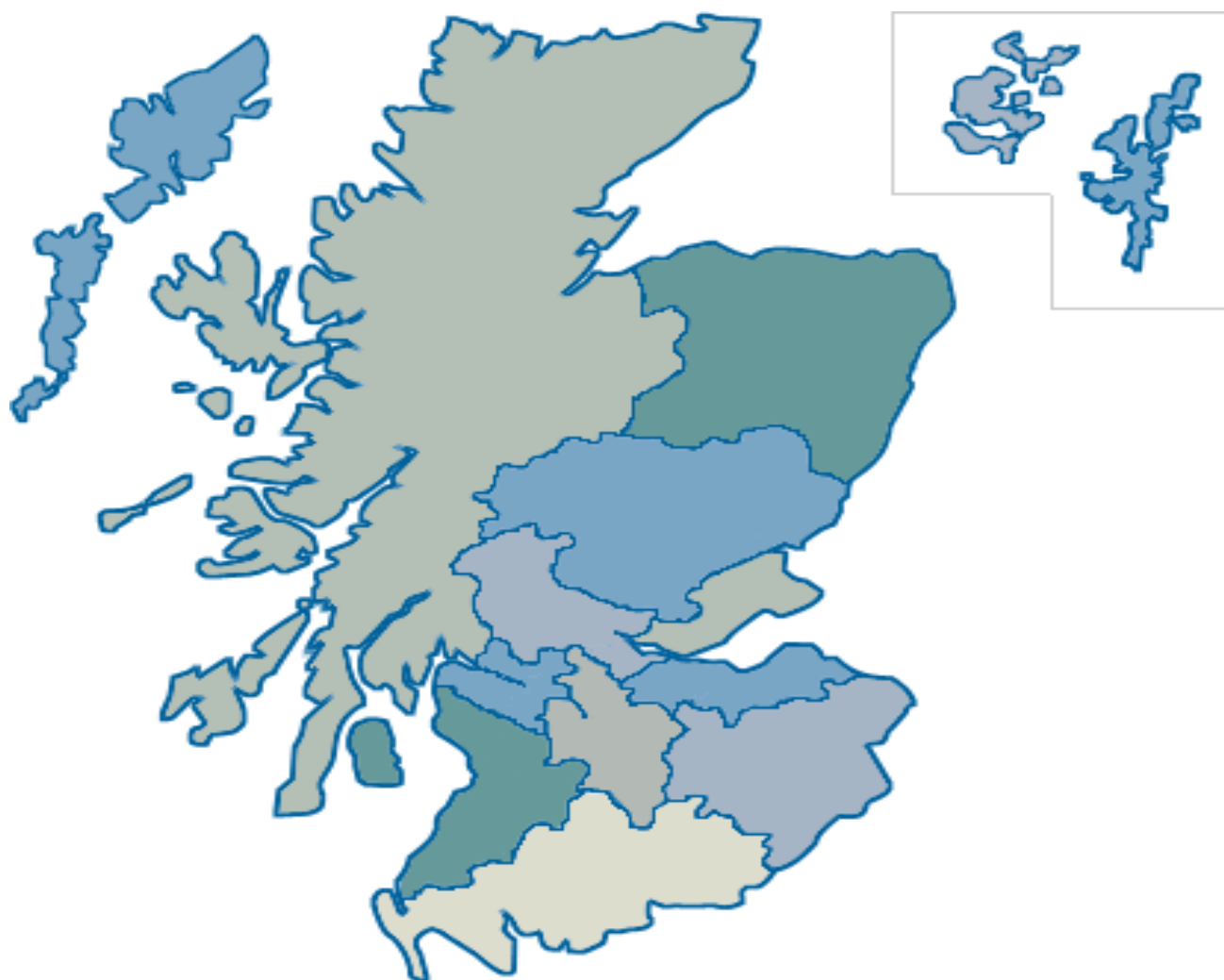


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NHSScotland Caldicott Guardians: – Principles into Practice



Foundation Manual for NHSScotland Caldicott Guardians
<http://www.knowledge.scot.nhs.uk/caldicottguardians.aspx>

FOREWORD

The delivery of “*world leading quality healthcare services*¹” depends on sharing information among professionals and sometimes with external organisations. It is essential that the information that underpins the provision of healthcare is of a high quality and is shared to the benefit of the individual and wider society, making the role of the Caldicott Guardian increasingly important.

I am therefore delighted to have been asked to provide a foreword for the work which has been undertaken here in Scotland to build upon the Caldicott principles; to reiterate them and to provide you, the Caldicott Guardian, with tools which I hope will be of real value to you; making it easier to fulfil your role locally.

This manual has been revised to meet the wider concerns identified by the Caldicott community regarding the confidentiality and security of patient information and appropriate, legal information sharing.

All of these areas fall within the duties of the Caldicott Guardian or those carrying out similar roles. This **Foundation Manual** tells you ***what you need to do*** and ***why you need to do it*** while the Caldicott Guardian [website](#) shows you ***how to do it*** - providing advice, guidance, exemplar policies and other resources.

I am very appreciative of all the work that has produced the updated guidance and website and extend my thanks to everyone responsible.

Dr Harry Burns
Chief Medical Officer

¹ [The Healthcare Quality Strategy for NHSScotland, The Scottish Government, May 2010](#)

This manual is supported by the NHSS Caldicott Guardian website “ *Principles into Practice*” which is accessible at:

<http://www.knowledge.scot.nhs.uk/caldicottguardians.aspx>

Introduction and document structure

Having set out how Caldicott Guardians came into being, Part one outlines who should be a guardian, the role and responsibilities. The Caldicott Guardian plays a central part in Information Governance (IG); this term is defined along with the closely associated area of Information Assurance. Information and records management is a core part of IG and each organisation needs a policy statement and strategy in this area. Key concepts, such as information life-cycle, organisational responsibilities and operations in this area are outlined as well as the Caldicott role in handling privacy breaches and security incidents relating to personal data. Increasingly, systems and processes (manual and digital) require ‘privacy’ to be built in at the design stage and this is explained along with the importance of positive patient identification.

The legislative and compliance landscape is extremely complex and Part two is designed to show an interconnecting mesh rather than a strict hierarchy of laws. The Human Rights Act 1998 is introduced, along with the Data Protection Act 1998 (DPA) that is directly informed by it. The essential elements of DPA are discussed (particularly the role of Data Controller, Eight Principles, Rights of Data Subjects and fees) rather than every aspect of Data Protection. Finally, other legislation is introduced (human fertilisation and embryology, deceased patients and Freedom of Information) that interplays with DPA and has some bearing on disclosure decisions.

In addition to statute law, Guardians need to be aware of how common law issues of confidentiality underpin decisions affecting personal data. ‘Consent’ is a fundamental concept and this document links the Code of Practice and other documentation that is used to better inform patients about how they can give consent (implicitly or explicitly). Consent is not absolute; and there are lawful ways in which personal data can be disclosed (e.g. by court order, and public interest).

Part three aims to show how a grounding in information law and ethical issues can then be used to make decisions relating to research and secondary purposes. In many ways this gets to crux of what the Caldicott Committee intended: more information flows of patient identifiable information for purposes other than direct health-care provided necessary scrutiny measures are in place.

