Policy/Procedure/Guideline

Information Governance Policy

Version no: 1.0

Issue Status: Approved

Date of Ratification: April 2016

Ratified by: Clinical Governance & Risk Board

Policy Author: Bradley Woods

Policy Owner: CG&RB

Review Frequency: 2 yearly

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Last Review: April 2020

Next Review: April 2022

POLICY AWARENESS	
People who need to know this policy in detail	All staff who develop policies, procedures and guidelines
People who need to have a broad understanding of this policy	Authors of clinical and non-clinical policies. Policy owners and managers
People who need to know this policy exists	All current staff and those on Induction

CHANGE CONTROL DETAILS			
Date DD/MM/YY	**Version**	**Description**	**Reason for changes**
18/04/2016	1	New policy	New Policy

Policy location:
Main Policy Folder in Control Room and Crew Room
On PTUK Server

CONTENTS

1.0 Introduction

Information is at a vital asset, both in terms of the clinical management of individual service users and the efficient management of services and resources. Information governance plays a key part in supporting quality governance, service planning and performance management.

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

PTUK believes that accurate, timely and relevant information is essential to deliver the highest quality services.

2.0 Purpose

To ensure that PTUK has in place a comprehensive Information Governance Framework to manage the processes for acquisition, processing, storage, sharing and disposing of the information assets for which it is responsible.

3.0 Definitions

Information Governance (IG): IG is a framework to bring together all of the requirements, standards and best practice that apply to handling information.

IG Committee: The Committee responsible for developing the procedures for IG and generally promoting IG best practice throughout PTUK.

Senior Information Risk Owner (SIRO): The PTUK board member responsible for leading the organisations IG programme and acting as advocate for information risk on the board.

Caldicott Guardian: The senior clinical professional who has a strategic role for the management of Service User Information, including agreeing and reviewing protocols governing the protection, use and disclosure of Service User Information.

Information Governance Statement of Compliance (IGSoC): The process by which organisations enter into an agreement with The Health and Social Care Information Centre (HSCIC) for access to the NHS National Network (N3).

IG Toolkit: The HSCIC tool used for assessing an organisations compliance with a number of specific IG requirements. An organisation needs to complete the IG Toolkit on an annual basis to maintain the Information Governance Statement of Compliance (IGSoC).

4.0 Scope

Scope of Policy

For the purposes of this and related policies, 'information' is defined as – data that can be stored in any format, e.g. paper, electronic, audio or visual, or can be passed by word of mouth.

This policy covers all aspects of information within the organisation including:

- Service User Information
- Personnel Information
- Organisation Information

This policy covers all types of information including:

- Structured record systems: paper and electronic
- Unstructured information: paper and electronic
- Transmission of information: fax, email, post and telephone

This policy covers all information systems purchased, developed and managed by, or on behalf of, the organisation and any individual directly employed or otherwise by the organisation.

Scope of Information Governance

Information Governance is a framework to enable PTUK to handle personal and corporate information legally, securely, efficiently and effectively to deliver the best possible service. It is formed of the following initiatives:

- Information Security and Risk Management
- Data Protection and Confidentiality
- Records Management

5.0 Responsibilities

The management of Information Governance across the organisation will be coordinated by the IG committee.

The Director having responsibility for Information Governance is the Senior Information Risk Owner.

The IG Committee's role is to:

- Ensure a coordinated approach to Information Governance across PTUK.
- Identify best practice, define and deliver improvement plans.

- Work closely with employees across the organisation to ensure that Information Governance standards are understood and adhered to.

PTUK Registered Managers are responsible for ensuring that the policy and supporting standards and guidelines are built into local processes and for monitoring compliance.

All employees, whether permanent, temporary or contracted, are responsible for ensuring that they are aware of the requirements incumbent upon them for ensuring that they comply with these on a day to day-to-day basis. Guidance for employees is given in their staff handbook and the appropriate policies.

6.0 Policy

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

PTUK fully supports the principles of corporate governance and recognises its public accountability, but equally places importance on the confidentiality of, and the security arrangements to safeguard both personal information about Service Users and employees and commercially sensitive information.

PTUK also recognises the need to share Service User data with other health organisations and other agencies in a controlled manner consistent with the interests of the Service User and, in some circumstances, the public interest.

PTUK will develop and maintain a communications strategy to ensure that Service Users (and relatives) are aware of the need for PTUK to hold their personal information, the processes with PTUK use, and the rights they hold as data subjects and Service Users.

PTUK undertakes to maintain high standards of information handling and in order to do this, will abide by the following principles:

- PTUK seeks to protect its computer systems from misuse and minimise the impact of service breaks through general compliance with the principles of ‘best practice’ and the development of procedures to manage and enforce this.
- PTUK endeavours that all information recorded by PTUK is accurate, complete and available appropriately.
- PTUK will use all appropriate and necessary means to ensure that it complies with the Data Protection Act (1998) and associated Codes of Practice issued by the Information Commissioners Office.
- PTUK will obtain and share information in compliance with the common law of confidentiality.
- PTUK will use all appropriate and necessary means to ensure that it complies with the Freedom of Information Act (2000) and associated Codes of Practice issued by the Information Commissioners Office. In practice, this means that PTUK will comply with any contractual requirements regarding the Freedom of Information Act (FOIA)

and as a general rule will refer any FOIA request back to the public body who commissioned the services.
- PTUK will have a systematic and planned approach to the management of records within the organisation, from their creation to their ultimate disposal.

7.0 Year on Year Improvement Plan and Assessment

A self-assessment of compliance within the requirements of the Information Governance Toolkit, will be undertaken each year by the IG Committee.

In response to the above assessment, PTUK will formulate an Information Governance Improvement Plan each year, which will detail action plans that have been raised through the toolkit.

PTUK will undertake audits of compliance with the policies and procedures relating to Information Governance on a regular basis.

8.0 Awareness and Training

All employees should complete, as part of their induction, a training session on Information Governance.

Top-up or role-based training will be given, or organised, where necessary; this can be organised by an individual wanting personal development or arranged at the discretion of a line manager. Contact should be made with a member of the IG Committee with regard to this.

PTUK will undertake to ensure the members of the IG Committee are given the appropriate training necessary to fulfil their role.

PTUK will also take steps to ensure that there is the appropriate level of awareness within the organisation and arrange awareness campaigns as appropriate.

Appendix A

Equality Impact Assessment Tool

To be completed and attached to any procedural document when submitted to the appropriate committee for consideration and approval.

		Yes/No	Comments
1.	**Does the policy/guidance affect one group less or more favourably than another on the basis of:**		
	• Race	No	
	• Ethnic origins (including gypsies and travellers)	No	
	• Nationality	No	
	• Gender	No	
	• Culture	No	
	• Religion or belief	No	
	• Sexual orientation including lesbian, gay and bisexual people	No	
	• Age	No	
	• Disability - learning disabilities, physical disability, sensory impairment and mental health problems	No	
2.	**Is there any evidence that some groups are affected differently?**	No	
3.	**If you have identified potential discrimination, are any exceptions valid, legal and/or justifiable?**	No	
4.	**Is the impact of the policy/guidance likely to be negative?**	No	
5.	**If so can the impact be avoided?**	N/A	
6.	**What alternatives are there to achieving the policy/guidance without the impact?**	N/A	
7.	**Can we reduce the impact by taking different action?**	N/A	

If you have identified a potential discriminatory impact of this procedural document, please refer it to Human Resources, together with any suggestions as to the action required to avoid/reduce this impact.

Appendix B

Checklist for the Review and Approval of Procedural Document

To be completed and attached to any document which guides practice when submitted to the appropriate committee for consideration and approval.

	Title of document being reviewed:	Yes/No/ Unsure	Comments
1.	**Title**		
	Is the title clear and unambiguous?	Yes	
	Is it clear whether the document is a guideline, policy, protocol or standard?	Yes	
2.	**Rationale**		
	Are reasons for development of the document stated?	Yes	
3.	**Development Process**		
	Is the method described in brief?	Yes	
	Are people involved in the development identified?	Yes	
	Do you feel a reasonable attempt has been made to ensure relevant expertise has been used?	Yes	
	Is there evidence of consultation with stakeholders and users?	Yes	
4.	**Content**		
	Is the objective of the document clear?	Yes	
	Is the target population clear and unambiguous?	Yes	
	Are the intended outcomes described?	Yes	
	Are the statements clear and unambiguous?		
5.	**Evidence Base**		
	Is the type of evidence to support the document identified explicitly?	Yes	
	Are key references cited?	Yes	
	Are the references cited in full?	Yes	
	Are supporting documents referenced?	Yes	
6.	**Approval**		
	Does the document identify which committee/group will approve it?	Yes	
	If appropriate have the joint Human Resources/staff side committee (or equivalent) approved the document?	Yes	

	Title of document being reviewed:	Yes/No/ Unsure	Comments
7.	**Dissemination and Implementation**		
	Is there an outline/plan to identify how this will be done?	Yes	
	Does the plan include the necessary training/support to ensure compliance?	Yes	
8.	**Document Control**		
	Does the document identify where it will be held?	Yes	
	Have archiving arrangements for superseded documents been addressed?	Yes	
9.	**Process to Monitor Compliance and Effectiveness**		
	Are there measurable standards or KPIs to support the monitoring of compliance with and effectiveness of the document?	Yes	
	Is there a plan to review or audit compliance with the document?	Yes	
10.	**Review Date**		
	Is the review date identified?	Yes	
	Is the frequency of review identified? If so is it acceptable?	Yes	
11.	**Overall Responsibility for the Document**		
	Is it clear who will be responsible for co-ordinating the dissemination, implementation and review of the document?	Yes	

Individual Approval			
If you are happy to approve this document, please sign and date it and forward to the chair of the committee/group where it will receive final approval.			
Name		Date	19/04/2020
Signature			
Committee Approval			
If the committee is happy to approve this document, please sign and date it and forward copies to the person with responsibility for disseminating and implementing the document and the person who is responsible for maintaining the organisation's database of approved documents.			
Name		Date	19/04/2020
Signature			