Ref: PL015

Liverpool Women's NHS Foundation Trust

Management, Disposal and Destruction of Confidential Paper Waste Policy

Version	1.3
Designation of Policy Author(s)	Head of Information Governance and Patient Records
Policy Development Contributor(s)	Head of Estates and Facilities
Designation of Sponsor	Chief Information Officer
Responsible Committee	Information Governance Committee
Date ratified	14/02/2023
Date issued	01/04/2024
Review date	31/03/2025
Coverage	Trust Wide

The Trust is committed to a duty of candour by ensuring that all interactions with patients, relatives, carers, the general public, commissioners, governors, staff and regulators are honest, open, transparent and appropriate and conducted in a timely manner. These interactions be they verbal, written or electronic will be conducted in line with the NPSA, 'Being Open' alert, (NPSA/2009/PSA003 available at www.nrls.npsa.nhs.uk/beingopen and other relevant regulatory standards and prevailing legislation and NHS constitution)

It is essential in communications with patients that when mistakes are made and/or patients have a poor experience that this is explained in a plain language manner making a clear apology for any harm or distress caused.

The Trust will monitor compliance with the principles of both the duty of candour and being open NPSA alert through analysis of claims, complaints and serious untoward incidents recorded within the Ulysses Risk Management System.

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1 Executive Summary

1.1 Applicability and Scope

i. This policy is applicable Trust-wide and details the approach adopted by the Trust to the management of Confidential Waste produced as a result of ongoing operational practices.

2 Introduction

i. The Trust regards all person identifiable information that it holds or processes as confidential and will implement and maintain policies to ensure compliance with all necessary mandatory obligations.

ii. Effective Information Governance gives assurance to the Trust and to individuals that personal information is dealt with legally, securely, efficiently, and effectively in order to deliver the best possible care.

iii. The Trust will ensure that information is efficiently managed, and that appropriate policies, procedures and management accountability and structures provide a robust governance framework for information management.

iv. This policy does not apply to medical records that are held on paper, which are subject to separate arrangements.

3 Policy Objectives

The objectives of this Disposal of Confidential Waste Policy will provide:

a) Appropriate governance of the security of Trust information that is held on paper.

b) Evidence that appropriate methods for the disposal of general confidential waste are in place.

c) Assurance reports to the Trust Board via the Information Governance Committee that general confidential waste is disposed of in accordance with statutory regulations.

d) Demonstrate continuous improvement to meet the national guidelines for the disposal of general confidential waste.

e) Support a culture that the disposal of ~~all~~ confidential waste is an individual responsibility for all staff, patients and visitors.

4 Duties and Responsibilities

4.1 The Senior Information Risk Owner

- Is accountable for Information Governance and Information Security at a Trust level, which includes the risk assessment process for information risk, including review of annual information risk assessments that support and inform the Statement of Internal Control.
- Reviews and approve actions in respect of identified information risks
- Ensures that the organisation's approach to information risk is effective in terms of resource, commitment, and execution
- Sets the overall objectives for Information Security for the Trust

4.2 Chief Information Officer

- Takes overall responsibility for IT Services for the Trust
- Ensures that the organisation complies with all mandatory requirements in respect of Information Technology, Information Security and Cyber Security -
- Has overall responsibility for Information Security for the Trust
- Ensures the overall approach taken to managing Information Security, Information Systems and Information technology is appropriate

4.3 Head of Estates and Facilities

- Is responsible for overseeing the management of Confidential Waste (excluding medical records) for the Trust.
- Monitors local responses to Confidential Waste Management incidents and provide support in developing proportionate and effective responses to manage such risk.

5 Main Provisions

5.1 General Provisions

i. All staff are responsible for ensuring that any media that contains confidential information and is destined for disposal or destruction is not left unattended, unsecured, open, visible or in a condition or position which could lead to it being viewed by anyone that is not authorised to view the information

ii. All staff are responsible for ensuring that any media that contains confidential information and is destined for disposal or destruction is not left in a physical location that could or would lead to it being removed by anyone who is not authorised to remove such information

iii. All staff are responsible for ensuring that any paper media that contains confidential information is placed in the correct physical confidential waste container, as defined within this policy, and is not placed in any waste receptacle that is not designated by the Trust for that purpose.

iv. Managers will ensure that staff within their department or area are given sufficient opportunity to undertake appropriate induction, training, and support in order to ensure that those staff will be sufficiently familiar with local confidential waste management procedures, general obligations to secure confidential waste management and awareness of any relevant policy or obligation.

v. Managers are responsible for the systems and processes in operation within their department or area, to manage media containing confidential material that is destined for disposal or destruction and will ensure acceptable standards are maintained.

vi. Managers are responsible for ensuring compliance to this policy for any individual who is not directly employed by the Trust for any period of time that the individual is working within, for, or on behalf of, their department or area.

vii. Where an individual is not directly employed by the Trust and is not working within a department or area covered by a specific manager then it will the responsibility of the manager who engaged the services of the individual, who is not directly employed by the Trust, to ensure compliance with this policy.

viii. The Trust will take appropriate action against any individual who has been found to have deliberately, or by deliberate omission of action, failed to maintain the minimum standards of conduct expected of them and as specified within this policy.