Since the Caldicott Report was published in 1997, the need for data sharing among health professionals (and non-health professionals) across organisations and sectors has increased. The manual introduces some specific legislation that enables sharing of data. But most data sharing is the result of protocols put in place between organisations. Finally, there are links to some further training and awareness guidance.

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PART ONE

1. Caldicott Report and Principles

The 1997 Caldicott report made a number of recommendations for regulating the use and transfer of patient-identifiable information between NHS organisations and between NHS organisations and non-NHS bodies. The Caldicott Committee's remit included all patient-identifiable information passing between organisations for purposes other than direct care, medical research or where there was a statutory requirement for information. The aim was to ensure that patient-identifiable information was shared only for justified purposes and that only the minimum necessary information was shared in each case. The Committee also advised on where action to minimise risks of confidentiality would be desirable. While the report's focus was on the NHS in England, the recommendations and principles were adopted by the NHS in Scotland.

The recommendations of the Caldicott Committee influenced the confidentiality agenda for NHS organisations for a number of years. Central to the recommendations was the appointment in each NHS organisation of a "Guardian" to oversee the arrangements for the use and sharing of patient-identifiable information. In Scotland these recommendations did not apply to Local Authorities. A key recommendation was that use of patient-identifiable information should be regularly justified and routinely tested against the following principles:

Principle 1 - Justify the purpose(s) for using confidential information

Principle 2 - Only use it when absolutely necessary

Principle 3 - Use the minimum that is required

Principle 4 - Access should be on a strict need-to-know basis

Principle 5 - Everyone must understand his or her responsibilities

Principle 6 - Understand and comply with the law

Since then developments in information management in NHSScotland (NHSS) have influenced the Caldicott role including:

- Data Protection Act 1998
- Human Rights Act 1998
- Freedom of Information (Scotland) Act 2002
- NHSS Code of Practice on Protecting Patient Confidentiality.
- eHealth developments (such as the ECS , SCI Store, SCI DC etc)

This manual takes account of these developments and, importantly, sets the role of the Caldicott Guardian within an organisational Caldicott/Confidentiality function, which is itself a part of the broader Information Governance agenda.

This manual does not aim to reproduce or codify all the guidance available, but it updates existing materials where necessary and provides pointers to other current sources of guidance and standards which are available via the Caldicott Guardian website. The website is intended to be a 'one stop shop' for template policies and procedures, and links to legislation, Codes of Practice and Professional Standards.

The manual and website replaces the UK Caldicott Guardian manual and will be subject to regular review and updated as necessary.

2. Who should be the Caldicott Guardian?

The Guardian will be in priority order:

- an existing member of the management board of the organisation
- a senior health professional
- an individual with responsibility for promoting clinical governance within the organisation

Responsibility for ensuring that patient-identifiable information remains confidential is both an organisational and individual one. It is the responsibility of the Caldicott Guardian to facilitate understanding and awareness of this responsibility and to ensure that all such activities within an organisation are proportionate and lawful.

It is particularly important that the Guardian has the seniority and authority to exercise the necessary influence on policy and strategic planning and carry the confidence of his or her colleagues. Within NHS Boards, the Medical Director may take up the role of Caldicott Guardian.

All GP or Dental Practices, Opticians and Pharmacists must meet their information governance obligations. Although they do not need to appoint a Caldicott Guardian, they do need to have an Information Governance lead who, if they are not a clinician, will need advice and support from a clinically qualified individual.

The specialist area of Information Governance is an integral part of activity within the NHS. It is here that most of the day-to-day actions governed by expectations of confidentiality and the protection of patient-identifiable information take place and here that responsibility usually lies for the appropriate policies and procedures that should operate throughout the NHS body.

All patients have a right to expect that information relating to them will be properly created and managed; that it will be handled in confidence and that patient-identifiable information will only be shared with those whose justification for receiving such information has been rigorously tested.

Each organisation must put in place an Information Governance Strategy and supporting policies which will enable the organisation to meet its legislative requirements and ensure operational and management information is timely, robust and reliable.

3. What is the role of the Caldicott Guardian?

Acting as the ‘conscience’ of an organisation, the Caldicott Guardian should also actively support work to facilitate and enable information sharing, advising on options for lawful and ethical processing of information as required. Local issues will inevitably arise for Caldicott Guardians to resolve. Many of these will relate to the legal and ethical decisions required to ensure appropriate information sharing. It is essential in these circumstances for Guardians to know when and where to seek advice.

The Caldicott Guardian plays a key operational role in ensuring that NHS and partner organisations satisfy the highest practical standards for handling patient identifiable information.

In all but the smallest organisations the Caldicott Guardian should work as part of a broader Information Governance function with support staff, Caldicott or Information Governance leads, Data Protection Officers, Freedom of Information leads, Health Records Managers and IT Security staff contributing to the work as required.

3.1 Key Caldicott Responsibilities

The Caldicott Guardian also has a strategic role, however, that it is less appropriate to delegate.

Strategy & Governance:

- Act as an advisor and accountable for that advice
- Sit on an organisation’s Information Governance Board/Group or equivalent
- Ensure that governance arrangements regarding Information Governance are in place and are effective in their organisation
- Advise the Management team or the CEO of any issues relating to confidentiality assurance so they can be included in the Statement of Internal Controls.
- Act as enabler for appropriate information sharing.

Confidentiality & Data Protection expertise:

- Ensure that confidentiality issues are raised and minuted at Board/management team level,
- Ensure that results/implications of internal and external audits relating to confidentiality and DP assurance and options for improvement where necessary are raised at Board level
- Develop a knowledge of confidentiality and data protection matters, drawing support from subject topic experts working within the organisation and external sources of advice and guidance where available.

Information Processing:

- Ensure that annual IG performance assessments are undertaken by staff involved in the Caldicott function
- Ensure that confidentiality issues are appropriately reflected in organisational strategies, policies and working procedures for staff.

Information Sharing:

- Provide advice on individual cases where there are any concerns about the potential for the disclosure of patient-identifiable information.
- Oversee all arrangements, protocols and procedures where confidential patient information may be shared with external bodies both within and outside the NHS e.g. disclosure to research interests and other agencies e.g. the police
- Oversee all arrangements to ensure that Information Governance is embedded in all clinical and research governance.

Please see: [Job profile of Caldicott Guardian](#) – The UK Council of Caldicott Guardians has endorsed a job description for NHS Caldicott Guardians. This job description forms a generic baseline of functions that Caldicott Guardians are likely to perform. The content can be amended to make it more specific to an individual role and organisation.

Caldicott Guardians are central to the confidentiality and data protection function, so much so that this is often referred to as the Caldicott function. Examples of how a range of organisations have supported their Caldicott function can be accessed through links found on the accompanying website.

In addition to the key area of confidentiality and data protection, the Caldicott Guardian needs to provide input into the other areas of Information Governance. The reverse is also likely to be the case, with staff working on other aspects of Information Governance being well placed to contribute to confidentiality and data protection work. It is important that organisations put in place effective governance arrangements to ensure that the organisation's approach to information governance is coordinated and inclusive.

