



Llywodraeth Cynulliad Cymru  
Welsh Assembly Government

# WELSH HEALTH CIRCULAR

**Issue Date: 14 March 2006**

**Status: Direction**

**Title: THE CONFIDENTIALITY AND DISCLOSURE OF INFORMATION: GENERAL MEDICAL SERVICES AND ALTERNATIVE PROVIDER MEDICAL SERVICES DIRECTIONS 2006**

**For Action by:**  
Chief Executives of Local Health Boards

**Action required** *See paragraph(s) :*

**For Information to:**  
Local Health Boards – Medical Directors

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**Enclosure(s): Confidentiality and Disclosure of Information Directions 2006 & Code of Practice**

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## **Summary**

1. This Confidentiality and Disclosure of Information: GMS& APMS Code of Practice sets out guidance on the confidentiality of information held by contractors who provide General Medical Services and Alternative Provider Medical Services. It also sets out guidance on the provision of contractor-held information to Local Health Boards, and access by, and disclosure of, that information to LHBs or a person authorised in writing by LHBs.
2. The Directions came into Force on 8<sup>th</sup> March 2006.
3. The Directions and Code of Practice can also be found at <http://howis.wales.nhs.uk/sites3/page.cfm?orgid=480&pid=8035> or <http://www.wales.nhs.uk/sites3/page.cfm?orgid=480&pid=6062>

## **Action**

4. To comply with the Confidentiality and Disclosure of Information: GMS & APMS Directions 2006 and follow the Code of Practice.

Yours sincerely

John Sweeney  
Director of Community, Primary Care & Health Services Policy Directorate  
Health & Social Care Department

NATIONAL ASSEMBLY FOR WALES

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SUBORDINATE  
LEGISLATION

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2006 No. 14

NATIONAL HEALTH  
SERVICE, WALES

The Confidentiality and Disclosure  
of Information: General Medical  
Services and Alternative Provider  
Medical Services Directions 2006

*Made* 7 March 2006

*Coming into force* 8 March 2006

The National Assembly for Wales, in exercise of the powers conferred on it by section 16BB(4) of the National Health Service Act 1977(a) and of all other powers enabling it in that behalf, hereby gives the following Directions:

**Application, commencement and interpretation**

1.—(1) These Directions, which are called the Confidentiality and Disclosure of Information: General Medical Services and Alternative Provider Medical Services Directions 2006, are given to Local Health Boards in Wales and come into force on 8 March 2006.

(2) In these Directions—

“1977 Act” (“*Deddf 1977*”) means the National Health Service Act 1977;

“APMS contract” (“*contract APMS*”) means arrangements made under section 16CC(2)(b) of

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(a) 1977 c.49. Section 16BB was inserted by the National Health Service Reform and Health Care Professions Act 2002 (c.17) (“the 2002 Act”) section 6(1) and amended by the Health and Social Care (Community Health and Standards) Act 2003 (c.43), section 184 and Schedule 11, paragraphs 7 and 10.

the 1977 Act for the provision of primary medical services**(b)**;

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

“GMS Contract” (“*Contract GMS*”) means a contract under section 28Q of the 1977 Act**(d)**;

“GMS Contract Regulations” (“*Rheoliadau Contractau GMS*”) means the National Health Service (General Medical Services Contracts) (Wales) Regulations 2004**(e)**.

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

2. 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 76 (provision of information) or 79 (annual review) of Schedule 6 to the GMS Contract Regulations;
- (b) any equivalent terms to those specified in paragraph (a) in a default contract; or
- (c) any equivalent terms to those specified in paragraph (b) in an APMS contract,

a Local Health 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 paragraphs 19 to 23, 29, 30, 34 to 37 and 39 of the document entitled “Confidentiality and Disclosure of Information: General Medical Services (GMS) and Alternative Provider Medical Services (APMS) Code of Practice” dated 13 October 2005**(f)**.

Signed on behalf of the National Assembly for Wales

7 March 2006

*D. Elis-Thomas*

The Presiding Officer of the National Assembly

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**(b)** Section 16CC was inserted into the 1977 Act by section 174 of the Health and Social Care (Community Health and Standards) Act 2003 (c. 43) (“the 2003 Act”).

