NDG National Data Guardian
for health and social care

# National Data Guardian position on the use of confidential patient information in reflective practice

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# 1 Purpose of this position statement

This National Data Guardian for Health and Social Care position paper considers the requirement for regulated health and social care professionals to engage in reflective practice as part of their professional registration and, in some cases, revalidation/renewal processes. The position sets out that enabling health and social care professionals to undertake reflective practice is integral to the delivery of safe direct care.

In most cases, those engaging in reflective practice will not require access to confidential patient/service user information. General Medical Council (GMC) guidance on reflective practice for doctors and medical students states that anonymised information should be used wherever possible in reflection.[1] However, in some circumstances, it may be impossible for practitioners to effectively reflect without having access to confidential patient information (CPI). In recognising this, the GMC highlights the importance of sharing data with supervisors that is 'non-anonymised' in the process of reflection.[2]

In some instances, a regulated health and social care professional may not be able to reflect on their practice without access to CPI about an episode of care they provided. If health and social care practitioners are unaware of the impact that their assessments, decisions and care provided had on the patient, this may undermine their ability to be reflective practitioners, hindering their ability to meet regulatory requirements and resulting in missed opportunities to improve the safety and quality of patient care. Where regulated practitioners are able to justify the need to access CPI to reflect on their practice and assure safe and high-quality care, it is the NDG's position that CPI can be accessed on the basis of implied consent to satisfy the common law duty of confidentiality. This approach is subject to the existence of procedures and safeguards that ensure that local reflective practice processes are compliant with information governance.

In considering when regulated health and social care professionals may be able to justify access to CPI for reflective practice, this position paper examines the regulatory requirements for health and care professionals to undertake reflective practice. It then looks at where reflective practice sits in relation to the concept of direct care – and the circumscribed set of activities that can be considered direct care – as described in the Information Governance Review 2013 (IGR).[3]

Finally, the paper outlines the limitations and safeguards that are required where a regulated health or social care professional seeks to access CPI for the purposes of reflecting on the

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[1] https://www.gmc-uk.org/-/media/documents/dc11703-pol-w-the-reflective-practioner-guidance-20210112_pdf-78479611.pdf p.9

[2] Ibid, p 7.

[3] Information: To share or not to share? The Information Governance Review (March 2013) p.35

episode of care they provided. These limitations and safeguards are analysed through the lens of the Caldicott principles.

This paper does not specify how reflective practice should be undertaken. It does not stipulate that CPI should be accessed for reflection or that reflective practice must take place using a formalised or multidisciplinary approach. Determining how reflective practice should be undertaken, and whether access to CPI is justified in each circumstance, is a decision for the regulated health and care professional(s) undertaking the reflection and for those supervising them.

This paper solely considers the access to CPI where the regulated professional has determined that access to CPI is necessary and justified for the purpose of their reflective practice.

The interpretation of reflective practice discussed in this paper rests on the definitions of reflective practice as used and described by statutory regulators. Thus, the standards relating to reflective practice discussed here pertain to registered and regulated health and social care professionals only. This position on reflective practice does not extend to access to CPI by those who do not have a regulatory responsibility to undertake reflective practice.

# 2 Professional regulators' reflective practice requirements

Reflective practice is a key activity in identifying opportunities to improve care quality and patient safety. In recognition of the role that reflective practice plays in delivering safe and high-quality care, standards set by regulators require health and social care professionals to engage in reflective practice. Actions, including sanctions and/or removal of professional registration, can be taken if these standards are not met.

## 2.1 The Nursing and Midwifery Council

The Nursing and Midwifery Council (NMC) guidance states that reflection is important to *deliver high-quality and safe care to patients*.[4] The NMC's standards of proficiency for registered nurses require that: *Registered nurses continually reflect on their practice.*[5]

These standards of proficiency require that at the point of registration, the registered nurse is able to:

[4] Revalidation requirements: Reflection and reflective discussion | Royal College of Nursing (rcn.org.uk)

[5] Future Nurse: standards of proficiency for registered nurses (17th May 2018) p. 7

*critically reflect on near misses, critical incidents, major incidents and serious adverse events in order to learn from them and influence their future practice.*[6]

The NMC also regulates midwives and nursing-associates whose standards of proficiency also require reflective practice, stating that:

*At the point of registration, the (midwife or nursing associate) will be able to take responsibility for continuous self-reflection, seeking and responding to all support and feedback to develop their professional knowledge, understanding, and skills.*[7]

Professionals regulated by the NMC must demonstrate several reflective practice requirements when renewing their registration with the NMC through revalidation every three years.[8]

## 2.2 The General Medical Council

The General Medical Council (GMC) requires that doctors *reflect regularly on their standards of practice and use feedback and evidence to develop personal and professional insight.*[9] The reflective practitioner guidance developed by the Academy of Medical Royal Colleges, the UK Conference of Postgraduate Medical Deans, the General Medical Council and the Medical Schools Council states the reflection empowers medical students and doctors to identify opportunities to improve quality and patient safety in organisations.[10]

Revalidation requires all licenced doctors to participate in regular appraisals. The GMC's Guidance on supporting information for appraisal and revalidation explains that reflection is a core requirement for revalidation.[11]

## 2.3 The Health and Care Professions Council

The Health and Care Professions Council (HCPC) regulates 15 health and care professions in the UK.[12] HCPC guidance 'Reflection and meeting your standards' states that:

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[6] Ibid. p. 22

[7] standards-of-proficiency-for-midwives.pdf (nmc.org.uk)p.15, nursing-associates-proficiency-standards.pdf (nmc.org.uk) p.6

[8] reflective-practice-guidance.pdf (nmc.org.uk)

[9] Good medical practice - professional standards - GMC (gmc-uk.org) p.8

[10] The reflective practitioner AMRC, COPMeD, GMC, MSC The reflective practitioner - guidance for doctors and medical students - GMC

[11] Guidance on supporting information for revalidation guide - GMC

[12] Arts therapists, biomedical scientists, chiropodists/podiatrists, clinical scientists, dieticians, hearing aid dispensers, occupational therapists, operating department practitioners, orthoptists, paramedics,

*Your standards of proficiency require you to understand the value of reflective practice and the need to record the outcome of such reflection to support continuous improvement*.[13]

### 2.4 Social Work England

Social Work England regulates social workers in England. Its professional standards set out what a social worker in England must know, understand and be able to do.[14]

Social workers are expected to uphold 6 overarching professional standards. Standard 4 covers continuing professional development (CPD). CPD requirements state:

*Reflection is essential for meaningful CPD; you should include it in every piece you record*.[15]

The CPD requirements recognise that: *Reflection involves reviewing your experiences to help make positive changes for your future practice*.[16]

### 2.5 Statutory regulators joint statement on reflective practice

The importance of reflective practice across health and social care regulators is further demonstrated by the joint statement of the Chief Executives of nine statutory regulators of health and care professionals. The statement sets out the regulators' common expectations for health and care professionals to be reflective practitioners, states that health and care professionals should engage meaningfully in reflection and the benefits it brings.[17]

Thus, to meet the standards required by their regulators for proficient practice, revalidation/renewal and professional registration, regulated health and care professionals are required to be reflective practitioners.

## 3 What does reflective practice require?

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physiotherapists, practitioner psychologist, prosthetists/orthotists, radiographers, speech and language therapists.

[13] Reflection and meeting your standards | (hcpc-uk.org)

[14] Professional standards - Social Work England

[15] Reflection - Social Work England

[16] Reflection - Social Work England

[17] benefits-of-becoming-a-reflective-practitioner---joint-statemnient-2019.pdf (nmc.org.uk) Joint statement signed by: Nursing and Midwifery Council, General Chiropractic Council, General Dental Council, General Medical Council, General Optical Council, General Osteopathic Council, General Pharmaceutical Council, Health and Care Professions Council and the Pharmaceutical Society of Northern Ireland.