The Statement on Internal Control is part of the annual assurance process on governance within NHS organisations. As part of this process, NHS Boards need to identify sources of assurance and evidence of compliance to enable them to produce a meaningful statement on the system of internal control within an organisation. This would include an assessment of the effectiveness of the internal control and risk management arrangements covering overall good governance and the four specific strands of governance:

- Clinical Governance
- Staff Governance
- Financial Governance
- Information Governance

All procedure documentation should be regularly reviewed and updated as appropriate.

The Caldicott Guardian should either be directly involved in or have given documented delegated authority to a colleague to validate and authorise the clinical information assurance required for the implementation of new systems and services.

The Caldicott Guardian should ensure that they are notified of all research and clinical education activities to verify the appropriate use of personal identifiable information for these purposes, in line with the Caldicott principles and data protection requirements.

Given the potential scope for the volume of research projects, it is appropriate for the Caldicott Guardian to give documented delegated authority for this to a suitable senior colleague. Or where the organisation has a defined post in the organisation for Research and Development management, the Caldicott Guardian should ensure they work closely with the post holder and act as final arbiter where a research project is in dispute, in terms of its appropriateness or clinical validity.

Local projects for clinical education should seek the opinion of the Caldicott Guardian on aspects of clinical governance. Such projects are usually authorised by the Lead of the clinical service, e.g. Director of Post-Graduate Medical and Dental Education and the Director of Nursing.

4. Information Governance

Information Governance is an established term used throughout the NHS to describe the entire framework of policies, procedures for decision-making, and guidance that relate to the capture, use, re-use, access, sharing and management of all data and information throughout its life-cycle. This framework takes into account the complex mesh of legislation (such as the Data Protection Act 1998 and the Freedom of Information (Scotland) Act 2002) as well as issues such as confidentiality, quality, and staff training. Information Governance needs to interact across all aspects of the service and be seen in its totality; so although specialist staff may work in areas such as records management, health informatics or information security they can all be said to all be working to achieve the same end: information governance appropriate for the organisation and in accordance with the law.

5. Information Assurance

Information Assurance (IA) is a closely associated but narrower term that describes the set of activities designed to ensure that the availability, integrity and security of data and information is maintained at the agreed level. IA is relatively recent term and has its origins in corporate risk management: given the fast changing ICT environment it has become clear that relying on traditional audit methods (usually reactive rather than proactive) is no longer adequate. Instead, at the initial design stage risks need to be identified, assessed and proportionate measures put in place. Some measures are technical but increasingly cultural and organisational factors need to be considered. It is the risk owners who make the final decisions, and not those carrying out the assurance. This is why IA work needs to be seen within an overall Information Governance framework (e.g. Caldicott Guardians and decision makers looking across the whole information landscape and balancing competing operational, ethical and legal issues). There is a close interdependency between information assurance objectives and all the other components of IG. If basic

information and records management is lacking, for example, then security controls can rarely be well enforced.

The agreed [NHS Scotland Information Assurance Strategy](#) is not a replacement for a IG strategy (or new branding for Information Governance). Rather, there was a recognition by board Chief Executives that there was a particular need to improve the availability, integrity and security of information.

NHSScotland is transforming the way it uses information, sharing considerable amounts of data and joining up services and IT systems on an unprecedented scale. These changes are key underpinnings of the [Quality Strategy](#).

The IA Strategy emphasises that Boards need to focus on using the information they hold wisely and well, as well as responsibly and with care. Boards will outline their contribution to achieving these outcomes in local Information Governance strategies and eHealth plans.

6. Information policy and strategy

Each NHS organisation should have in place an overall policy statement, endorsed by the Board and made readily available to staff at all levels of the organisation on induction and through regular update training, on how it manages all of its records, including electronic records. Induction material should incorporate the [Induction Standards and Code of Conduct for Healthcare Support Workers](#).

The policy statement should provide a mandate for the performance of all records and information management functions. In particular, it should set out an organisation's commitment to create, keep and manage records and document its principal activities in this respect.

The policy should also:

- outline the purpose of records management within the organisation, and its relationship to the organisation's overall strategy;
- define roles and responsibilities within the organisation including the responsibility of individual NHS staff to document their actions and decisions in the organisation's records, and to dispose of records appropriately when they are no longer required;
- define roles, responsibilities and procedures for safe transfer, storage or confidential disposal of records when staff leave an organisation, or when NHS Board premises are being decommissioned;
- define the process of managing records throughout their life cycle, from their creation, usage, maintenance and storage to their ultimate destruction or permanent preservation;
- provide a framework for supporting standards, procedures and guidelines; and
- indicate the way in which compliance with the policy and its supporting standards, procedures and guidelines will be monitored and maintained.

The policy statement should be reviewed at regular intervals (a minimum of once every 3 years or sooner if new legislation, codes of practice or national standards are

introduced) and, if appropriate, it should be amended to maintain its currency and relevance.

For further advice you should contact your Local Health Records or Corporate Records Manager.

Alternatively, if you are seeking policy advice in relation to the NHSS Records Management Code of Practice, please contact the Information Assurance Team, eHealth Division at: ehealthinformationassurance@scotland.gsi.gov.uk

7. Information and records management operations

Although Caldicott Guardians are not responsible for the daily running of information and records management, it is important to understand the key concepts and responsibilities of all staff.

The [Scottish Government Records Management NHS Code of Practice](#) provides guidance on the required standards of practice in the management of records for those who work within or under contract to NHS organisations in Scotland. It is based on legal requirements and professional best practice.

7.1 NHS Records Management and Information Lifecycle

Records and information are considered to have a “lifecycle” from creation or receipt in the organisation, throughout the period of its “active” use, then into the period of “inactive” retention, (such as closed files which may still be required occasionally) and then finally to either confidential disposal or (for a very small proportion) permanent preservation in an archival facility.

A similar “information lifecycle” approach applies to managing the flow of an information system’s data and associated metadata from creation and initial storage to the time when it becomes obsolete and is deleted.

7.2 Roles and Responsibilities for Records Management and Organisational Responsibility

The records management function should be recognised as a specific corporate responsibility within every NHS organisation. It should provide a managerial focus for records of all types in all formats, including electronic records, throughout their life cycle, from planning and creation through to ultimate disposal. It should have clearly defined responsibilities and objectives, and necessary resources to achieve them. Great care must be taken when transferring clinical records between one site and another (e.g. for disposal) and only receptacles approved for the storage and transportations of health records should be used, to prevent such records falling into the wrong hands.

Designated members of staff, of appropriate seniority (i.e. Board level or reporting directly to a Board member), should have lead responsibility for corporate and health records management within the organisation. The model within each NHS Board may

differ depending on local accountability. This lead role should be formally acknowledged and made widely known throughout the organisation.

The manager, or managers, responsible for the records management function should be directly accountable to, or work in close association with, the manager, or managers, responsible for Freedom of Information, Data Protection and other information governance issues, as well as the Medical Director, who is operationally accountable for the quality of clinical information contained within personal health records in the organisation.

The NHS Board: is responsible for ensuring that it corporately meets its legal responsibilities, and for the adoption of internal and external governance requirements.

The Chief Executive: has overall responsibility for records management in the NHS Board. As accountable officer he/she is responsible for the management of the organisation and for ensuring appropriate mechanisms are in place to support service delivery and continuity. Records Management is key to this as it will ensure appropriate, accurate information is available whenever required.