**(c)** S.I. 2004/477 (W.47).

**(d)** Section 28Q was inserted into the 1977 Act by section 175(1) of the 2003 Act.

**(e)** S.I. 2004/478 (W.48).

**(f)** A copy of this Code of Practice is available on the Welsh Assembly Government’s website at <http://www.wales.nhs.uk/gms>





Llywodraeth Cynulliad Cymru  
Welsh Assembly Government

**Confidentiality and Disclosure of Information:  
General Medical Services (GMS) and Alternative Provider  
Medical Services (APMS) Code of Practice (Wales)**

**13 October 2005**

# **CONFIDENTIALITY AND DISCLOSURE OF INFORMATION: GMS 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) and Alternative Provider Medical Services (APMS). Similarly where the term “contract” or “contracts” is used in this document it refers to the contracts entered into by those who provide GMS and APMS (unless there is a specific reference to the contrary). It also sets out guidance on the provision of contractor-held information to Local Health Boards (LHBs), and access by, and disclosure of, that information to LHBs or a person authorised in writing by LHBs.
2. This Code has been developed by the Welsh Assembly Government in consultation with the General Practitioners Committee (Wales) (GPC(W)) of the British Medical Association, and other key stakeholders, including representatives from patient bodies. It makes explicit existing legal and ethical obligations of confidentiality, placing them in the context of new 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 Local Health Boards (LHBs) who commission services from them. It also describes circumstances in which the Welsh Assembly Government (WAG) may request access to certain contractor-held information. LHBs are required by Directions to comply with the provisions of this Code when exercising certain functions<sup>g</sup>. LHBs should normally seek actively to involve and engage Local Medical Committees in relation to the Code where there are any potential issues of contention or where contractors may require additional support.
3. Local Health Board Medical Services (LHBMS) are not covered by the Directions to LHBs since the arrangements for providing LHBMS differ in certain respects from the other primary care contractual arrangements. However, LHBs providing LHBMS are

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<sup>g</sup> The Confidentiality and Disclosure of Information – General Medical Services and Alternative Provider Medical Services (Wales) Directions 2005 dated (Complete date) 2005

expected to follow the principles in this Code, when appropriate, performance managed by Welsh Assembly Government on this basis.

## Legal Context

4. The NHS (General Medical Services Contracts) (Wales) Regulations 2004<sup>h</sup>, and the APMS Directions<sup>i</sup> (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 and APMS contracts must contain a term requiring contractors, at the LHB’s written request, to produce to the LHB, or a person authorised in writing by the LHB; or allow access by the LHB, or a person authorised in writing by the LHB, to:-
- (i) information which is reasonably required by the LHB for the purposes of, or in connection with the GMS Contract or APMS contract; and
  - (ii) any other information which is reasonably required in connection with the LHB’s functions<sup>j</sup>.

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

5. This Code does not detail each specific provision within the regulations that deal with obligations on a contractor to provide specific information or reports to LHBs or other bodies, for example:-
- (i) the requirement to send clinical reports to the LHB where services are provided to non-registered patients (see, for example, Schedule 6 paragraph 7 of the GMS Contracts Wales Regulations);
  - (ii) notifications of deaths (see, for example Schedule 6 paragraph 85 of the GMS Contracts Wales Regulations).

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<sup>h</sup> S.I. 2004/478

<sup>i</sup> The Alternative Provider Medical Services Directions 2004 dated 22 November 2004.

<sup>j</sup> See paragraph 76 of Schedule 6 to the NHS(GMS Contracts) Wales Regulations.

## Scope of the Code

6. This Code applies to contractors and to LHBs, to all the staff employed by the practice and LHBs 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 LHB 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<sup>k</sup>.
7. Four categories of information are covered in this Code:-
  - (i) anonymised or aggregated patient information;
  - (ii) confidential patient 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 (eg locum GPs).
8. In dealing with disclosure of information, contractors, LHBs and the other bodies referred to in this document should have regard to other publications issued to support implementation of the GMS Contract, and APMS, and to:-
  - (i) the NHS Wales Confidentiality site on HOWIS (<http://howis.wales.nhs.uk/microsite/page.cfm?OrgID=305&PID=568>)
  - (ii) Guidance Notes on Section 60 of the Health and Social Care Act 2001, for those wishing to use patient identifiable information for an acceptable purpose as defined by the Act ([www.dh.gov.uk/PublicationsandStatistics](http://www.dh.gov.uk/PublicationsandStatistics))

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<sup>k</sup> Detailed guidelines on the operation of the QOF are set out in *eg Delivering Investment in General Practice*: HOWIS (Intranet) - <http://howis.wales.nhs.uk/microsite/documents/480/chapter1%2De%2Epdf> or HOWIS Internet) - <http://www.wales.nhs.uk/sites/documents/480/chapter1%2De%2Epdf>

*Annual QOF Review Process Guidance*:

HOWIS (Intranet) - <http://howis.wales.nhs.uk/microsite/documents/480/AnnualReviewVisitsGuidance%2Epdf> or HOWIS (Internet) - <http://www.wales.nhs.uk/sites/documents/480/AnnualReviewVisitsGuidance%2Epdf>

<sup>l</sup> The Control of Patient Information Regulations made under section 60 are of general application. They do not override powers in paragraph 76 of Schedule 6 of the NHS (GMS Contracts) (Wales) Regulations or similar provisions in the NHS (APMS) Directions 2004 to provide information in particular circumstances.