5.2 **Paper Confidential Waste**

i. Only Trust approved receptacles and containers shall be used for the storage of paper confidential waste.

ii. Managers of Departments or areas where confidential paper waste is processed shall ensure that there are sufficient receptacles and containers available to staff within their departments or areas.

iii. Managers of Departments or areas where confidential waste is processed shall ensure that receptacles and containers do not exceed the maximum permitted volume or weight of the receptacle.

iv. No member of staff may remove confidential waste for personal use under any circumstances, regardless of whether such information has been shredded.

v. No member of staff may deposit personal confidential paper waste in any container other than a receptacle or container that has been designated for that purpose.

vi. Confidential waste containers shall be clearly marked as being for those purposes.

vii. Where it is considered necessary to locate confidential waste containers in public areas or rooms or officers that are accessible by members of the public then the following conditions shall apply:

   a. Containers shall be locked with controls in place as to who can unlock those containers.
   b. Containers should be emptied at a frequency meaning there would be no prospect that they exceed their capacity.
   c. The containers shall be of such construction and design that no contents can be viewed from outside the container itself.
   d. That the container shall be constructed of such materials that they can be either fixed to the fabric and structure of the building or can be made sufficiently heavy as to be unmovable

viii. Where confidential waste is being transported through the Trust then it should be transported in sealed receptacles and should, if at all possible, not be transported through public areas.

ix. Unless it is necessary as part of the confidential waste management process or for other operational reasons, confidential waste shall not be taken outside

x. Where it is necessary to temporarily store confidential waste paper within the Trust then it shall be stored in a central, designated, secure location that is accessible to named individuals only.

xi. Where the Trust engages with a company to provide paper waste processing service, then the following conditions would be applicable to the contract that is signed with the company:

a. That confidential waste shall be transported on a point-to-point basis meaning that it shall be collected from the Trust site and then transported immediately and directly to the processing facility.
b. The confidential waste shall not be stored within the contractors building for a period of more than 24 hours. In the event that such processing does not occur resulting in the storage time exceeding 24 hours then it shall be for the processing company to inform the Trust, confirm the expected revised timescales and specify remedial actions.
c. Certificates of destruction shall be automatically provided to the Trust, or will be available direct and on demand, confirming the date and the volume or weight of the confidential waste that has been processed by that company.
d. Where a company wishes to recycle paper confidential waste then it will be up to the company to demonstrate that there is no realistic possibility that the nature or details of the personal confidential waste can be ascertained at any point during the recycling process.
e. No company may recycle any Trust paper confidential waste that has not been shredded or treated in some other way that renders the information unreadable prior to it beginning the recycling process.
f. No company may sell or pass on Trust personal confidential information once it has been recycled unless it has been pre-treated or sufficiently shredded so that information contained on the information is unreadable and cannot be re-joined having been previously scanned.
g. Processing facilities suppliers shall have all applicable certification that would ordinarily be expected and applicable to an organisation involved in processing, recycling, and destruction of confidential waste.

5.3 Home and Remote Working

i. Where staff are working at home or from a remote location then the standards of confidentiality that staff apply to the management of confidential waste material, shall continue to apply,

ii. In order to avoid the generation of confidential paper waste, staff shall not use, generate, print or process paper waste where there is an ability to process such information via electronic means, such as via remote access

iii. Where it is necessary to dispose of confidential paper waste, staff may use the disposal facilities at a remote NHS location so long as the standards of disposal are of equivalent standard to those deployed within the premises of the Trust.

iv. Where confidential paper waste disposal is required in any location where appropriate disposal facilities do not exist, such as a domestic setting or other non-NHS location, then staff shall ensure that the information is returned to the Trust or is taken to any suitable remote location as specified in Paragraph 5.3.iii (above) at the first opportunity.

v. Where, due to work commitments, or other operational constraints, staff are unable to take paper confidential waste to the Trust, or any location specified in Paragraph 5.3.iii (above) the same day for disposal, then staff are permitted to hold the information until the next working day at which point it shall be taken to such a location for disposal.

vi Where it is necessary for staff to physically transport confidential paper waste then, unless there are operational reasons not to do so, staff will be expected to only transport confidential paper waste where the journey is for the purpose of disposing of that confidential paper waste.

vii. Confidential paper waste shall, at all times during transport, be physically protected to the same extent as all other types of confidential information and shall, under no circumstances, be left in a position where it can be seen as being present in the vehicle or is placed at risk by being present in that vehicle.

5.4 Authority to Act

i. Approving Officers are, for the purposes of this Policy:
   - Chief Information Officer
   - Head of Information Governance and Patient Records
   - Head of Estates and Facilities

ii. Authority to vary from this policy for a specific reason and a time limited period can be given by an Approving Officer.

iii. An Approving Officer shall not be allowed to give authority where giving such authority would give rise to a conflict of interest.

iv. Authority to vary from this Policy, which is not time-limited, may initially be given by an Approving Officer but this must then be approved by the Information Governance Committee at the first opportunity.