The Caldicott Guardian: has a particular responsibility for reflecting patients' interests regarding the use of patient-identifiable information. They are responsible for ensuring patient-identifiable information is shared in an appropriate and secure manner (as previously mentioned in this document).

The Health Records Manager: is responsible for the overall development and maintenance of health records management practices throughout the organisation. They have particular responsibility for drafting guidance to support good records management practice in relation to clinical records and for promoting compliance with the Records Management Code of Practice, in such a way as to ensure the efficient, safe, appropriate and timely retrieval of patient information.

The Corporate Records Manager: is responsible for the overall development and maintenance of corporate and administrative records management practices throughout the organisation. They have particular responsibility for drafting guidance to support good records management practice (other than for clinical records) and for promoting compliance with the Records Management Code of Practice.

Local Records Management Co-ordinator: The responsibility for records management at directorate or departmental level is devolved to the relevant directors, directorate and departmental managers. Senior managers of units and business functions within the NHS Board have overall responsibility for the management of records generated by their activities in compliance with the NHS Board's records management policy. Local Records Management Co-ordinators may be designated to support the Health and Corporate Records Manager(s) to oversee local implementation and compliance.

All Staff:

All NHS staff, whether clinical or administrative, who create, receive and use documents and records have records management responsibilities. All staff must

ensure that they keep appropriate records of their work and manage those records in keeping with the Records Management Code of Practice and the relevant policies and guidance within their Board.

Training

All staff, whether clinical or administrative, must be appropriately trained so that they are fully aware of their personal responsibilities as individuals with respect to record keeping and management, and that they are competent to carry out their designated duties. This should include training for staff in the use of electronic records systems. It should be done through both generic and specific training programmes, complemented by organisational policies and procedures and guidance documentation. For example, Health Records Managers who have lead responsibility for personal health records and the operational processes associated with the provision of a comprehensive health record service should have up-to-date knowledge of, or access to expert advice on, the laws, guidelines, standards and best practice relating to records management and informatics.

7.3 Incidents and Breaches

Caldicott Guardians have a key role to play in relation to incidents and breaches. In particular, they will be involved in:

- instigating investigations where incidents relate to patient-identifiable information;
- taking action in relation to incidents and breaches;
- updating Executive Team colleagues;
- keeping Board colleagues informed; and
- working closely with information governance and information security colleagues.

8. Privacy By Design

Privacy by design is becoming increasingly important as there is a recognition that many of the legal, consent and disclosure problems (described in [Part Two](#)) can be greatly reduced if adequate thought is given to privacy and wider IG issues at the outset when a new service/initiative that requires the processing of personal data is introduced.

Projects that involve personal information or intrusive technologies inevitably give rise to privacy concerns. The cumulative effect of many such initiatives during recent decades has resulted in harm to public trust and to the reputations of organisations.

Where the success of a project depends on people accepting, adopting and using a new system, process or programme, privacy concerns can raise significant risks to organisations. In order to address these risks, it is advisable to use a risk management technique commonly referred to as a Privacy Impact Assessment (PIA).

Purpose of PIA: to identify at an early stage of project development potential privacy risks so that steps to mitigate these risks can be designed into the project.

When: A PIA should be conducted at an early stage of a project.

Compliance checks, on the other hand, are usually performed later after business processes and rules have been specified sufficiently so that they can be assessed for their compliance with the law.

How: Integrate the PIA within the project plan as a whole, or within broader risk assessment and risk management activities.

How much effort: The scale of effort that is appropriate to invest in a PIA depends on the circumstances. A project with large inherent risks warrants much more investment than one with a limited privacy impact. Other projects may merely need a check of their compliance with privacy laws, and in particular with the provisions of the Data Protection Act 1998.

Who: The PIA is carried out by the Project or Programme Manager, taking advice from the Information Governance specialists within the organisation.

Role of Caldicott Guardian: Needs to be involved in any new projects relating to patient identifiable information:

- establish information flows
- ensure that data quality standards are being met; and
- protocols relating to security and information sharing are in place .

Further Information: The ICO Privacy Impact Assessment (PIA) handbook is available at:

http://www.ico.gov.uk/upload/documents/pia_handbook_html_v2/index.html

9 Positive Patient Identification

Fundamental to managing privacy issues is being able to identify an individual person who has come into contact with healthcare staff in NHSScotland and to then be able to manage the data throughout the patient's journey through care.

The CHI Number

It is NHSScotland policy that a CHI Number is allocated to every patient at the beginning of their journey through the NHS, and that it is used in all records associated with every episode of healthcare. Use of the CHI number on clinical communications is mandated across all NHSScotland IT systems.

The Caldicott Guardian should ensure that the organisation develops procedures for the determination, recording and use of CHI numbers for all 'active' patients, which should be used for both internal and external communications.

Since it is recognised that there are some patients for whom it is difficult to establish a CHI number, the Caldicott Guardian should ensure that this is part of the programme of work undertaken under the heading information management and that this area is the focus of constant attention and continuing effort.

Relative sensitivity and protective markings

Given the vast volumes of personal data that is held by NHS organisations, risk-based decisions do need to be made based on relative sensitivity. The impact of loss or misuse of a large digital dataset of patients or a single file on an identifiable vulnerable child are likely to be far higher than a single email about routine appointments correspondence, for example.

Protective markings, and accompanying handling instructions (that are based on the sensitivity and impact of loss or misuse) play a particularly important role when sharing information both inside and outside the organisation.

PART TWO

10 The legislative and compliance landscape

Caldicott Guardians and those who work closely with them in this dynamic area were not established by a specific Act of Parliament and so have no directly related legal basis for their functions. They do, however, have a complex mesh of legislation, non-statutory Codes of Practice and Protocols, which are the supporting mechanisms for everything they do.

In this section of the Manual, we identify the most important of these and explain in broad terms the duties and obligations they place on individuals and organisations working in, or in partnership with, the NHS who may have access to the patient record. Where more detailed explanations are given later in this Manual and on the associated website, references have been summarised or have not been included here in their entirety to reduce repetition.

Many of the benchmarks we talk about in this Manual have a basis in Administrative Law which governs the actions of public authorities. From well-established precedents we know that a public authority cannot do what it intends to do (its public task) unless it has the power to do so. If it does not have the necessary power and acts without it, it is acting outside the law i.e. *ultra vires*. Even where the powers are thought to exist, a public authority must exercise those powers for the purpose for which they were created or for purposes which are 'reasonably incidental' to the defined purpose.

These powers do not usually specify the role of the public authority in relation to the disclosure of information. It has therefore become common practice to introduce statutory gateways that deal with this lack of function, of which the Data Protection Act 1998 is a good example. In the context of healthcare, there is a specific medical purposes condition under Schedule 3 of the Data Protection Act 1998, which means that in most cases, where the processing of health information relates to medical and care purposes, explicit patient consent does not have to be obtained.

11 Human Rights and interplay with Data Protection

The rights of data subjects are often discussed in the context of the [Human Rights Act 1998 \(HRA\)](#). Article 8 of the HRA establishes a right to 'private and family life'.

