Data redaction and standardised adverse event review reports

Guidance paper 2.0 – March 2020
Introduction

“Good sharing of information, when sharing is appropriate, is as important as maintaining confidentiality. All organisations providing health or social care services must succeed in both respects if they are not to fail the people that they exist to serve.”

Dame Fiona Caldicott

Information: To share or not to share? The Information Governance Review (March 2013)

The adverse events national framework aims to support NHS boards to standardise processes for managing adverse events across NHSScotland to enable learning and improvement.

This paper presents a standard approach to writing adverse event review reports so that appropriate learning can be shared, whilst safeguarding patient, family and staff confidentiality. This includes writing review reports in a format that minimises the need to redact person identifiable information, such as patient, family, carer, blood donor or staff, so that information can be more freely shared. The paper also sets out guiding principles for NHS boards to consider when writing reports and deciding what information could be meaningfully shared with patients, families, carers, staff, partner organisations or across NHSScotland (see Appendices 1–3).

The standard approach applies to the following:

- all care settings within NHSScotland
- clinical adverse events, and
- non-clinical adverse events, for example, health and safety, theft, fraud or information governance (such as loss of confidential data).

The guidance has been shaped by adverse event review visits, review of existing guidance, discussions with key stakeholders, and responses received from NHS boards and relevant stakeholders following the consultation in August 2014.

We expect NHS boards to work to the principles of this guidance and to consider how they apply on a case by case basis. Where a decision is taken not to follow the guidance, the decision and reasons for variation should be clearly recorded.

Background

In order to improve safety, it is imperative that healthcare systems learn from mistakes. Too often, healthcare organisations do not advise others when an adverse event happens, and they do not share what they have learned through reviewing their own adverse events. As a consequence, the same mistakes can repeatedly happen in many similar settings and patients, staff or organisations can continue to be harmed by preventable errors.

Formal reviews of adverse events provide a wealth of information. A comprehensive review will identify the root cause of the event, the context in which it happened, and the contributory factors including any system failures or human error that led to the event happening. Reviews also determine lessons learnt following analysis of the key issues and put forward recommendations or actions for implementing improvements. To help prevent a similar event happening across other care settings or geographical areas, relevant learning must be shared beyond the review team and individual NHS board governance structures.
Before we share learning from adverse events, it is vital that we consider the confidentiality of individuals involved, such as the patient, family, carer or donor. NHSScotland is required to work within a framework of legislation and Codes of Practice which provide guidance on how person identifiable information should be managed.

We also need to protect the identity of individual staff involved. Traditional methods of reporting adverse events often focus on the unsafe actions of individual health workers, thereby fostering a culture of blame. This can lead to fear of retribution, resulting in the under-reporting of adverse events and reduced opportunity to learn and improve. Most people go to work with the safety and quality of their professional practice a priority. A confidential approach will help encourage an open reporting culture which focuses on learning and identifying how to share learning to reduce the risk of a similar event happening again.

This paper has been shaped by:

- the rolling programme of adverse event management reviews across NHS boards which highlighted variation in approach to data redaction (removing person identifiable information from adverse event review reports to minimise the risk of identifying people involved) and variation in editing text for publication, but also elements of good practice
- a review of existing data redaction guidance currently in use within some NHS boards
- discussions with key stakeholders, such as the Central Legal Office, Information Governance leads and Caldicott Guardians, to discuss the potential of moving to a consistent approach to data redaction across NHSScotland, and
- a workshop of key stakeholders held to consider data redaction issues and challenges.

**Context of data protection and patient confidentiality**

A number of statutes and Codes of Practice provide a framework within which NHSScotland is required to follow when it manages personal identifiable information. This includes:

- Data Protection Act 2018
- General Data Protection Regulation (EU) 2016/679 (GDPR)
- Human Rights Act 1998
- Freedom of Information (Scotland) Act 2002
- Common Law of Confidentiality, and
- NHSS Code of Practice on Protecting Patient Confidentiality

The Data Protection Act 2018 sets out the framework for data protection law in the UK. Part 2 of the Act contains The General Data Protection Regulation (EU) 2016/679 (GDPR). GDPR establishes a framework of key principles, rights and obligations for most processing of personal data except law enforcement and intelligence agency activity. The regimes for data processing linked to these activities are contained within the Act.

