SCOTTISH EXECUTIVE

Health Department

Dear Colleague

CONSULTATION ON DRAFT - A GOOD PRACTICE GUIDE ON CONSENT FOR HEALTH PROFESSIONALS IN NHSSCOTLAND

Please find attached the draft document 'A Good Practice Guide on Consent for Health Professionals in Scotland' which is issued for a limited consultation.

The Guide has been developed to replace the 1992 document 'A Guide to Consent, Investigation, Treatment or Operation' to incorporate the new policy on confidentiality, legislation around children, mental health and adults with incapacity, to bring our guidance into line with guidance issued by the Department for Health for the NHS in England and Wales, and reflect the changes to the way the NHS delivers services more generally.

The aim of the Guide is to assist health professionals working in NHSScotland to comply with their legal duties and to ensure that patients are able to make informed decisions about healthcare interventions. It does not attempt to clarify ethical situations such as such as obtaining consent for post-mortem examinations and retention of organs.

This is a Good Practice Guide which covers the main issues surrounding consent and confidentiality and is not a comprehensive account of the legal obligations faced by health professionals on this matter. It does refer to legal duties, obligations and statutory provisions but is not intended to have legal effect and, as such, organisations may require to take legal advice about particular issues.

Please circulate this document widely as you feel appropriate. It can be accessed at;
www.show.scot.nhs.uk/sehd/cmo/cmo_letters.htm
Comments are very welcome and should be addressed to Miss Lucy White at Ground East Rear, St Andrews House, Regent Road, Edinburgh, EH1 3DG or 0131 244 2454 no later than 17 June 2005.

The Guide will be revised to reflect the comments received and will subsequently be formally issued to NHS staff and other stakeholders, perhaps accompanied by a pocket-sized 'key points'/checklist for easy reference. Once this Guide has been

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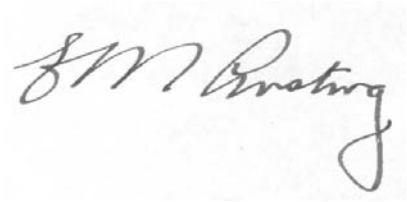
issued to staff, the Health Rights Information Project http://www.scotconsumer.org.uk/hris/ based in the Scottish Consumer Council, will develop and issue a complementary guide to consent for patients.

With best wishes.

Yours sincerely,



DR E M ARMSTRONG

A Good Practice Guide on Consent for Health Professionals in NHSScotland

A draft for consultation
Scottish Executive Health Department
Spring 2005

Contents Page

Introduction 3

Chapter 1 – Principles of Consent 4

Chapter 2 – Children 7

Chapter 3 – Adults with Impaired Capacity 9

Chapter 4 – Disclosure of Healthcare Information 14

Quick Reference to Key Points 17

Appendix A – Abbreviations 21

Appendix B – Further Reading 21

Introduction

This is a good practice guide and a summary of the main issues surrounding consent and confidentiality. Although it refers to legal duties and statutory provisions, this guide is not intended to have legal effect and you may wish to take advice about particular issues.

Its purpose is to assist health professionals working in NHSScotland to comply with their legal duties and to ensure that their patients make informed decisions about healthcare interventions. It excludes situations such as obtaining consent for research and authorisation for post mortem examinations and retention of organs.

This Guide replaces *A Guide to Consent to Examination, Investigation, Treatment or Operation* which was published by the NHS Management Executive in 1992. Since then, there have been important changes in the way that healthcare is delivered in Scotland.

The Adults with Incapacity (Scotland) Act 2000 was introduced in stages, with Part 5 Medical Treatment and Research coming into effect in July 2002. The Mental Health (Care and Treatment) (Scotland) Act 2003 will also come into effect in stages from April 2005. Both Acts have innovative proposals for delivering healthcare to people who lack the ability to make treatment decisions for themselves.

During the course of examining, investigating and treating, health professionals have access to confidential healthcare information about their patients. Normally the patient's consent is required before information can be shared outwith the care team. There are situations, however, in which this usual requirement to obtain consent is waived and these exceptions are outlined in Chapter 5. The guidance reflects the more extensive advice in *NHS Code of Practice on Protecting Patient Confidentiality* published by the Scottish Executive in Autumn 2003.

Chapter 1 Principles of Consent

Why obtain consent?

People have the right to decide whether or not to agree to healthcare interventions, including examinations, diagnostic procedures and treatment. It is important to respect this right, to provide information about the procedure and to obtain their permission or agreement before you proceed with the intervention. This is often described as "getting consent."

You must also respect your patients' rights to dignity, privacy and confidentiality. Normally, the consent of your patients is required before you disclose any information obtained in the course of their healthcare. There are some exceptions to this: see Chapter 5 and the Scottish Executive's booklet *Ensuring Confidentiality and Data Protection in the NHS* for further details.

Consent is a person's agreement to go ahead with the proposed healthcare intervention. To be valid, three conditions have to be satisfied:

1 Information

People should receive enough information, supplied in a way that they can understand, before they make up their minds about the proposed examination, diagnostic procedure or treatment. The information should include benefits, significant risks and the implications of any relevant options, including the option of not having the intervention. The person should be given information specific to their own circumstances. It is good practice to allow enough time for consideration and, if they wish, discussion with family and friends. If they ask questions, these must be answered honestly.

It is important to ensure that there is sufficient time for this process of sharing and considering information, even though this may be difficult to achieve in a busy surgery or clinic. You should be aware that some people, because of their background or circumstances, may need extra support to make an informed decision about what is right for them.