However, it is not the case that the Human Rights Act confers unlimited privacy. It is recognised that there are specified grounds on which it may be legitimate for authorities to limit or supersede those rights. It is generally accepted that compliance with the Data Protection Act 1998 and the common law duty of confidentiality will satisfy the requirements of the Human Rights Act 1998.

An important principle associated with the interpretation of the HRA when considering disclosure of confidential information is that of proportionality. Any proposal to waive the obligations of confidentiality by the application of legislation must:

- pursue a legitimate aim;
- be considered necessary in a democratic society; and
- be proportionate to a specified need.

Any activity which interferes with the right to respect for private and family life by, for example, disclosing confidential information, must also be justified as being necessary to support legitimate aims and be proportionate to need.

Any action against a public authority alleging a breach of the HRA will require the public authority to demonstrate that in making the decision it was aware of, and gave due consideration to, the rights granted by the Act and that the reasons for setting these aside were justified.

In order to demonstrate that to be the case, any decision to interfere with the provisions of the HRA must be subject to a specific Test of Proportionality, which balances the right of the individual to respect for their privacy with other important considerations such as the prevention and detection of crime or protecting others from harm. In this, the demands of the HRA are closely associated with the Principles of the Data Protection Act 1998.

12 Data Protection

The [Data Protection Act 1998](#) (DPA), based on an EU directive, establishes a framework of rights and duties which are designed to safeguard personal data. This framework balances the legitimate needs of organisations to collect and use personal data for business and other purposes against the right of individuals to respect for the privacy of their personal details.

The DPA relates to personal data, which is defined as data that relates to a living individual from which that individual could be identified either from that data alone or from that data in conjunction with other information in the possession of the Data Controller or information which would be reasonably accessible to anyone else.

Personal data includes such information as an individual's name, address, age, race, religion, gender and information relating to the individual's physical or mental health. The definition of personal data also includes expressions of opinions about individuals and indications of the intentions of persons in relation to individuals.

The DPA sets out a number of conditions which must be met before data can be processed. These are set out in Schedules 2 and 3 of the Act. To process any personal data a condition in Schedule 2 of the DPA needs to be met.

The Act goes further identifying certain kinds of data as Sensitive Personal Data, which includes Health Records, and introduces additional conditions for processing such data. These are set out in Schedule 3 of the DPA and the [Data Protection \(Processing of Sensitive Personal Data\) Order 2000](#).

12.1 The Data Controller

The Data Controller is the person who determines how and why personal information is processed. This is usually an organisational function but in practice the responsibility will lie with the Chief Executive, GP or Dental Practice, or an optician or pharmacist, who acts on behalf of their organisation. Detail is available at: http://www.ico.gov.uk/for_organisations/data_protection/the_guide/key_definitions.aspx

It is an offence under the DPA to process personal data (including, patient-identifiable data) in any way until you have completed a Notification to the Information Commissioner. Notifications to the Information Commissioner form part of the Public Register of Data Controllers which is accessible via the Commissioner's website: www.ico.gov.uk.

12.2 Eight Principles underpin compliance with the Data Protection Act 1998

1. Personal data must be processed fairly and lawfully.
2. Personal data must be obtained for one or more specified and lawful purposes in any manner incompatible with that purpose.
3. Personal data must be adequate, relevant and not excessive.
4. Personal data must be accurate and, where necessary, kept up to date.
5. Personal data processed for any purpose or purposes must not be kept for longer than is necessary for that purpose and those purposes.
6. Personal data shall be processed in accordance with the rights of data subjects under this Act.
7. Appropriate technical and organisational measures shall be taken against unauthorised or unlawful processing of personal data and against accidental loss or destruction of, or damage to personal data.
8. Personal data shall not be transferred to a country or territory outside the European Economic Community Area unless that country or territory ensures an adequate level of protection for the rights and freedoms of data subjects in relation to the processing of personal data.

These principles promote openness and fairness in the processing of personal information and they of course apply to patient-identifiable information.

12.3 Rights of the Data Subject under the Data Protection Act

The Data Protection Act 1998 also grants rights to an individual in respect of information held about them by others. These are:

- 1 the rights of subject access – individuals can ask for information held about them and find out how information may be used and the likely recipients of such information;
- 2 the right to prevent processing likely to cause unwarranted, substantial damage or distress;
- 3 the right to prevent processing for the purposes of direct marketing;
- 4 rights in relation to automated decision making;
- 5 the right to take action to rectify, block, erase or destroy inaccurate personal information; and
- 6 the right to make a request to the Information Commissioner for an assessment to be made as to whether any provision of the Data Protection Act 1998 has been contravened.

12.4 Fees and time limit under the Data Protection Act

Under the Data Protection Act 1998 (Fees and Miscellaneous Provisions Regulations 2000), an individual can be charged to view their health records, or to be provided with a copy of them.

Record Type		Max Fee
View Only	< 40 days	£0
	>40 days	£10
All Electronic	All	£10
Part Electronic and other media	Core Notes inc X-Rays	£50
All paper	Core Notes inc X-Rays	£50

A statutory time limit is imposed by the Act. In most cases, requests for access to health records must be completed within 40 calendar days of receipt of a completed application form and fee.

It is essential that before personal information is disclosed in response to a subject access request, all possible avenues are explored to ensure that no other prohibition applies.

Among these might be orders under S30 of the DPA, which limit subject access to information relating to some health, education and social work records which may be restricted or denied under Subject Access Modification Orders. There will also be circumstances where information has been provided with expectations of confidence by other third parties. In such circumstances and if appropriate the view of the third party involved should be sought and considered before any such information is disclosed.

There is often confusion between patient-identifiable information relevant to the health record and other information which does not constitute personal data – whether of the applicant or a third party under the DPA. In such cases, the information is not personal information and is not covered by a request.

13 Non-disclosure of Human Fertilisation and Embryology Data

The Data Protection Act is seemingly all encompassing; but there is other UK legislation that interplays with it.

In general terms the [Human Fertilisation and Embryology Act 1990](#), as amended by the [Human Fertilisation and Embryology \(Disclosure of Information\) Act 1992](#), prohibits disclosure of information by current and former members of the Authority and employees relating to entries in the Register of the Authority or any information obtained with an expectation of confidentiality. A further Regulation, [The Human Fertilisation and Embryology Authority \(Disclosure of Donor Information\) Regulations 2004 \(SI 1511\)](#) limits the information which will be provided by the Authority to persons who have attained the age of 18 and who may have been born in consequence of treatment services under the Act.

Further amendments to this legislation were introduced in 2008 following a review and consultation but these are unlikely to affect the disclosure of information. One of the most important tenets remaining is that this Act is retrospective and applies to information created both before and after the Act was passed.

The [2008 Act](#) mainly amends the Human Fertilisation and Embryology Act 1990. Key provisions of the 2008 Act include to:

- ensure that all human embryos outside the body – whatever the process used in their creation - are subject to regulation.
- ensure regulation of “human-admixed” embryos created from a combination of human and animal genetic material for research.
- ban sex selection of offspring for non-medical reasons. This puts into statute a ban on non-medical sex selection currently in place as a matter of HFEA policy. Sex selection is allowed for medical reasons – for example to avoid a serious disease that affects only boys
- recognise same-sex couples as legal parents of children conceived through the use of donated sperm, eggs or embryos. These provisions enable, for example, the civil partner of a woman who carries a child via IVF to be recognised as the child’s legal parent.