The GDPR establishes a framework of rights and duties which are designed to safeguard personal data. The 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. Personal data includes such information as an individual’s name, address, age, race, religion, gender and ‘special category’ information about the individual’s physical or mental health but it also includes include other identifiers such as an IP address or a cookie identifier. The definition of personal data also includes expressions of opinions about individuals and indications of the intentions of persons in relation to individuals.

All personal information must be processed lawfully, fairly and in a transparent manner. Processing must have an identified lawful basis and when processing special category data a second lawful basis must be identified. Learning lessons from adverse events is necessary to ensure the future safety and wellbeing of patients and processing of personal data and explicit, informed patient consent does not have to be obtained. Processing is underpinned by:

- Article 6 1 (e) of GDPR provides for processing that is necessary for the performance of a task carried out in the public interest or in the exercise of official authority vested in the controller”; and

- Article 9 2(h) provides for processing that is necessary for the provision of health or social care or treatment or the management of health or social care systems and services.

There is a strong interface between the GDPR and the Freedom of Information (Scotland) Act 2002 (FOISA). Unlike disclosures under the GDPR, information which is disclosed in response to a request under FOISA is considered to be disclosed into the public domain. There is an exemption in FOISA which allows public authorities to refuse to disclose personal data under FOISA if disclosure would breach the data protection principles contained in data protection legislation. Often, this comes down to the question of whether it would be fair to disclose the personal data. It might be fair to disclose the name of a senior member of staff involved in a review. It is highly unlikely that it will ever be fair to disclose information about an individual’s physical or mental health in response to a request made under FOISA. However, if the data can be anonymised in such a way that the subject of the information can no longer be identified, then the information can be disclosed in a redacted (edited) form. The Scottish Information Commissioner has published guidance on the personal data exemption in FOISA ¹.

The NHS Code of Practice on Protecting Confidentiality 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. It sets out the ways in which patients can provide consent to disclosure as well as circumstances where access can be obtained without consent.

In 1997, the Review of the Uses of Patient-Identifiable Information, chaired by Dame Fiona Caldicott, devised six general principles of information governance that could be used by all NHS organisations with access to patient information. The resulting 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 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 report’s recommendations and principles were adopted by the NHS in Scotland.

¹ http://www.itspublicknowledge.info/Law/FOISA-EIRsGuidance/section38/Section38.aspx
In January 2012, the NHS Future Forum work stream recommended a review to ensure that there is an appropriate balance between the protection of patient information and the sharing of information, for the benefit of all health users and to improve patient care. This was in response to a growing perception that information governance was being cited as an impediment to sharing information, even when sharing would have been in the patient’s best interest. The Government asked Dame Fiona Caldicott to lead the work which became known as the Caldicott 2 review. The review report\(^2\) was published on 26 April 2013.

The review concluded that there was widespread support for the original Caldicott Principles, which are as relevant and appropriate for the health and social care system today as they were for the NHS in 1997. However, evidence received during the review persuaded the panel to update the original principles to include an additional principle as follows:

“Principle 7. The duty to share information can be as important as the duty to protect patient confidentiality. Health and social care professionals should have the confidence to share information in the best interests of their patients within the framework set out by these principles. They should be supported by the policies of their employers, regulators and professional bodies.”

The full list of revised Caldicott Principles is attached at Appendix 4.

**NHS board approaches to data redaction and sharing learning from adverse events**

The national approach consultation exercise and programme of review visits revealed varying processes across NHSScotland for managing information governance and data redaction in relation to adverse events. There are also different experiences and understanding of transparency, support processes for redaction and general approaches to sharing information and learning from adverse event reviews. The following variations were identified:

- Varying procedures for redacting patient information such as name, gender, date of birth, age, address and CHI number, in adverse event review reports or associated documentation, such as Datix records and staff statements.
- NHS boards redact varying elements of staff details such as name, job title, age, department, years of service or qualifications, to prevent their identification, particularly within a small geographic community.
- Some NHS boards have strict redaction protocols and redact references to ‘his’ or ‘her’ for staff, patients and family, and also any reference to husband/wife/daughter/son that could lead to their identification. Some NHS boards also redact third party contractors or specialist company names.
- Varying approaches to sharing reports with staff. Some NHS boards openly share reports with staff involved in the adverse event and with other staff. Other NHS boards only share reports with those involved in the adverse event. NHS boards may be reluctant to share review reports with members of staff who were not involved in the adverse event and review, due to concerns about data protection.

