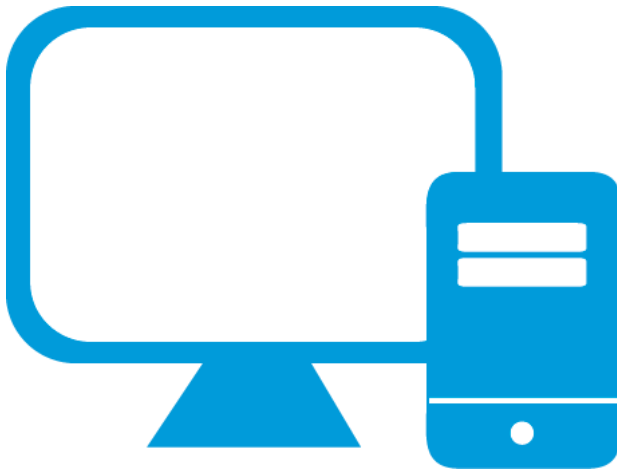


Patient and Personal Information and Confidentiality



This leaflet will tell you how our services protect and use information about you and how you can access this information.

The purpose of this leaflet

This leaflet explains:

- The type of information we record about you.
- How you can access it.
- What happens to it.
- How and when we may use your information.

All information we hold about you is stored securely and meets the requirements of the Data Protection Act 1998 and Caldicott Principles. This makes sure the information we hold about you is treated confidentially and legally.



Who can see the information about me?

Your information is seen by professionals involved in your care, such as primary care services, like General Practitioners (GPs). We will ask you who else you want us to share your information with, for example your carers.

There may be times where we might share your information without your consent. This will only happen when we are legally required to do so, or the law allows us to in order to protect you or other people. Such situations include:

- Where there is a risk of harm or abuse to you or other people.
- Where a serious crime, such as assault is being investigated or where it could be prevented.
- To control infectious diseases such as meningitis, tuberculosis (TB) or measles.
- Notification of a birth.
- Where the courts have made a formal order in relation to a court case.
- If you are undertaking assessment and treatment under the Criminal Justice Act.

How is my information recorded?

We use a variety of ways to record information about you.

This includes:

Electronic Patient Records

Electronic Patient Records are used by many parts of the NHS to record information. This includes some GPs, Hospitals, Child Health Services, Community Health and Mental Health Services.

The electronic record systems will prompt staff to discuss with you how widely you would like your information shared.

Case Notes

Case Notes are written case notes and letters that are held in your personal file by the service from whom you receive care.

This may also include written case notes and letters held by other professionals involved in your care, for example social workers, GPs and voluntary care organisations.

How can I look at information about me?

You have the right to see what is written about you. Sometimes we will not be able to show you everything but we will always explain why.

To look at your information, you have to write to the Trust.

Please tell us your name, address, date of birth and NHS number if you have it. When you write to us, please tell us you want to look at your information and let us know the dates that cover the information you want. Once we get your letter we will write to you and let you know the next steps.

You may ask someone else to look at your information on your behalf (such as a solicitor or advocate). To do this we would need your permission in writing.

How will my information be shown to me?

You will be sent a photocopy of the relevant parts of your information by post. If you require an explanation of any medical terms or abbreviations, or entries which are difficult to read, you may request an appointment with a member of staff to have these explained.

How long does this take?

Once we have your letter we will write to you within 21 days. Getting all of your information may take longer but we will write to you and let you know.

Can the Trust refuse to process an application for accessing my health record?

Under the Data Protection Act 1998, there are certain circumstances in which access may be denied, or limited.

For example:

- When the information may cause harm to a person's physical or mental wellbeing.
- If giving access would give information relating to, or provided by, a third party who has not given consent to the disclosure.
- If a request for information has previously been provided, a further identical or similar request may be denied, unless there is a reasonable gap since the last one.

How do we use your information?

Records we hold concerning you and our services may also be used for other purposes, such as:

- To train staff and monitor their work.
- To deal with complaints we receive (only staff dealing with complaints will have access to files relating to complaints or enquiries). We will only pass this information to another organisation if: i) another NHS organisation is coordinating a response that covers more than one service, ii) we are asked for information about your use of other services or enquires you have made to them, iii) or if you request that our response is reviewed by a separate regulating body e.g. the CQC.
- Statistics and certain information may be used for audit and research purposes, and to assist in service planning (all information used for these purposes is anonymous).

Can I change my records?

If you think your record is factually inaccurate, you can ask for it to be corrected. The Trust isn't obliged to accept your corrections, however, it does have to include a note in your records about why you think the information is inaccurate.

You will then be sent a revised copy free of charge.

Points to be aware of:

If you are seriously ill, staff will be able to access your record without asking. This type of use is actively monitored.

Within the Community Health Electronic Patient Record you can ask that specific entries in your record are marked as 'private'. This means that only the service recording the information will be able to see it. However, please be aware that having incomplete information may impact the care you receive.

For further Information:

If you have any remaining concerns or queries about the information we hold or how we use it, please contact our Caldicott Guardian:

Caldicott Guardian
Dorset HealthCare
Sentinel House
4–6 Nuffield Road
Poole, Dorset
BH17 0RB



The information in this leaflet is available in additional languages and alternative formats. Please contact the Trust for further details.

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