- retain a duty to take account of the welfare of the child in providing fertility treatment, but replace the reference to “the need for a father” with “the need for supportive parenting” – hence valuing the role of all parents
- alter the restrictions on the use of HFEA-collected data to help enable follow-up research of infertility treatment.

14 Disclosure issues and deceased patients

The DPA is designed to protect the privacy of the living and not the dead. However, a small part of the [Access to Health Records Act 1990](#) still remains and governs access to the medical records of deceased persons.

The issue of confidentiality remains after a patient has died. This is a contentious area; but one key test is how far disclosure of information affects the privacy of the living.

Under the Access to Health Records Act 1990, the personal representative of the deceased and people who may have a claim arising from the patient’s death are permitted access to the records. This applies to information provided after November 1991 and disclosure should be limited to that which is relevant to the claim in question.

Even where these tests are met this legislation does not grant a general right of access and there are circumstances which could limit disclosure:

- if there is evidence that the deceased did not wish for any part of their information to be disclosed
- if the disclosure would cause serious harm to the physical or mental health of any person
- if disclosure would identify a third party.

Further guidance is available at: [Access to Personal Health Data](#)

15 Freedom of Information

Personal data is exempt from disclosure under the [Freedom of Information \(Scotland\) Act 2002](#) (FOISA) and the [Environmental Information \(Scotland\) Regulations 2004](#). However, it is common for public authorities to receive ‘hybrid’ requests where there is a request for personal data and wider corporate information.

FOISA came into force on 1 Jan 2005. The main features of the Act are:

- gives anyone from anywhere in the world - a general right of access to recorded information of any age held by a wide range of bodies across the public sector in Scotland, subject to certain conditions and exemptions;
- in relation to most exempt information, the information should only be withheld if the public interest in withholding it is greater than the public interest in releasing it;

- the creation of the office of Scottish Information Commissioner (the Commissioner), with wide powers to promote good practice and to enforce the rights created in the Act;
- a duty on each Scottish public authority to adopt and maintain a publication scheme, approved by the Scottish Information Commissioner. Publication schemes must specify the classes and manner in which information is, or is intended to be, published, together with an indication of whether the information will be available free of charge or on payment of a fee;
- a duty on the Scottish Ministers to issue Codes of Practice containing guidance on specific issues e.g. general duties and records management (under section 60 and [61](#) of the Act).

All requests for information to public authorities are requests under FOISA if they are in writing, there is a name and a contact address (an email address is sufficient) for response and you can broadly speaking understand what information is being requested.

FOISA also imposes a statutory time limit within which requests must be dealt with (20 working days) and an upper limit applies to disproportionate costs for retrieving and collating information.

There is a strong interface with the DPA and with all other legislation which prohibits or limits the disclosure of personal information in any way.

If a request is for the Health Record of the patient themselves, FOISA takes us along a pathway to DPA and Subject Access Requests (the process for dealing with requests from individuals asking about themselves). However, FOISA also tells us what to do about requests for patient-identifiable information from third parties i.e. not from the subject themselves. We should still apply the principles of the DPA as the criteria on which decisions are made.

It is necessary for all organisations to have specific policies that ensure compliance with the FOISA. These should be statements of the organisation's principles and mechanisms which the organisation has adopted. Detailed guidance for staff should be posted on the organisation's intranet and leaflets made available for patients and staff.

Applicants for information under both the DPA and FOISA have the opportunity to complain if they feel that either Act has not been complied with by an NHS organisation. The DPA can be taken through the NHS complaints procedure. FOISA goes through a review process.

16 Common Law and Confidentiality

Where disclosure of patient-identifiable information is not specifically allowed under primary or administrative law, then the Common Law Duty of Confidentiality applies.

Common Law is the law of precedent. It is not written down and relies on the application of the findings in previous Court cases decided by sheriffs/judges.

The Common Law Duty of Confidentiality therefore means that it has been established that, when there is an expectation of confidentiality between two parties (in this case the Health Professional and the Patient), that confidence will not generally be broken without the explicit consent of the patient. In practice all patient information, whether held on paper, computer, video or audio tape, or even when it is simply held in the memory of a Health Professional, must not normally be disclosed to a third party without the consent of the patient.

This duty applies regardless of age, mental health or capacity.

17 Understanding consent

Within healthcare environments, there is a need to share personal information on staff and patients subject to the 10 principles within the [Access Framework](#). This framework is in line with the NHS Code of Practice on Protecting Confidentiality.

At a time when the emphasis is on sharing information, the Caldicott Guardian will need to ensure patients understand in what circumstances information is and where specific and informed consent will be sought. This is of great importance and in Scotland guidance has been made available to all those dealing with confidentiality through the [NHS Code of Practice on Protecting Confidentiality](#).

This Code of Practice recognises that while the provision and development of ever better healthcare is reliant on full, clear and accurate records, there will also be an ever-increasing requirement to share information. It reinforces the need for patients to be informed of the extent to which and with whom their information is being shared, their right to exercise choice over whether to give consent, and the importance of restricting such sharing of confidential information to those directly involved in their care.

This Code of Practice sets out four main requirements which must be met:

- Look after a patient's information;
- Allow individuals to decide, where appropriate, whether their information can be disclosed or used in particular ways;
- Always look for better ways to protect, inform and provide choice; and
- Ensure that patients are aware of how their information will be used.

In addition, Health Rights Information Scotland (HRIS) is funded by the Scottish Government to produce information for patients in Scotland about their rights and responsibilities when using the NHS.

HRIS has produced a set of core NHSS leaflets on rights and responsibilities when using the NHS. These include:

- [The NHS and You](#)
- [Complaints](#),
- [Confidentiality](#),
- [Consent](#)
- [health records](#)

There are separate versions of the leaflets for children and young people:

- [Consent - your rights](#),
- [Confidentiality - your rights](#)
- [Have your say - your right to be heard](#)

Information is also available relating to [eHealth](#) and the [emergency care summary](#). All of the information is produced by consulting with stakeholders including the public to make sure that it's as useful and useable as possible. The leaflets are also available in a variety of languages and formats.

If such information is being processed, as in a health record, the individual has the right to:

- be given a description of the information being processed;
- be told the purposes for which the information is being processed; and
- and be told those to whom such information has been or may be disclosed.

The individual also has the right to:

- have communicated to them the personal information held about them;
- have communicated to them any information available to the Data Controller about the source of the information; and
- be informed by the Data Controller of the criteria built into any automated decision-making processes which use personal information.

Issues of Consent

The National Creutzfeldt – Jakob Disease (CJD) Surveillance Unit and London School of Hygiene and Tropical Medicine embarked on a study to determine the risk factors for CJD. Following research and Ethics Committee Approval (REC), GP's were asked to contact relatives of both CJD sufferers and healthy controls (of a similar age and sex to those with CJD) to ask for their consent to be contacted by the Surveillance Unit. Three quarters of the GPs asked declined to participate; however, only 16% of the controls contacted by their GP's agreed to be interviewed.

This low response may compromise the validity of this study using this control group. The researchers were unable to get REC approval to telephone non-responders as it was considered a breach of patient confidentiality.