9. Although they are not explicitly covered by this Code, Annex A outlines the position in relation to:
- (i) Community Health Councils;
  - (ii) Healthcare Commission;
  - (iii) NHS Counter Fraud and Security Management Service (NHSCFSMS);
  - (iv) NHS Internal Audit;
  - (v) Social Services Departments;
  - (vi) National Patient Safety Agency (NPSA) - National Clinical Assessment Service (NCAS); and,
  - (vii) Researchers.

## **General Principles**

10. 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.
11. 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 management of healthcare services. When LHBs require 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 purposes of their individual healthcare needs. 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. The General Medical

Council's "Confidentiality: Protecting and Providing Information", April 2004, provides additional information (<http://www.gmc-uk.org/standards/confidentiality.htm>).

12. Patient 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 Data Protection Act.
  
13. The standards and constraints that apply to the holding, using and sharing of information are important components of Information Governance in the NHS. This Code of Practice reflects Information Governance principles in relation to the disclosure of, or access to, information. 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 LHBs need 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 LHBs 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 paragraphs 29-31), the process of obtaining such information will be open to audit and appropriate scrutiny – such as by the Welsh Assembly Government, 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 29-31).

14. Even though sharing information for healthcare purposes will be lawful within GMS or APMS practices, 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 involved in the care of patients, eg nurses and allied health professionals employed by the contractor or other organisations such as the LHB. 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 .

### **Providing a Secure & Confidential Service**

15. 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 29-31). Where such consent is not sought or is not required, the reasons for disclosure must be demonstrated and recorded, and there must be a clear audit trail, available for

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**m** All qualified nurses are required to be registered with the Nursing Midwifery Council and are therefore required to abide by the Code of Professional Conduct, which includes protection of confidentiality of the patient or clinical record. Nurses are personally accountable for their own practices. Allied Health Professionals are regulated by similar requirements.

scrutiny by bodies such as the Welsh Assembly Government, NHS Audit and Caldicott Guardians - see paragraph 31).

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<sup>n</sup>. 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 must ensure that their Patient Information 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<sup>o</sup>. The leaflet should refer to the possibility of anonymised or patient-identifiable information being

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<sup>n</sup> See paragraph 74 to Schedule 6 of the NHS (GMS Contracts) (Wales) Regulations 2004

<sup>o</sup> See paragraph 75 to Schedule 6 and Schedule 10 of the NHS (GMS Contracts) (Wales) Regulations 2004

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:-

## **Anonymised or aggregated patient information**

### **General**

19. 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.
20. 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. LHBs 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.
21. 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.

## **LHBs**

22. LHBs require 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 LHBs require 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 LHB has concerns about a contractor's compliance with its contract.
23. A person acting on behalf of the LHB, must, if requested, produce written authorisation to the contractor in order to see or access information held by the contractor.

## **Welsh Assembly Government**

24. Anonymised or aggregated information may also be requested for certain purposes by the Welsh Assembly Government.
25. Under paragraph 76 of Schedule 6 to the NHS (GMS Contracts) (Wales) Regulations 2004 or its APMS equivalent, a contractor is only required to provide information to the LHB or a person authorised in writing by the LHB. There may be some occasions

where the information needs of the Welsh Assembly Government can be more effectively met by asking a contractor directly for anonymised or aggregated information. This may be, for example, where the Welsh Assembly Government, in fulfilling its performance management function of a LHB, needs to clarify an aspect of the LHB's performance. Failure to comply with a request for information from the Welsh Assembly Government will 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 LHB in accordance with the terms of the contract and this Code.

26. This situation does not affect any separate contractual obligations that a contractor might have to provide information to the Welsh Assembly Government, for example, in relation to disputes on assignments<sup>p</sup>.
27. The Welsh Assembly Government may request information deriving from practices in order to support the Welsh Assembly Government's work. This data, such as the Attribution Dataset (Annex B) for resource allocation, will usually be requested via LHBs.