Some NHS boards prefer to obtain consent from patients or their family before disclosing information. Some NHS boards seek consent from patients and their families to share anonymised details of adverse events more widely within the NHS board.

Varying levels of guidance in adverse event management policies and procedures to guide staff as to what specific information should be redacted. Some NHS board policies for adverse events do not include any guidance on data redaction.

Guiding principles and checklist for data redaction to support the sharing of learning

Our review visits revealed that staff can be reluctant to report adverse events due to a perceived blame culture and unwillingness to see their name highlighted in an adverse event review report and the impact it could have on their professional integrity. However, to reduce the likelihood of adverse events happening again, it is imperative that learning is shared.

Discussions at the data redaction stakeholder workshop highlighted an opportunity to write the initial draft review report without reference to person identifiable information, whether relating to patient, family, staff, donors or others. This would avoid any requirement to redact data in the final version of the report or later in the adverse event management process.

Writing the initial adverse event review report in such a way to minimise the disclosure of personal information would provide the following benefits:

- It makes it easy to share learning points without disclosing personal information.
- It focuses on the learning from adverse events and the systemic issues.
- It encourages staff to report adverse events without fear of disclosure or litigation.
- It makes the learning more relevant for all staff as the report would highlight staff roles or grades rather than individual names. This makes the learning personally relevant for similar grade staff and will enable them to identify the risk of a similar event happening again if the learning from an adverse event is not considered and acted upon.
- It avoids staff having to spend time editing and redacting the report for sharing purposes.

The Scottish Public Services Ombudsman (SPSO) publishes reports on its website using generic references such as Patient A, Doctor B or Hospital C, to avoid identifying patients or staff. This paper presents a similar approach using generic references to patients, family, carers, donors, staff and location. It is vital that staff consider all information that could inadvertently identify the people involved.

A checklist is attached at Appendix 3. This checklist lists person identifiable criteria that staff should consider for redaction (information to be omitted from adverse event review reports to minimise the risk of identifying people involved). This checklist has already been adopted by a couple of NHS boards.

The data redaction workshop discussions identified generic principles for staff to apply, when writing an adverse event review report. These principles support the sharing of learning from reviews whilst safeguarding patient or staff confidentiality.

Staff should use both the checklist (Appendix 3) and guiding principles for sharing information (Appendix 2) to support consistent and informed sharing of information about adverse event reviews. For more information on where to go for advice, see Appendix 5.

3 http://www.spso.org.uk/decision-reports
Minimum information to include within a review report to promote consistent capture and sharing of learning

Our discussions with stakeholders at the workshop revealed varying opinions as to whether a standardised review report template could meet the needs of different audience groups, such as internal governance groups, patients, families, carers or staff.

NHS boards need to consider the appropriateness of a standard template within the context of their own governance processes and guidance policies on being open with patients, families and carers.

Appendix 1 suggests the minimum items that should be recorded in the review report. This will promote consistent capture and sharing of learning from adverse events, where they are clinical or non-clinical incidents. The list aligns with the National Patient Safety Agency (NPSA) concise RCA review report example template⁴.

Reviews often rely on the quality of information recorded on the adverse event reporting form which is completed directly after the adverse event happened. NHS boards should consider how staff record information when they first report an adverse event. The way in which information is gathered and handled is important in determining the quality of the review report. Systems which have too many closed questions do not allow free expression of ‘what actually happened’. It is vital that staff are given the opportunity to tell their own version of event. Such data can reflect the true nature of the adverse events, chronology of events, and provide a better feel for the multitude of factors that impacted on the adverse event. The reporting form should give guidance on structure while providing plenty of free space for free text description.

⁴ http://www.nrls.npsa.nhs.uk/resources/?entryid45=59847
### Appendix 1: Recommended aspects to include in adverse event review report template