See: <http://www.parliament.uk/documents/upload/POSTpn235.pdf>

Organisations cannot comply with the requirements of the DPA without having supporting policies and processes in place. These policies, which should be part of the Information Management Strategy, should:

- define all information covered by the DPA;
- list all the DPA principles;
- outline the organisational policy for holding, obtaining, sharing, recording, using and storing personal or sensitive data;
- provide guidance on the acceptable use of such information; and
- describe corporate and personal responsibility.

18 Lawful disclosure

There are four sets of circumstances in which the disclosure of confidential information to a third party is lawful:

- where the patient has given express consent;
- where there is a statutory basis which permits disclosure;
- where disclosure is in the overriding public interest; or
- where there is a legal duty to disclose for example by court order.

Confidentiality

Health Professionals are usually aware of their duty of confidentiality in relation to one-to-one consultations and in relation to written health records or consultations; curtains are not sound-proof and other patients or staff are likely to overhear.

The Caldicott Guardian must make sure that staff are aware of the need to comply with the common law duty of confidentiality at all times and not just in relation to formal records. On the other hand there will be circumstances where information relating to a patient or patients should and can be released without breaching these principles. It is perfectly acceptable to include patient data which has been anonymised or depersonalised to support research projects or to answer requests for information – the concept of confidentiality of patient-identifiable information should not be confused with the use and application of patient data which is not individually identifiable.

18.1 Disclosure in the Public Interest

An American citizen was found to have contracted TB just prior to coming to Europe for his honeymoon. He was strongly advised not to travel but decided to do so, flying first to England and then onto Italy.

Public Health Authorities only discovered what had happened after he had left the United States. They alerted their colleagues in England and Italy and it was decided to publish details of the individual because of the very real danger to the health of a large number of people as this person travelled around, particularly since he was known to be using airlines.

* The circumstances in this case are exceptional but it is the exception which proves the rule. There will occasionally be times when the balance of the public interest demands a breach of confidentiality in the 'interest of the greater good'.

Clearly there will be circumstances in which it will not be possible or appropriate to obtain or rely on the consent of the patient. Where this is not possible an organisation may be able to rely on disclosure being in the overriding public interest. Here a judgement needs to be made between the rights of the patient, in the interest of providing appropriate care, the public interest in maintaining trust in a confidential service, and any overriding public interest in disclosure.

The public interest in maintaining trust in a confidential service is a very important principle and should only be breached in exceptional circumstances. Applying the public interest test is not about considering what the public are interested in but about 'the greater good' taking the course of action which is believed to be the least dangerous. Any decision to disclose information without consent must always be capable of a robust defence must be justified on a case-by-case basis and must be fully documented.

If there is any concern at all that such disclosure might be unjustified then disclosure should be refused and the applicant referred to legal remedies which will include application to a Court. Far better to take this course of action than to disclose and realise later that a mistake has been made – once information has been disclosed there is no opportunity to get it back again!

If a disclosure is made which is not permitted by Statute, Common Law or approved process, the patient can bring a legal action against both the organisation and the individual concerned.

Any legal proceedings notified to public authorities relating to a request for patient-identifiable information should be urgently referred to legal advisers so that the interests of the public authority and, separately if appropriate, the patient, may be represented in any proceedings.

18.2 Disclosure by Court Order

The case of R (TB) v Stafford Crown Court and others was about a patient's clinical records and whether an NHS hospital trust should disclose them for the purpose of criminal proceedings. The Court held that where a disclosure application is made, the patient should herself be invited to respond to it.

The patient, a 14 year old girl referred to as 'TB', was a witness at the trial of a man charged with various sexual offences. The man, W, wanted to see her medical records, in order to look for information that might undermine her credibility. He was allowed to do so following a hearing of which TB was unaware and at which she was not represented.

The Divisional Court said TB should have been notified of the original disclosure hearing so that she could object to disclosure of her records; the judge had failed to take into account TB's Article 8 EHRC right to confidentiality. It was unreasonable to leave it to the NHS trust to present her arguments to court.

PART THREE

19 Research and Audit

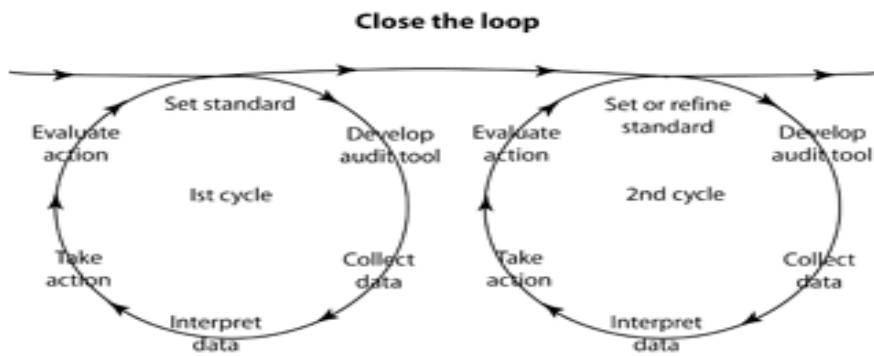
Wherever possible, patient-identifiable information should not be used for such purposes and would not therefore normally involve the disclosure of patient-identifiable information. Research Ethics Committees routinely require patient information to be anonymised or pseudonymised. However, particular care should be taken with 'small number data' when even with anonymisation or depersonalisation it may still be possible to identify the patient. Further guidance relating to 'small number data' is available from the Office of National Statistics. The [ISD Statistical Disclosure Protocol](#) provides information regarding assessing and mitigation of the risk of identifying individuals in statistical publications.

Exceptionally it is necessary to use patient-identifiable or potentially identifiable information and responsibility for decisions regarding the appropriate use of such information lie with the data controller and their Caldicott Guardians. Scotland has no law defining acceptable purposes in these situations. The current approach is informed by '[Protecting Patient Confidentiality](#)', the Report of the Confidentiality and Security Advisory Group 2002. In England acceptable purposes are defined in Section 251 of the [NHS Act 2006](#) and advice on each case is provided to the relevant data controllers by the Ethics and Confidentiality Committee of the National Information Governance Board.

Currently there is no standard source of advice or procedure to assist data controllers in decisions regarding the use of information throughout Scotland. The [NSS Privacy Advisory Committee](#) (PAC) advises NHS National Services Scotland and the [National Records of Scotland \(NRS\)](#) on the processing of patient information, particularly the appropriate use of the national datasets. The committee meets twice a year and carries on most of its work by mail and email. Applications for access to data held by ISD and other divisions of National Services Scotland are scrutinised by PAC before permissions are granted. Researchers who wish to use datasets controlled in other boards apply to each Caldicott Guardian individually where local procedures will apply.

Each NHS Board sets a programme of prioritised clinical audit for the year. The Clinical Governance Committee approves and monitors achievement of the clinical audit programme. Progress against the audit programme will also be used as an indicator of performance and as a basis for external monitoring/assessment.

Clinical audit is an ongoing cycle of continuous improvement. As a tool it suggests a number of questions about practice to help reflect, review and act to resolve problems and make changes to improve patient care. Clinical audit is often represented as an audit cycle or spiral.