5.11 Reporting

i. The Information Governance Committee shall be informed of any incidents where the cause is a systematic failure of any of its systems of control.

ii. All Managers will provide reasonable access to any system, area or individual that will allow the Information Governance Department to assess compliance to this policy through the Spot-check Programme

6 Key References

i. The Data Protection Act 2018
ii. The UK General Data Protection Regulations
iii. The Information Security NHS Code of Practice
iv. The NHS Confidentiality Code of Practice
v. The Records Management NHS Code of Practice
vi. Data Security and Protection Toolkit

7 Associated Documents

8 Training

i. Training for implementation of this policy is contained within the Trust overall training program and is reference by the Information Governance and Information Security Policy and Framework

9 Policy Administration

Consultation, Communication and Implementation

Consultation Required	Authorised By	Date Authorised	Comments
Impact Assessment			
GDPR	R. Cowell	14/04/2023	
Have the relevant details of the 2010 Bribery Act been considered in the drafting of this policy to minimise as far as reasonably practicable the potential for bribery?	Yes		
External Stakeholders			
Trust Staff Consultation via Intranet	Start date: February 2023		End Date: February 2023
Describe the Implementation Plan for the Policy (and guideline if impacts upon policy) (Considerations include; launch event, awareness sessions, communication / training via CBU's and other management structures, etc)			By Whom will this be Delivered?

Version History

Date	Version	Author Name and Designation	Summary of Main Changes
25/03/2021	1.0	Russell Cowell, Head of Information Governance	New Policy
31/03/2022	1.1	Russell Cowell, Head of Information Governance	Review only and re-approval. No changes
31/03/2023	1.2	Russell Cowell, Head of Information Governance and Records	General wording review and re-approval by Information Governance Committee. Update to job title of Head of Information Governance to add “and Records” to title. Re-allocation of policy sponsorship to the Chief Information Officer
31/03/2024	1.3	Russell Cowell, Head of Information Governance and Patient Records	Minor wording update. Insertion of a clause stating that this policy does not apply to the management of medical records that are in paper form.

10 Equality Impact Assessment

Does The Policy Affect:	Staff		Patients		Both	X

Equality Group	Impact (Positive/Negative/Neutral)
Race (All Ethnic Group)	Neutral
Disability (Inc Physical, long term health conditions & Mental Impairments)	Neutral
Sex	Neutral
Gender Re-Assignment	Neutral
Religion Or Belief	Neutral
Sexual Orientation	Neutral
Age	Neutral
Marriage & Civil Partnership	Neutral
Pregnancy & Maternity	Neutral
Other e.g., caring responsibilities, human rights etc.	Neutral

For each protected characteristic, consider whether the impact is positive. If so, provide supporting evidence to demonstrate how your decision was made and the impact that the policy will have with consideration of each protected characteristic (e.g., protected characteristic – impact – rationale)
Not Applicable
For each protected characteristic, consider whether the impact is negative. If so, provide supporting evidence to demonstrate how your decision was made and the impact that the policy will have with consideration of each protected characteristic (e.g., protected characteristic – impact – rationale)
Not Applicable
If your assessment has identified any negative impacts, please detail any actions that have been put in place to mitigate these (upon approval of EIA these actions will be shared with the Equality, Diversity and Inclusion Committee):

Outcome	Actions Required	Time Scale	Responsible Officer

Is there evidence that the s. 149 Public Sector Equality Duties (PSEDs) will be met? Consider whether the proposed policy will…

- Eliminate discrimination, victimisation, harassment, and any unlawful conduct that is prohibited under this act
- Advance Equality of opportunity
- Remove or minimise disadvantages suffered by people who share a relevant protected characteristic that are connected to that characteristic
- Take steps to meet the needs of people who share a relevant protected characteristic that are different from the needs of people who do not share it
- Encourage people who share a relevant protected characteristic to participate in public life or in any other activity in which participation by such people is disproportionately low.
- Foster good relations between persons who share a relevant protected characteristic and persons who do not share it. (Consider whether this is engaged. If engaged, consider how the project tackles prejudice and promotes understanding - between the protected characteristics)

Explain your answers below.

The policy is an administrative policy, which implements established legal obligations neutrally.

Does the EIA have regard to the need to reduce inequalities for patients with access to health services and the outcomes achieved? (this section is a requirement for any services outlined within the NHS England and Improvement Core 20 Plus 5 approach to health inequalities) Explain.

The policy is an administrative policy, which implements established legal obligations neutrally.

Section 2:

To be completed by the EDI Manager authorising the EIA

Anything for noting or any recommendations for consideration by the Board

Guidance Note: Will PSEDs be met? Are Core 20 Plus 5 services considering patient health inequalities?

Review Date:	

Additional Supporting Evidence and Comments: