, documents and correspondence relating to any financial or other relevant transactions, including documents of a confidential nature. They are required to provide assurances about the systems of internal control and may on occasion require access to contractor and patient records in order to establish the validity of claims, for example, in respect of minor surgery or diabetes clinics. The access to patient records is likely to be infrequent and focused on areas of high risk where they have identified control weaknesses.

### **Social Services (DQ: Local Authorities?)**

It may sometimes be necessary to share confidential personal information with Social Services Departments to protect children or other vulnerable individuals. In such cases, contractors or other health professionals employed by them should provide relevant information in a timely manner and should keep a record of the disclosure and the justification in case of subsequent challenge or proceedings.

### **Research purposes**

The use of anonymised data is preferable for research purposes. Where systems that are capable of providing anonymised data sets for researchers do not yet exist, the use of identifiable patient information to support research may be appropriate and necessary but will require explicit patient consent. If a patient cannot be contacted to obtain consent, it should not be assumed that their medical details can be used for research purposes. Further information about access to NHS record for research purposes is in the NHS Code of Practice on Confidentiality and in Guidance Notes to section 251 of the NHS Act 2006.