The Academy of Medical Royal Colleges and the Conference of Postgraduate Medical Deans (COPMeD) 'Reflective Practice Toolkit' states:

*Reflective practice is the process whereby an individual thinks analytically about anything relating to their professional practice with the intention of gaining insight and using the lessons learned to maintain good practice or make improvements where possible.*[18]

The Royal College of Nursing also provides a definition of reflective practice in its Revalidation requirements: reflection and reflective discussion, stating that reflection is:

*A conscious effort to think about an activity or incident that allows us to consider what was positive or challenging and if appropriate plan how it might be enhanced, improved or done differently in the future.*[19]

Social Work England states:

*Reflection involves thinking about what needs to be changed to improve future outcomes. Developing and building self-awareness is important so you can recognise areas for improvement and identify your learning needs to make positive changes.*[20]

In many cases, the health and care professional will be able to reflect on an episode of care they have provided without needing to access any CPI relating to it. However, where it is necessary for them to access CPI to effectively reflect, they should be supported in accessing this information as part of the process of reflection.

The Royal College of Physicians notes the importance of access to relevant information in enabling reflective practice:

*'Information and systems need to support clinical decision-making, reflective practice, quality improvement'.*[21]

# 4 Timing of reflection

The Academy and COPMeD toolkit notes that reflection *'can take place during or after the situation.'*[22]

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[18] Academy of Medical Royal Colleges and COPMeD reflective practice toolkit (2018) Reflective_Practice_Toolkit_AoMRC_CoPMED_0818.pdf

[19] Revalidation requirements: Reflection and reflective discussion | Royal College of Nursing (rcn.org.uk)

[20] Reflection - Social Work England

[21] Hospitals on the edge? The time for action | RCP London, P 8.

[22] Ibid. p1

Similarly, the Royal College of Nursing Revalidation requirements: reflection and reflective discussion recognise that reflection can be either 'in action' or 'on action'.[23]

In most cases, the reflective practitioner who continues to have a legitimate relationship with the patient for their care, will have access to CPI after the episode of care they are reflecting on.[24] However, sometimes, the reflective practitioner may no longer be able to access information they need to be able to reflect on care they provided, because the patient has moved on from their care. In these circumstances, the regulated health and care professional who has a legitimate relationship with the patient for the care episode they are reflecting on, may need time-limited access to CPI regarding that care and the impact it had on the patient to undertake the reflective practice necessary to ensure safe, high-quality care. Where the health and care professional can justify the need to access the CPI to reflect on practice, they can access this information on the basis of implied consent for direct care.

# 5 A team approach to reflective practice

Professional regulatory standards set out that reflective practice may involve a discursive, team approach. The Academy of Medical Royal Colleges and COPMeD Reflective Practice Toolkit states that:

*reflection should thus demonstrate analytical thinking, learning accrued from various sources, including discussion with peers and supervisors, and action planning.*[25]

Providing further guidance for professionals on a team approach to reflective practice, HCPC states that:

*Employers and managers are also likely to see the positive impact where professionals have a space to discuss best practice and to learn how things could have gone better. We therefore encourage employers and managers to support their staff to undertake regular reflection as this can lead to a more confident, insightful, open and honest culture.*[26]

Social Work England also recognises the importance of reflection with peers in the peer reflection CPD requirement:

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[23] Revalidation requirements: Reflection and reflective discussion | Royal College of Nursing (rcn.org.uk) *'Reflection in action' means to think about or reflect while you are carrying out the activity. 'Reflection on action', however, means thinking about the practice undertaken after the event and turning that information into knowledge.*

[24] See the section below on compliance with the Caldicott Principles to see the limitations and safeguards that accompany access to CPI for the purposes of reflective practice.