## **Confidential Patient Information**

### **General**

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

### **LHBs**

29. The circumstances in which the LHB, or persons authorised by the LHB, may need to access and obtain information that identifies individual patients should be limited. A decision to disclose such information to the LHB 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 LHB reasonably requires and which it has requested in

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<sup>p</sup> See, for example, paragraph 36 of Schedule 6 to the NHS (GMS Contracts) (Wales) Regulations 2004.

accordance with the relevant requirements of this Code. The circumstances in which, in the view of the Welsh Assembly Government, patient identifiable information would generally be reasonably required by the LHB 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 LHB in patient identifiable form (but see paragraph 31).
- (ii) where the LHB 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 (eg because of poor record keeping);
- (iv) where the LHB considers there is a serious risk to patient health or safety;
- (v) investigation of suspected fraud or any other potential criminal activity;

30. 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 LHB requires access to 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.

Where a LHB 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 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,

the practice should explain its reasons for non-disclosure to the LHB and ask the LHB to select a different record. LHBs 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.

31. Where the patient's consent is not sought to identifiable information, the reasons why must be documented, and there must be a clear audit trail. Where a practice is making a disclosure on the basis that it is justified in the public interest (eg 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.

### **Welsh Assembly Government**

32. The Welsh Assembly Government may need to see patient-level data in certain circumstances. For example, the Welsh Assembly Government is responsible for resolving certain disputes under the GMS contract and APMS agreements, and may be responsible for resolving patient complaints. Where the Welsh Assembly Government

needs to see patient-level data, data must be anonymised, unless there are exceptional reasons why identifiable data is required – in which case, the patient’s consent should be sought and obtained. Where, exceptionally, consent is not forthcoming, the conditions described in paragraphs 29-31 apply equally to the Welsh Assembly Government. Welsh Assembly Government staff must ensure that appropriate information governance arrangements are in place to safeguard all the information they hold.

33. It is not, in general, necessary for the Welsh Assembly Government to see individual patient level data. However, the Assembly 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 Assembly 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 Assembly is involved in development work using the GP practice code and data on deceased patients but all data is anonymised and then aggregated.

## **Practice Level data**

### **General**

34. 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 Medical Committee (LMC).

### **LHBs**

35. LHBs 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 Contract Manager, which will provide

monthly reports on each contractor's performance against the QOF to the contractor's LHB. LHBs will also require access to end-year data— for example, for planning purposes, and to confirm payments to be made to the contractor under the QOF.

36. In all cases, it will be necessary for the LHB to be able to identify, from practice-level data, contractors within the LHB area. This will enable the LHB, 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 LHB 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.
37. LHBs and contractors will agree between them arrangements for the annual contract review and visit, and the annual QOF review and visit<sup>q</sup>. Where practicable, both reviews may be combined. Following either review, or as a result of issues which arise in-year, the LHB may require additional information, possibly combined with further visits by the LHB or a person or persons acting on its behalf.

## **Welsh Assembly Government**

38. As part of their performance management responsibility, The Welsh Assembly Government will need to see in-year data from different LHBs within the Regional Office areas, in order to compare performance, monitor financial performance and LHB management of the contract/agreements. Such data will be required on a monthly basis. It will not usually be necessary for in-year contractor identifiable data to identify individual contractors. However, LHBs may provide data to the Assembly which identifies an individual contractor if that contractor agrees, or where, subject to The Welsh Assembly Government will also need to see end-year practice-level data as part of their performance management function. The provisions of the Data Protection Act if applicable, there are circumstances such as a need to safeguard public health,

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<sup>q</sup> Paragraph 79 of Schedule 6 to the NHS (GMS Contracts) (Wales) Regulations 2004

understand significant performance variations or respond to a request under the Freedom of Information

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

### **General**

39. 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 1998.

### **LHBs**

40. LHBs 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.

### **Welsh Assembly Government**

41. The Welsh Assembly Government may require practice-level workforce information to support the development of planning across their health economy and for statistical purposes, e.g.: to-
- (i) inform workforce planning policy;
  - (ii) form a realistic view on the size of the workforce, taking into account staff who work in more than one place;
  - (iii) allow retention, recruitment and other flows to be measured.
42. Wherever possible, anonymised data will be used in accordance with the principles outlined in paragraphs 19-21. As an example of access to such data, each year the Welsh Assembly Government produces information on earnings and expenses of GPs. Tax returns received by the Inland Revenue are used as the source of the data. To meet 19-21 confidentiality and disclosure obligations, the analysis is conducted by the Inland Revenue. Once the analysis has been completed, the Inland Revenue provides the Department with only aggregated results. Anything which could allow individual

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

43. 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 Welsh Assembly Government, 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.