<table>
<thead>
<tr>
<th>Section</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Background and summary</strong></td>
<td>Describe the background to the adverse event including ‘who, when and how’ and record the resulting outcome. Use narrative to help highlight the context and conditions contributing to the event and provide meaningful insight into the nature of any underlying systems defects that caused the adverse event.</td>
</tr>
<tr>
<td><strong>Description of review team</strong></td>
<td>List job roles or grades of the members of the review team and describe the multidisciplinary approach.</td>
</tr>
<tr>
<td><strong>Review timescales</strong></td>
<td>Record review start and finish dates.</td>
</tr>
<tr>
<td><strong>Scope and level of the review</strong></td>
<td>Identify the purpose and terms of reference of the review, including key issues to be addressed. Document the methodology used. For example, review of medical records, written accounts from staff, interviews with staff, cause and effect (Fishbone) diagram or Five Whys Tool.</td>
</tr>
<tr>
<td><strong>Patient, family, carer, donor and staff involvement</strong></td>
<td>Record relevant contact with the patient, family, carer, donor or staff. For example, dates they were informed, communications, feedback provided, meetings, any involvement within the review and what documentation was shared with them. Document rationale for not involving the patient, family or carers.</td>
</tr>
<tr>
<td><strong>Timeline</strong></td>
<td>List dates and times of key events or actions taken in chronological order (or attach timeline as an appendix).</td>
</tr>
<tr>
<td><strong>Care and/or service delivery issues</strong></td>
<td>Document any identified issues. For example, incorrect or incomplete observations, issues with procedures not being followed, delays in treatment.</td>
</tr>
<tr>
<td><strong>Contributory factors</strong></td>
<td>Document any factors (patient, staff, task, technology and environment) which may have contributed to the event outcomes. For example, patient cognition issues resulting in communication difficulties, busy ward environment, short staffed, poor equipment design, absence of protocols and poor communication between staff.</td>
</tr>
<tr>
<td><strong>Root causes or key issues and opportunities for improvement</strong></td>
<td>Identify the factors that caused the adverse event using root cause analysis tools or methodologies.</td>
</tr>
<tr>
<td><strong>Assessment and findings</strong></td>
<td>Provide a full commentary of the adverse event and findings from the review.</td>
</tr>
<tr>
<td>Review outcome</td>
<td>Indicate which of the following outcomes best applies:</td>
</tr>
<tr>
<td>----------------</td>
<td>------------------------------------------------------</td>
</tr>
<tr>
<td></td>
<td><strong>1. Appropriate care</strong> - The adverse event review concluded that the care and/or service was well planned and appropriately delivered; no care or service delivery problems were identified; and the adverse event outcome was ultimately unavoidable. However, it is likely there are still learning points (especially good practice points).**</td>
</tr>
<tr>
<td></td>
<td><strong>2. Indirect system of care issues</strong> - The adverse event review identified indirect or incidental sub-optimal care or service issues and lessons that could be learned (and good practice points). However, these were unlikely to have affected the final outcome. For example, a protocol was not strictly followed or there was a delay in accessing the case notes, but these were unlikely to have affected the final outcome.**</td>
</tr>
<tr>
<td></td>
<td><strong>3. Minor system of care issues</strong> - The adverse event review identified minor or suboptimal care or service provision and that a different plan or delivery of care/service may have resulted in a different outcome. For example, system or management factors were identified (such as incomplete records or a delay in transferring the patient or service user), but there was uncertainty regarding their impact on the final outcome. Learning points have been identified and improvement plans developed.**</td>
</tr>
<tr>
<td></td>
<td><strong>4. Major system of care issues</strong> - The adverse event review identified that a different plan and/or delivery of care or service would, on the balance of probability, have been expected to result in a more favourable outcome. Factors were identified which negatively influenced or contributed to the adverse event outcome. For example, how the case was managed had a significant impact on the level of harm. Learning points have been identified and improvement plans developed.**</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Good practice identified</th>
<th>Highlight any good practice identified. For example, good note keeping, appropriate patient care, procedures in place.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recommendations</td>
<td>Present recommendations to address each of the root causes. These may be for local action, unit action or for the NHS board.</td>
</tr>
<tr>
<td>Lessons learned</td>
<td>Record the lessons identified through the review.</td>
</tr>
<tr>
<td>Arrangements for sharing lessons or learning points</td>
<td>Document how lessons learned will be disseminated and who the learning points will be shared with. Record the rationale for any decision not to share the learning.</td>
</tr>
<tr>
<td>Action plan development</td>
<td>A separate action plan should be compiled at the most appropriate level, for example by the relevant management or service team (rather than the review team) to ensure ownership. The action plan should identify the owner of each</td>
</tr>
<tr>
<td>Document control</td>
<td>action, timescale for completion (if appropriate) and progress status. Identify how the action plan will be developed and who will be responsible for monitoring completion of actions. Record the rationale for decisions made not to produce an action plan.</td>
</tr>
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<tr>
<td></td>
<td>Include version number and date on all versions of the review report and ensure the final version is labelled ‘final’.</td>
</tr>
</tbody>
</table>
Appendix 2: Guiding principles for sharing information from adverse event reviews

Achieving the correct balance between the duty to protect confidentiality and the duty to share information can be achieved by following the steps below.