[25] Academy of Medical Royal Colleges and COPMeD reflective practice toolkit (2018) Reflective_Practice_Toolkit_AoMRC_CoPMED_0818.pdf p.2

[26] What is reflection? | (hcpc-uk.org)

Social workers must include a peer reflection within their CPD. Peer reflection means the social worker *has discussed the content of their CPD activity with a peer, manager or another professional.*[27]

The Regulators Joint Statement on reflective practice[28] also recognises the importance of a team approach to reflection:

*Care for individuals and service delivery improves when teams and groups are given opportunities to explore and reflect on their work together. These interactions often lead to ideas or actions that improve care.*

Where health and social care professionals need to discuss the episode of care that they are reflecting on with other members of the care team, they should be supported to do this. Reflection may include a number of members of staff who were involved in providing the particular episode of care to the patient. Reflection may also include supervisors or mentors who can help, and where appropriate, supportively challenge individuals in their reflection. Where a team approach to reflective practice is taken, some members of that team who were clinically involved in providing the episode of care to the patient may not be required to be registered with a regulator. For example, non-registered nursing staff and emergency medical technicians may provide clinical care to patients but are not currently regulated by the NMC or HCPC. Where non-regulated staff were clinically involved in the provision of the episode of care to the patient, they can be part of a team reflective practice approach where all the following criteria are met. These are based on criteria set out in the Information Governance Review 2013 for access to CPI for non-regulated staff for the purposes of direct care:[29]

- The reflective practice, and the decision on whether it appropriate to access CPI for the purposes of reflection, is led and supervised by a registered and regulated health or social care professional
- The non-regulated member of staff has a legitimate relationship to the patient for care and was involved in the provision of the episode of care reflected upon
- The non-regulated member of staff is subject to terms and contractual obligations of employment which include an explicit duty of confidentiality

[27] Peer reflection - Social Work England

[28] benefits-of-becoming-a-reflective-practitioner---joint-statement-2019.pdf (nmc.org.uk)

[29] Information: To share or not to share? The Information Governance Review (March 2013) p.40-41

# 6 How the requirement to undertake reflective practice is integral to safe direct care

When examining information sharing in support of patients' direct care, Dame Fiona Caldicott described a 'culture of anxiety' that permeates many health and social care organisations'.[30] This anxiety can lead to a risk averse approach to information sharing that prevents professional staff at the front-line co-operating as they would like.

The IGR found that:

*The constant message from caring and committed staff was that there should be a presumption in favour of sharing for an individual's direct care and that the exceptions should be thoroughly explained, not vice versa.*

The IGR suggested that:

*The motto for better care services should be: 'To care appropriately, you must share appropriately'*[31]

Reluctance to share information between professional health and care staff involved in a patient's health or social care can have implications for patient safety.

As NICE guidelines state:

*Relevant information should be shared between professionals and across healthcare boundaries to support high-quality care'*[32]

The IGR is widely acknowledged to provide the accepted definition of direct care and to describe the circumstances in which consent may be implied for access to CPI to support the provision of direct care. Direct care is described as:

*'A clinical, social or public health activity concerned with the prevention, investigation and treatment of illness and the alleviation of suffering of individuals. It includes supporting individuals' ability to function and improve their participation in life and society. It includes the assurance of safe and high-quality care and treatment through local audit, the management of untoward or adverse incidents, person satisfaction including measurement of outcomes*

[30] Information: To share or not to share? The Information Governance Review (March 2013) p35

[31] Information: To share or not to share? The Information Governance Review (March 2013) p35.

[32] Patient experience in adult NHS services: improving the experience of care for people using adult NHS services (CG138).

*undertaken by one or more registered and regulated health or social care professionals and their team with whom the individual has a legitimate relationship for their care.'*[33]

The IGR further describes where consent may be implied for sharing information to support the provision of direct care, outlining three conditions, all of which should be met affirmatively:

*Is the person sharing the information a registered and regulated professional or one of their direct care team?*

*Is the activity a type of direct care within the scope specified by the professional's regulatory body?*

*Does the professional have a legitimate relationship with the person or persons concerned?*[34]

The NDG has taken care to consider how far reflective practice by regulated health and care professionals aligns with the accepted definition of direct care in the IGR.

This has been a careful process, as the NDG believes that caution should be exercised when determining the scope of the concept of direct care and, as previous NDG reports have set out,[35] attempts to overstretch it should be resisted. This is particularly important because of the convention that where direct care is being delivered, there is no need to seek explicit consent from a patient to access their information, instead it may be implied. Even though their explicit consent is not sought, the patient's understanding is preserved by the requirement set out in the IGR:

*These assumptions should only be made if it is reasonable to expect the patient understands how the information will be used.*

This places a great responsibility on the health or care professional who is relying on implied consent not to abuse the relationship of trust and overstep what the patient would reasonably expect in relation to who can access their confidential information and for what purposes. The scope of the activities that are understood to fall within direct care, and thereby benefit from access to CPI based on implied consent, should not extend to circumstances and activities that would surprise individual patients.[36]

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[33] Ibid. p128.

[34] Ibid. p56.

[35] https://www.gov.uk/government/publications/sharing-data-in-line-with-patients-reasonable-expectations

[36] Some limited evidence from a patient panel demonstrating that people assume that information about the subsequent progress of patients conveyed to hospital by ambulance crews was always shared with the ambulance crews can be found here: PHEM Feedback

The IGR definition focusses on the delivery of care to an individual patient. However, it also includes the processing of information to enable the provision of *safe and high-quality care and treatment through local audit, the management of untoward or adverse incidents, person satisfaction including measurement of outcomes undertaken by one or more registered and regulated health or social care professionals and their team.* The definition cites local audit, management of incidents and measurement of outcomes, but not reflective practice, as being direct care activities that contribute to the aim of the '*provision of safe and high-quality care'*.

The NDG has considered how closely the activity of providing regulated health and care professionals with access to CPI to undertake reflective practice is analogous to regulated health and care professionals having access to CPI to undertake local audit, measurement of outcomes or management of adverse or untoward incidents – as all these activities are undertaken to provide *safe and high-quality care*. In doing this, the NDG has taken a number of factors into account.

First, the NDG considered whether the fact that reflective practice may take place after the provision of the episode of care[37] meant that it should not be considered part of direct care. It is true that, for the most part, CPI is used to deliver direct care to patients by health and care professionals during a time period where treatment is ongoing. However, by encompassing activities such as local clinical audit, the management of untoward or adverse incidents and person satisfaction including measurement of outcomes within the sphere of direct care, the IGR definition recognises that CPI can also be accessed by those with a legitimate relationship to the patient for care after an episode of care has ended.

In this post-care context, the importance of the 'legitimate relationship' between the person accessing the confidential information and the patient is crucial to the definition of direct care. The legitimate relationship is the relationship that exists between an individual and the health and social care professionals and staff providing or supporting their care.

The IGR describes the various ways in which such a relationship may be established and sets out that the legitimate relationship is important where using CPI for local clinical audit*: The use of personal confidential data for local clinical audit is permissible within an organisation with the participation of a health and social care professional with a legitimate relationship to the patient through implied consent.* Just as with clinical audit, the management of untoward or adverse incidents, person satisfaction, including measurement of outcomes, reflective practice may require access to CPI after the relevant episode of care has ended. Thus, the IGR definition of direct care recognises the ongoing legitimate relationship that regulated

[37] Although as the regulators outline above reflection can take place in action or on action.

health and care professionals may have with their patient after a particular episode of care has ended.

However, it is key to the definition of direct care that this ongoing legitimate relationship only exists to enable *local clinical audit, the management of untoward or adverse incidents and person satisfaction including measurement of outcomes* because they are crucial to enable the *assurance of safe and high-quality care*.

One of the questions which arises is whether the post-care provision activities that *are* listed in the IGR, such as clinical audit, reflect formal processes which are undertaken in the context of preestablished criteria. When determining whether an activity can be considered direct care, the formality of the process is not a crucial condition; it is the activities capacity to impact safe and high-quality care when undertaken by one or more registered and regulated health or social care professionals. Other local activities for managing adverse incidents and person satisfaction, including measurement of outcomes may or may not reflect the same formal process that applies to local clinical audit.[38]

The list of direct care activities in the definition in the IGR was not intended to be a comprehensive and static list of activities. This is made clear in the definition's wording, which states that direct care *includes* the activities described. In other words, the IGR list is not a definitive, fixed list of direct care activities; it can be added to if the (IGR defined) criteria are met.