### **Community Health Councils**

CHCs monitor and evaluate the effectiveness of health services from the patients' perspective and will ensure that patient's views are fed into local decision making processes. CHCs also have a statutory duty to respond to consultations undertaken by LHBs and NHS Trusts on substantial service changes. CHCs also have a statutory duty to provide advocacy support to people who wish to make a complaint about an NHS organisation in Wales. In carrying out these functions, CHCs have a statutory right to request information and this information must be provided subject to the limitations set out in the regulations.

### **Healthcare Inspectorate Wales (HIW)**

HIW carries out reviews and investigations into the provision of healthcare by and for NHS bodies under the Health and Social care (Community Health and Standards) Act 2003. HIW has powers to require information, documentation and to interview persons and may in exercising its functions require confidential, personal data and aggregated anonymised information.

### **National Patient Safety Agency (NPSA) – National Clinical Assessment Service (NCAS)**

The purpose of the NCAS is to protect patients by helping the NHS to address concerns about doctors. The NCAS provides advice to Local Health Boards (LHBs) 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 LHB will need to arrange for the casework manager to access a sample of patient records for the purpose of examining the quality of the records kept by the doctor, and the quality of care provided, as evidenced in the records.

## **NHS Counter Fraud and Security Management Service (NHS CFSMS)**

The NHS CFSMS has responsibility for reducing NHS losses to fraud and corruption to an absolute minimum. The NHS CFSMS regional team for Wales was established in 2001 to prevent and detect fraud in the NHS in Wales. The team is assisted by a network of local counter fraud specialists within NHS Trusts and the Business Services Centres established under directions issued in 2001. LHBs also have responsibility for countering fraud in the NHS. The NHS CFSMS has agreed a memorandum of understanding with relevant professional bodies to facilitate access to information in the investigation of allegations of fraud and corruption

Examples of the kind of information NHS CFSMS 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 Departments**

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 records for research purposes can be found in Guidance Notes to section 60 of the Health and Social Care Act 2001.

**ATTRIBUTION DATA SET 2004 – DATA REQUIREMENT**
**ANNEX B**

<b>Field Type</b>	<b>Max. Characters</b>	<b>Field Content</b>
Q Code	3	Every patient Q Coded according to postcode. Where a postcode is not available, patients GPs responsible HA Q Code is utilised until the postcode is established.
PCG/LHB code	5	Every patient PCG/T coded according to GP, where available.
Practice Identifier	6	GP National Code of Senior Partner (Partnership assumed to be broadly equivalent to Practice). (6 numerics) Fringe Partnerships are to be extracted. 'Ended' GPs are to be allocated the Practice Identifier of the Senior Partner of the practice the GP was last associated with.
GP GNC Code	6	GP National Code of each GP. GNC Code of "ZZZ001" to be used for patients removed from previous GPs list at doctor's request. GNC code of "ZZZ002" to be used for patients removed from previous GPs list at patient's request. If GNC Code for a real GP cannot be ascertained, a GNC Code of "UNKNOWN" will be utilised.
GP Status Code	1	Status of each as either GMS or PMS. "G" = GMS, "P" = PMS
Postcode	8	Valid postcode formats are: "AnbbbNAA", "ANNbbNAA", "AANbbNAA", "AANNbNAA", "ANAbbNAA" or "AANAbNAA". For those patients without a postcode, a value of "UNKNOWN" will be utilised.
Sex code	1	"M", "F". Records with unknown sex to default to female. Counting and reporting of unknown sexes separately is not required.
Age Range Code	1	5 year age bands codes - A = "00", B = "01-04", C = "05-09", D = "10-14", E = "15-17", F = "18-19", G = "20-24", H = "25-29", I = "30-34", J = "35-39", K = "40-44", L = "45-49", M = "50-54", N = "55-59", O = "60-64", P = "65-69", Q = "70-74", R = "75-79", S = "80-84", T = "85+", U = "UNKNOWN"
Nursing/ Residential Home marker	1	Records whether the patient resides in a nursing/residential home or not. "Y" or null.
Patient Capitation	6	Count of the number of patients - <b>as at April 2004 (dependent on the run date)</b> – with a GP, with a postcode reported by Age Range Code band within Sex Code. <b>NOTE: the minimum number will be "1" ie zero entries will not be shown.</b>