1. **Awareness of information sharing**
   a. Inform patients, family, carers, donors and staff of an intention to share adverse event review reports for the purpose of lesson learning, education, training, reflective practice and improvement.
   b. Provide assurance that information will be anonymised as far as possible to minimise risk to privacy.
   c. Be clear that information may still be potentially identifiable.

2. **Writing a shareable adverse event review report (sharing with those involved in the event/review)**
   a. Avoid using obvious personal identifiers when writing the report. Refer to the checklist for help.
   b. Keep a separate record of the personal details of the individuals involved in the adverse event, for example patients, family, carer, donors, staff, care partners, with a unique identifier for use in the report (see below). This record is confidential and should be kept securely with restricted access.
   c. Use a standard naming convention to refer to individuals in the report. For example, refer to the person by their role plus a sequential capital letter based on the chronological order in which they are referred to in the report. A generic role may be sufficient, for example a doctor or nurse, although a more specific role reflecting the level of seniority may be helpful (such as Patient A, FY1 B, Consultant C, Staff Nurse D, Consultant E, Family member F). Be careful that the selected coding does not equate to people’s initials.

3. **Reviewing the report before wider sharing (sharing beyond those involved in the event/review)**
   a. Review each report on a case by case basis, taking into account the intended audience, to decide the appropriate approach.
      i. Suitable for wider sharing as it is.
      ii. Some data needs to be redacted by a suitably skilled person (provided the report will remain meaningful following this).
      iii. A separate summary report needs to be written for the purpose (for example to highlight key points where the report is lengthy; where a large amount of data would be redacted making the report difficult to read or understand) Note: care has to be taken when responding to a request made under FOISA. Under FOISA, it is a criminal offence to alter a record with the intention of preventing it being disclosed. If you receive a FOISA request for a copy of an adverse event review report, you cannot just prepare a summary report and provide it to the requester – at least without applying exemptions to the source report and explaining to the requester what you are doing. If you are in doubt, seek advice from the Scottish Information Commissioner – contact details can be found at [www.itsspublicknowledge.info](http://www.itsspublicknowledge.info).
   b. Seek relevant expertise from information governance and clinical colleagues to help.
      i. Consider the risk of indirect person identification, for example a rare condition, an uncommon procedure, a highly specialist service, a group or population with small numbers, or an unusual set of circumstances.
      ii. Ensure there is sufficient context and information about the event for the report to meaningfully support openness, learning and improvement.
iii. Consider what information is already in the public domain, for example, through the media.
iv. Consider the impact on the patient, family or carer of wider sharing and take their views into account.

c. Gain sign-off by a suitable person that the report is suitable for wider sharing, for example the review chair person, and obtain Caldicott Guardian approval.
Appendix 3: Criteria to consider for redaction before external release\(^5\)

All of the items below should be considered on a case by case basis, taking into account the context and potential privacy impact. If in doubt, seek advice from your NHS board Information Governance colleagues or see guidance issued by the Information Commissioner’s Office.\(^6\)

<table>
<thead>
<tr>
<th>Category of Data</th>
<th>Must be redacted</th>
<th>Consideration to be given to redaction on an individual basis</th>
</tr>
</thead>
</table>
| **Patient personal details** | • Name (both surname and forename)  
• Date of birth  
• Specific age reference  
• Hospital number  
• CHI number  
• Address (own or associated)  
• Postcode  
• GP  
• ‘Direct lift’ clinical information taken from patient /deceased patient’s medical records  
• Detailed clinical investigation results  
• Full medical history  
• Date adverse event happened | • Assess the uniqueness of the disease/diagnosis/testing - some common diagnoses combined with other data may risk identification. For example, childhood leukaemia is not unique, but is rare, and when given with other details such as a single hospital in a small NHS board area, it potentially identifies individuals  
• Consider providing the following if it would help provide context and support understanding and learning (unless, with other information, it could identify people):  
  • relevant medical history or clinical information  
  • patient’s age range, for example ‘60-70 year old’, and  
  • the month and/or year the adverse event happened |
| **Family, carer or donor details** | • Name (both surname and forename)  
• Address (own or associated) |  |
| **Gender identification or relationship terms for patients, family, carer, donor or staff** | The following must be redacted if, with other information, it could potentially identify people involved:  
• His/Her  
• He/She  
• Male/female  
• Relationship terms, such as mother, wife, grandfather or partner | • Consider including gender reference if the context is relevant and gender specific, for example the adverse event involved a pregnant woman |
| **Staff personal details (does not apply to staff)** | • Name (both surname and forename) | • Generic job title or occupation can be retained, for example Nurse A, Doctor B or Consultant C |