The concept of reflective practice is an activity that may not have been considered at the time of writing the IGR. Indeed, the suite of regulatory guidance referred to in this paper (regarding the standards professionals must achieve regarding their own reflective practice) was published after the IGR.[39] Although reflective practice is not directly referenced in the direct care definition, it is considered in the *Record access and direct care section* of the IGR. This section refers to a public statement from the Royal College of Physicians that encapsulates what is required. It says:

*We must revolutionise the way we use information. We must create pathways in which information moves with patients across the system in real-time. We must enhance electronic patient records and promote common record standards. Information and systems need to*

[38] Indeed, there may be significant local variation in how these activities are undertaken. Furthermore, in some case reflective practice activities may be reflecting on untoward or adverse incidents.

[39] All of the regulatory guidance referred to in this paper has been published post 2013. A crucial piece of guidance denoting the importance of reflective practice for all regulated health and care professionals is the 2019 joint statement signed by nine regulators. See footnote 14 above.

*support clinical decision-making, reflective practice, quality improvement and meaningful patient choice.*[40]

Having carefully considered these factors, the NDG concludes that when access to CPI is necessary to undertake reflective practice effectively, it is integral to the provision of safe and high-quality care. As such, providing access to CPI is reasonable and in alignment with the existing definition of direct care. However, the position in this paper only extends to the provision of reflective practice as interpreted here, and in line with the limits and safeguards outlined in this paper. This paper now turns to considering these limits and safeguards through the lens of the Caldicott Principles.

# 7 Reflective practice as integral to direct care and the Caldicott Principles

**Principle 1: Justify the purpose(s) for using confidential information**

*The purpose of reflective practice is to gain insight using the lessons learned to maintain good practice or make improvements where possible thereby promoting patient safety.*[41]

Health care practitioners are required to engage in reflective practice by their regulators to improve care quality and patient safety. However, practitioners must be able to justify why access to CPI is necessary in relation to the reflection activity they are undertaking, and how it will impact on their ability to provide *safe and high-quality care*. Where reflection can be undertaken without access to CPI, the CPI should not be accessed.

Where CPI is accessed for reflective practice outside of the routine access required to provide the current episode of care, it is good practice for the practitioner to make a brief entry into the patient's records to justify their access on this basis.

**Principle 2: Use confidential information only when it is necessary**

If access to CPI is essential to effectively reflect on care provided but not possible, it could affect the regulated professional's ability to provide safe, high-quality care and meet their regulatory requirements.

In line with principle 1, the regulated health professional must demonstrate that access to CPI is necessary for them to be able to reflect on the episode of care in question. Where

[40] Information: To share or not to share? The Information Governance Review (March 2013 P. 104.

[41] See the Academy of Medical Royal Colleges and COPMeD reflective practice toolkit (2018) and the description of reflective practice by various professional regulators discussed above.

access to CPI can be justified on the basis of implied consent for direct care, it must only be to the necessary information required for the reflection on the episode of care.

For reflective practice to enable *safe and high-quality care* and therefore be permissible on the basis of implied consent for direct care, it should relate to a recent episode of care, where the practitioner's timely understanding of the impact of the care they provided could have a timely effect on the safety of the subsequent care they provide.

Access to this information on the basis of implied consent for direct care should be time-limited and restricted to recent episodes of care. Professional and organisational circumstances will dictate how long that time limit needs to be. For instance, the timings of professional's clinical supervision cycles or the processes for regular team reflection. In most cases, a time limit of up to six months will be sufficient to allow for these activities.[42]

It follows that access is *not* justifiable on the basis of implied consent for direct care (Caldicott Principle 1, above) longer-term where it is not necessary for reflection on a recent episode of care to provide subsequent safe high-quality care.

This position on reflective practice does not extend to broader organisational or system learning that may arise from an individual's reflective processes. As such, the position in this paper relates to individual learning and should not be relied on in the context of organisational or system learning.

**Principle 3: Use the minimum necessary confidential information**

In most cases it will be possible to reflect effectively on episodes of care without access to CPI. Furthermore, many health and social care professionals who wish to reflect on an episode of care, will have ongoing access to information about the patient who may remain under their care. Thus, the usual professional standards for access to CPI for the purposes of direct care would apply.