Clinical audit is used to compare current practice with evidence of good practice. It can be used to make changes that improve the delivery of care. It can:

- Provide evidence of current practice against national SIGN guidelines or NHS Healthcare Improvement Scotland (NHS HIS) standards
- Provide information about the structures, the processes or outcomes of a healthcare service
- Assess how closely local practice resembles recommended practice
- Check "Are we actually doing what we think we are doing?"
- Provide evidence about the quality of care in a service to establish confidence amongst all of its stakeholders - staff, patients, carers, managers.

Clinical audit happens at different levels within an organisation. Audits can:

- Identify major risk, resource and service development implications in an NHS Board
- Reinforce implementation of evidence-based practice
- Influence improvements to individual patient care
- Provide assurance on the quality of care.

20 The Law and Information Sharing

We have thus far largely concentrated on legislation and Codes of Practice which prohibit or limit access to patient identifiable information. However there are also important legislative mechanisms that lay out conditions which state where information should be shared. Indeed the need for data sharing across health and non-health organisations is increasing.

More information about these and other mechanisms for data sharing can be accessed via the [Caldicott website](#). For reference purposes, we have included the most important here:

- [The Abortion Regulations 1991](#) provide a statutory gateway for disclosure of certificates of opinion to the Chief Medical Officer as required by the Abortion Act 1967.
- [Multi Agency Public Protection Arrangements \(MAPPA\)](#) The Management of Offenders (Scotland) Act 2005 required the police, local authorities and the Scottish Prison Services (known as the 'Responsible Authorities') to jointly establish arrangements for the assessment and management of risk posed by

sex offenders and violent offenders. In practice this will be undertaken by the establishment across Scotland of 'Multi Agency Public Protection Arrangements' or MAPPAs. As well as having implications for the responsible authorities (which includes health boards in the case of mentally disordered offenders), the MAPPA's have an impact and requirement for agencies who have a 'Duty to Co-operate' under the 2005 Act.

- [The Public Health \(Scotland\) Act 2008](#) updates the law on public health, enabling Scottish Ministers, health boards and local authorities to better protect public health in Scotland. It will also assist Scottish Ministers to meet their obligations under the International Health Regulations. The Act also makes provision relating to the use, sale or hire of sunbeds, clarifies statutory responsibility for the provision of mortuaries and post mortem facilities and amends the law on statutory nuisances.
- [The Gender Recognition \(Disclosure of Information\) Scotland Order 2005](#) is gateway legislation which allows disclosure of information to a health professional which is otherwise prohibited by the Gender Recognition Act 2004.
- **The Road Traffic Acts (RTAs)** also make provision for the disclosure of information by NHS bodies to enable the recovery of any costs of treatment. RTAs also require the NHS to provide any information which it is in their power to give and which may lead to the identification of a driver who has committed an offence under the Acts.

Only the most important legislation has been dealt with in detail here but links are available on the website to other legislation which has some interface with the protection or disclosure of patient-identifiable information.

- **Gun and Knife Wounds** raise issues that warrant special consideration with regards to the sharing of information with the police. The General Medical Council (GMC) requires doctors to inform the police or social services whenever they treat a patient who is a victim of gun or knife crime, particularly those under 18. [Guidance is available from the GMC](#) and also the [BMA](#).

In addition to the above there is an increasing need to share personal data with other partners (e.g. as integration between social care and health is increased; health records between NHS and prisons or the armed forces etc). Where sharing on a regular basis is going to take place there must be an information sharing protocol.

The Information Commissioner's Office have issued a [Data Sharing Code of Practice](#), which is a key item of guidance on this topic.

Many of the partners that an NHS organisation will share with such as the emergency services, central and local government use the [Government Protective Marking Scheme](#). It is vital that where such markings are used, all partners have an agreed understanding of how the markings are used (and the handling instructions and technical security that is required for information at that level). Simply considering all

NHS personal data to be RESTRICTED, for example, seriously undermines the protective marking system. Similarly, continuing to use terms such as 'NHS Confidential' for external data sharing (a term that is not understood outside the NHS) can lead to confusion.

21 Further resources and Networking Opportunities

Caldicott Guardian Forum:

The bi-annual forum enables Guardians to share best practice, obtain the advice of their peers on pressing problems and identify whether issues are likely to be of national significance.

The UK Council of Caldicott Guardians

The Council is an elected body made up of Caldicott Guardians from health and social care from across the UK, including three representatives from NHSScotland.

The aims and objectives for the Council are:

- To be the national body for Caldicott Guardians
- To promote the roles and activities of Caldicott Guardians within the United Kingdom
- To be a forum for the exchange of information, views and experience amongst all Caldicott Guardians
- To seek, consider and to represent the views of Caldicott Guardians on matters of policy relating to the organisation and delivery of Information Governance
- To be a channel of communication upon Caldicott matters with national organisations concerned with the NHS, the independent health sector, local government and health and social care professionals
- To act as a resource centre, provide support and arrange learning opportunities for Caldicott Guardians, both current and of the future.

The council meets quarterly, with more information available on the [website](#).

Training and Awareness

Some training courses available to Caldicott Guardians are listed below. These are provided for information only and are not endorsed by SG Health and Social Care Directorates.

○ **General Medical Council**

Good Medical Practice in Action is an interactive web section which brings the GMC's ethical guidance to life. More information is available at: http://www.gmc-uk.org/guidance/case_studies.asp

○ **BMJ Learning**

Primary care and hospital practitioners and Practice Staffs learning needs. Choose from both clinical and non-clinical modules, covering access to health records, data protection and confidentiality. To log on please visit: <http://www.bmjlearning.com/planrecord/index.jsp>

○ **ISEB- Data Protection**

Provides a recognised industry qualification at certificate level for those with data protection responsibilities, as well as providing an effective conversation route for those needing to update their knowledge of and practice under the DPA. More details are available at: <http://www.bcs.org/server.php?show=nav.6925>

○ **Royal College of Surgeons of Edinburgh – Health Informatics Postgraduate Programme**

The aim of the programme is to provide working health professionals and others working in the health sector with knowledge of the technical, social, regulatory and management issues involved in delivering health informatics effectively and its role in improving patient care and public health. Some of the topic areas that will be included in the programme are:

- Clinical Databases
- Confidentiality and Data Protection
- Healthcare Systems
- Electronic Patient Records/Electronic Health Records
- Clinical Coding, Standards and Interoperability
- System Design and Evaluation
- Decision Support
- Human Computer Interaction
- Telehealth and Telecare
- Project Management

Further information is available at: <http://www.fhi.rcsed.ac.uk/site/2687/default.aspx>

- **Postgraduate Health Informatics modules (CPD)**

Further details are available at: <http://www.fhi.rcsed.ac.uk/site/2761/default.aspx>

- **Law and Medical Ethics Course - Edinburgh Law School**

A seven or ten-week course, or as individual modules delivered entirely by distance learning. The programme is aimed at medical practitioners and assumes no prior knowledge of law. Further details of the programme, including cost and start dates can be found at: <http://www.law.ed.ac.uk/ahrc/teaching/cpd/lawandmedicalethics/>

Data Protection Courses and Freedom of Information Courses

<http://www.law.ed.ac.uk/ahrc/teaching/cpd/dataprotection/>