\(^5\) This checklist is an adaptation of the checklist originally developed by NHS Lanarkshire  
| identified as investigator or report author | • Specific age  
• Years of service  
• Qualifications | • Consider providing a general indication of staff’s level of experience or skills if it would support learning, for example ‘an experienced senior nurse’ (unless, with other information, it could identify people) |
| Hospital/Site | • Ward | • Consider the description of specific, specialist or small services, departments, clinics or hospitals - replace with more generic terms, for example ‘community services’, ‘clinic A’, ‘Health Centre B’ |
| Other identifying factors | The following must be redacted if, with other information, it could potentially identify people involved:  
• third party contractors/specialists  
• named contracted/commercial companies | • Third party hospitals providing specialist services |
## Appendix 4: Revised list of Caldicott Principles 2013

<table>
<thead>
<tr>
<th>Principle</th>
<th>Description</th>
</tr>
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<tbody>
<tr>
<td><strong>1. Justify the purpose(s)</strong></td>
<td>Every proposed use or transfer of personal confidential data within or from an organisation should be clearly defined, scrutinised and documented, with continuing uses regularly reviewed, by an appropriate guardian.</td>
</tr>
<tr>
<td><strong>2. Don’t use personal confidential data unless it is absolutely necessary</strong></td>
<td>Personal confidential data items should not be included unless it is essential for the specified purpose(s) of that flow. The need for patients to be identified should be considered at each stage of satisfying the purpose(s).</td>
</tr>
<tr>
<td><strong>3. Use the minimum necessary personal confidential data</strong></td>
<td>Where use of personal confidential data is considered to be essential, the inclusion of each individual item of data should be considered and justified so that the minimum amount of personal confidential data is transferred or accessible as is necessary for a given function to be carried out.</td>
</tr>
<tr>
<td><strong>4. Access to personal confidential data should be on a strict need-to-know basis</strong></td>
<td>Only those individuals who need access to personal confidential data should have access to it, and they should only have access to the data items that they need to see. This may mean introducing access controls or splitting data flows where one data flow is used for several purposes.</td>
</tr>
<tr>
<td><strong>5. Everyone with access to personal confidential data should be aware of their responsibilities</strong></td>
<td>Action should be taken to ensure that those handling personal confidential data — both clinical and non-clinical staff — are made fully aware of their responsibilities and obligations to respect patient confidentiality.</td>
</tr>
<tr>
<td><strong>6. Comply with the law</strong></td>
<td>Every use of personal confidential data must be lawful. Someone in each organisation handling personal confidential data should be responsible for ensuring that the organisation complies with legal requirements.</td>
</tr>
<tr>
<td><strong>7. The duty to share information can be as important as the duty to protect patient confidentiality</strong></td>
<td>Health and social care professionals should have the confidence to share information in the best interests of their patients within the framework set out by these principles. They should be supported by the policies of their employers, regulators and professional bodies.</td>
</tr>
</tbody>
</table>
Appendix 5: Where to go for advice

**Information Commissioner’s Office (ICO)**

Information Commissioner’s Office  
45 Melville Street  
Edinburgh  
EH3 7HL

Telephone: 0131 244 9001  
Fax: 0131 244 9046  
Email: Scotland@ico.org.uk  
Website: www.ico.org.uk

For secure emails over gsi, please use Scotland@ico.gsi.gov.uk

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**Scottish Information Commissioner (OSIC)**

Scottish Information Commissioner  
Kinburn Castle  
Doubledykes Road  
St Andrews  
Fife  
KY16 9DS

Telephone: 01334 464610  
Fax: 01334 464611  
Email: enquiries@itspublicknowledge.info  
Website: www.itstpublicknowledge.info