Where the patient has moved on from the practitioner's care and access to CPI is necessary for the process of reflection, the information required can be accessed on the basis of implied consent for direct care. However, there must be clearly defined local processes to

[42] It is important to make clear at this point that this suggested timeframe relates only to the access to CPI to undertake reflective practice. This is not a suggestion that reflective practice itself should occur within this timeframe. As recognised in this statement, CPI will not be necessary for many cases of reflective practice. Furthermore, where access to CPI is required, we are recommending that the access to the information occur within the suggested six-month timeframe. This limit does not impact on when or how long after the event the healthcare professionals continues to reflect on the information they have accessed relating to the care they delivered.

govern access, mitigate risk, and ensure that access is appropriate and is limited only to necessary information.

This will include ensuring that:

- access to CPI for the purposes of reflective practice should only be permitted for regulated health and social care professionals who are required to reflect on their practice by their professional standards and have a legitimate relationship with the patient for the episode of care they wish to reflect upon
- the information accessed is limited to information about relevant aspects of the care and treatment that the practitioner provided to the patient
- direct patient identifiers are removed from any reports that might be produced to support the reflective practitioner. This does not change the status of the information (because the professional will know the identity of their patient), but it makes it less likely that the patient or service user's identity will be ascertainable to others who contribute to the reflective process

**Principle 4: Access to confidential information should be on a strict need-to-know basis**

As outlined in relation to principles 1 and 2, access to the CPI in question must be necessary for the practitioner to reflect on the episode of care provided – and this must be demonstrated and justified by the practitioner.

There are different models for engaging in reflective practice. In many cases, it may be one regulated professional who provided care and needs access to the relevant information to reflect on it.[43] However, in other cases, the care and treatment to be reflected upon might have been provided by several members of a (multi-disciplinary) team.[44] In such a case, those who provided care may wish to reflect on and discuss the impact of their actions on the patient together.[45]

In some circumstances, reflective practitioners may need the support of their supervisor if they are to effectively reflect on the practice they provided,[46] for example, if the professional has concerns or questions as to whether the care provided was optimal, or whether appropriate alternatives were sufficiently considered. Where this is the case, the supervisor

[43] If the professional is non-regulated but has a legitimate relationship to the patient for the provision of clinical care in the episode of care reflected upon, they will only be able to access CPI under the supervision of a regulated professional within the criteria set out in the 'Team approach to reflective practice' section above.

[44] This may be particularly likely to be the case where the care to be reflected on was provided in an emergency situation.

[45] See section 5 above for the regulator's recognition of a team approach to reflective practice in some cases.

[46] See section 5 above for the importance of involving supervisors in regulated practitioner's reflective practice.

would normally be part of the team providing care where the patient was treated during the episode of care being reflected upon.

In some circumstances a practitioner may receive clinical supervision from someone outside that clinical team (for example, if their clinical supervisor works elsewhere in the organisation, as there is no-one senior from their clinical profession within the team itself). In these circumstances, CPI would only be shared, where necessary, in the context of reflective practice within this supervisory arrangement, which would be formalised at an organisational professional level.

Like the reflective practitioner, the supervisor should be a member of the regulated profession providing care and treatment to patients. The supervisor should only have access to the CPI that is necessary to help the professional to effectively reflect on their practice. This access should be limited in the same way as described in relation to Caldicott Principles 2 and 3 above.

As outlined above, the definition of reflective practice discussed in this paper rests on the definitions given by regulators of health and social care professionals. If the professional who provided clinical care in the episode of care reflected upon is non-regulated, they will not be able to independently access CPI for the purposes of reflection under this position statement. However, where the non-regulated professional fits within the criteria set out in the 'Team approach to reflective practice' section above, they are able to access CPI under the supervision of a registered and regulated professional who is leading the reflective practice.

Where the reflective practitioner no longer has access to the information needed to effectively reflect on their practice, they may be reliant on those to whom they subsequently handed over the patient's care to provide feedback about the impact of their care on the patient. These may be individuals or organisations. For example, pre-hospital emergency medicine professionals may need to seek feedback from the hospital teams they handed the patient's care over to.

Access to CPI by those who are required to feedback the information to the reflective practitioner should be limited in the same way as described in relation to Caldicott Principles 2 and 3 above.

**Principle 5: Everyone with access to confidential information should be aware of their responsibilities**

We would expect that before access is granted to CPI for the purpose of reflective practice, any professional involved in accessing CPI for reflective practice is:

- subject to terms and contractual obligations of employment which include an explicit duty of confidentiality
- up to date with information governance training mandated by their organisation

- made aware of local procedures and expectations regarding the use of CPI for reflective practice, noting that procedures are likely to vary locally

**Principle 6: Comply with the law**

Implied consent is the appropriate common law duty of confidentiality legal basis for accessing CPI to deliver and support direct care to individuals. The rationale for this is that people expect those who care for them to have access to the confidential information needed to provide that care.[47]

This paper has set out how reflective practice, where this is performed by registered and regulated health or social care professionals with a legitimate relationship with the patient for their care, is an integral aspect of safe and high-quality direct care. As such, implied consent may be used to meet the common law duty of confidentiality.

In the context of regulated professionals undertaking reflective practice to ensure safe and high-quality direct care, we think patients will reasonably expect the professionals who cared for them to have access to information about that episode of the care, where this is necessary to understand its impact, as part of the professional's reflective practice.[48]

Equally, health and social care professionals should respect any patient objections to information sharing for their own care. The Health and Social Care Act 2012 provides (at section 251B(4)) that information does not need to be shared under the duty to share information for the care of the individual if the individual objects, or would be likely to object, to the disclosure of information.[49] Thus, reflective practitioners must establish whether the patient has objected to access to their CPI which should prevent it being accessed for their reflective practice and consider whether, given their relationship with the patient during the episode of care provided, the patient would be likely to object to that professional having access.

**Principle 7: The duty to share information for individual care is as important as the duty to protect patient confidentiality**

Reflective practice is required by bodies regulating health and care professionals and aligns with direct care activities described in the IGR, namely: *the assurance of safe and high-quality*

[47] For support for the principle that people expect their healthcare professionals to share and use confidential patient information to provide care see the IGR p. 12.

[48] For support see the Annex (separate document) which sets out the results of Kantar polling of representative samples of the UK population which demonstrates overwhelming support for access to confidential patient information for the purposes of reflective practice by those polled. See also evidence from a patient panel demonstrating that people assume that information about the subsequent progress of patients conveyed to hospital by ambulance crews was always shared with the ambulance crews can be found here: PHEM Feedback

[49] Health and Social Care (Safety and Quality) Act 2015 (legislation.gov.uk)

*care and treatment and the management of untoward or adverse events*. Thus, health and social care professionals should be able to access confidential patient information as set out in this position statement if it necessary for their reflection and the provision of safe and high-quality care. Further, in line with principle 7, reflective practitioners, and access to the information and systems needed for reflective practice, should be supported by the policies of employers, regulators and professional bodies.

**Principle 8: Inform patients and service users about how their confidential information is used**

Patients and service users should be informed about the uses of their information, as well as their choices in respect of each use.

Caldicott Principle 8 states that although the type of actions necessary to inform people are dependent on the envisaged use, *'as a minimum, this should include providing accessible, relevant and appropriate information'*.[50]

This can often be achieved by organisations meeting their obligations under data protection law.[51] For many elements of direct care it may be clear to patients that their information will be used to provide them with care. However, where aspects of direct care are perhaps less well understood, extra measures to inform patients and service users should be considered.

Where organisations have processes to enable reflective practice across organisational boundaries, they should make it clear in their privacy policies. Such policies should set out that a professional care giver who has a legitimate relationship with the patient can access CPI regarding the episode of care they provided where this is essential to meet the reflective practice requirements of their regulator, and to ensure provision of safe and high-quality care.

[50] The Eight Caldicott Principles.

[51] See UK GDPR Articles 13 and 14.