

Your Information Rights



Produced using
Photosymbols 4



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This leaflet has been developed by St Andrew's staff and patients.

Introduction

This booklet tells you:

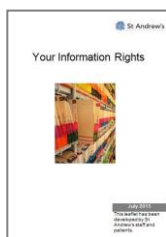
- about your information rights
- what information St Andrew's holds about you and why
- how St Andrew's keeps your information safe
- how St Andrew's uses your information
- who sees your information



St Andrew's has to follow the law, especially the "Data Protection Act" about holding and processing people's information.



St Andrew's also has to ensure that the way that information is handled does not interfere with people's rights under the Human Rights Act 1998.



St Andrew's must tell people what information it holds about them and how St Andrew's uses this information, so St Andrew's made this booklet for patients.

What information is held about you?



St Andrew's holds information about you so it can give you the best possible care. This information comes from:

- things you, carers or families have said
- information such as healthcare records from other organisations such as the NHS
- things that St Andrew's have recorded while you are under its care.



Examples of information St Andrew's holds about patients:

- name
- date of birth
- home address
- diagnosis and medication
- allergies
- "nearest relative"
- equalities information such as my gender, religion, nationality, disability and sexual orientation.

How does St Andrew's keep your information safe?

St Andrew's keeps your information



- in a folder on the ward (the “care folder”). It contains paper records.



- on a secure computer system (the “electronic record”). It cannot be accessed by anyone outside St Andrew's.



Confidentiality: Access to your records, both paper and the electronic record, is on a “need to know” basis. This means that only people directly involved in your care can see that patient's information.



When you leave St Andrew's, the “Health Records Team” will keep your information safe. They will arrange for all your records to be held on the secure computer system, not on paper.

How is patient information used?

Examples are:



Treatment and Care: The information held about you will be used by your Multi-Disciplinary Team (“MDT”) to make decisions about your treatment and care.

They will create new records about your care.

Audit



Your information might be checked as part of a “clinical audit” by St Andrew’s clinical audit team to help improve services.

Your MDT may ask you to be involved in this. If you agree, you may be asked about

- being admitted to St Andrew’s
- how you feel about your ward
- your treatment and care.



Research

Information about patients can help improve healthcare for other people (“research”). For example, it can help to understand more about diseases and how well treatments work.



“Anonymous data” (information which does not identify you) may be used in research without your consent.



If you can be identified from information, St Andrew’s will ask for your consent to use the information. Your MDT will explain what the research is about and what information they need. You can choose to give your consent or to refuse to give your consent.

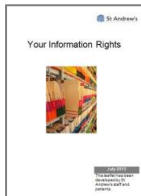
What are my rights?

The “Data Protection Act” gives you rights about your information (sometimes called “records” or “data”).





Access to your health records: you have the right to look at or have a copy of the information that St Andrew's holds about you. This is covered in more detail in another leaflet.



Knowing how your information is used: this booklet tells you why we hold your information and how it is used.



Confidentiality: you have the right to ask that information is not shared with some people, for example some relatives or healthcare professionals.



Amending or Correcting your information: If you think that the information held in your care record is not right, you can discuss this with your MDR or care co-ordinator.



If you agree that the information is not right, they will be able to arrange for this to be corrected for you.

If the MDT or care co-ordinator think that the information recorded is right, the information will stay in your record, but they can arrange for an update to be made which shows that you do not agree with the information recorded.

Who will see my information?



Some people at St Andrew's will need to see your information:



- Staff who work on your ward
- Secretaries and staff who support the ward
- Students working with the ward
- People doing the clinical audit
- People doing research

Sometimes staff from other organisations involved in your direct care may look at your notes. They will only see your notes if they really need to. Examples of these are the commissioners (the people that pay for you to stay at St Andrew's) or local hospitals, if you are admitted for emergency treatment.



Sometimes your lawyer ("solicitor" or "barrister") will look at your notes but only if you give consent to allow them to do so.



Staff will tell your family, friends and carers about your care and treatment, if you have asked them to.



If you do not want your family, friends and carers to know about your care and treatment staff will not tell them, even if they ask.



The law says that some organisations can look at your information but they cannot tell people what they have seen. They do not use your name or anything else that will tell people who you are. These organisations include:

- Care Quality Commission (CQC)
- General Medical Council (GMC)
- NHS Digital (formerly HSCIC)



These organisations may look at your information to check that St Andrew's are providing you with quality care.

Sometimes the law says that St Andrew's has to share information about you. This could happen where there is a:

- court order
- a child protection issue
- risk of serious harm to other people
- you have a disease which could affect other people.



St Andrew's does not tell other people if you have HIV or AIDS

**For more information contact St Andrew's
Data Protection Officer:**



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Email

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