2 Freedom of Choice

Patients' agreement to proceed must be given voluntarily without pressure, deceit or undue influence being used. Health professionals have a duty to ensure that patients have reached their own decisions and understand that they can change their minds if they do not wish to continue with the procedures.

3 Capacity

The law in Scotland presumes that people aged 16 and over have the capacity to make their own decisions. Having capacity means being able to understand, believe and remember what is being proposed, to weigh up the relevant information, including its benefits, hazards and options, and to use this in reaching a decision. People may have enough capacity to take some healthcare decisions for themselves but may lack the capacity to decide about other, more complex, healthcare matters.

You should be aware that decisions which are unusual, unexpected or not what you would have chosen do not necessarily mean that a patient lacks capacity: instead, it may highlight the need for further information or a clearer explanation. People under the age of 16 may have sufficient capacity to make healthcare decisions for themselves (see Chapter 2).

Ongoing process

Consent to be examined, investigated and treated is usually an ongoing process, not a single event. People can change their minds and withdraw their consent at any time. If you are in doubt, check with your patient to ensure that they still wish to continue with the healthcare being offered. People may be willing to participate in some parts of the proposed treatment, but decline others. This has particular implications for antenatal screening.

Should consent be in writing?

The main point is that the patient understands and agrees to the healthcare intervention. This agreement need not necessarily be in writing: it will depend on the nature of the proposed intervention and on your Board's policy about written consent. It is often helpful to have a record of the process and outcome. In other situations, the patient may give their agreement

verbally or by their actions. Whatever the process, it is important that you and your patient both understand what has been agreed.

Who should ask for consent?

It is usually preferable for the health professional who will be carrying out the examination, diagnostic procedure or treatment to explain it to the patient and obtain their agreement to proceed. However, you can seek consent on behalf of colleagues, provided that you are able to undertake the intervention or have been appropriately trained in obtaining consent for it.

When should this be done?

The timing can be important. It should be sufficiently close to the intervention for the person to recall what they have been told about it. It is often helpful to reinforce what you have said with printed information which they can keep. However, seeking consent from a patient immediately before a procedure, for example, when they are in the anaesthetic room, is unlikely to withstand a challenge on validity, as the patient may feel under pressure to comply or may be under the influence of pre-medication.

What if consent is refused?

People have the right to say what is or is not going to happen to their bodies and people with capacity may choose to refuse to have the proposed healthcare intervention. Unless Part X of the Mental Health (Scotland) Act 1984 (see Chapter 3) or the provisions of the new Mental Health (Care And Treatment) (Scotland) Act 2003, when they come into effect in stages from April 2005, apply, this decision must be respected. You should be aware that the Mental Health Acts can only be used for treatment for mental, not physical, disorder. Failure to respect their wishes and treating people in the absence of consent can leave health professionals open to criminal charges, civil actions and allegations of professional misconduct.

What about emergencies?

In an emergency, it is acceptable for you to act without obtaining consent in order to save life or prevent serious deterioration in someone's medical condition.

Chapter 2 Children

In Scots law, when someone reaches their 16th birthday they gain the legal capacity to make decisions which have legal effect (Age of Legal Capacity (Scotland) Act 1991). However, even under the age of 16, a young person can have the legal capacity to make a decision on a healthcare intervention, provided that they are capable of understanding its nature and possible consequences (See Section 2(4) of the 1991 Act).

This is a matter of clinical judgement and will depend on several things, including:

- the age of the patient
- the maturity of the patient
- the complexity of the proposed intervention
- its likely outcome
- the risks associated with it.

If the child is not capable of understanding the nature of the healthcare intervention and its consequences, then you should ask the parent or guardian for permission to proceed with the intervention. Sometimes the parent is not available. If the intervention cannot be deferred until you can speak to the parent, then Section 5 of the Children (Scotland) Act 1995 gives a person who has care or control of the child the power to do what is reasonable in all the circumstances to safeguard the child's health, development and welfare. This person may consent to any surgical, medical or dental treatment or procedure where the child cannot give consent on his own behalf and it is not within the knowledge of the person that a parent of the child would refuse.

In addition to capacity, the other requirements about sufficient information and voluntariness apply to decisions about healthcare for patients under the age of 16.

Occasionally you may be involved in the examination or treatment ordered under the Children (Scotland) Act 1995 by a Children's Hearing. If the child has the necessary capacity then you must obtain the child's consent.

It is good practice for you to encourage the young person to involve their parents in the healthcare decision-making process. Occasionally, there may be a difference of opinion between the young person and the parent. Dealing with the situation professionally and tactfully may help reach an agreement. However, where the child has the capacity to make the healthcare decision in question, then the child's decision must be respected even if it differs from the parents' views or yours.

In an emergency, where the child is unable to consent and treatment cannot be delayed until the parent or person with parental rights or responsibilities is consulted, you should give the treatment which is required to save life or to avoid deterioration in the child's health.

Chapter 3 Adults with Impaired Capacity

The principles of consent (information, voluntariness and capacity) apply to all patients. It is important to be aware that most people suffering from a mental illness (including people with dementia) or learning disability retain the capacity to make most healthcare decisions for themselves. An individual's capacity to reach a decision on their healthcare will depend on the decision in question, their intellectual state at the time and the nature of their disorder.

Adults with Incapacity (Scotland) Act 2000

In Scotland, approximately 100,000 people over the age of 16 have difficulties in taking decisions for themselves because of mental disorder or a communication disorder due to a physical and/or learning disability. Part 5 of the Adults with Incapacity (Scotland) Act 2000 dealing with medical treatment and research came into effect in July 2002. Application of the Act's principles and provisions should ensure that these adults receive equity of access to healthcare.

The Act defines incapacity as being incapable of:

- acting or
- making decisions or
- communicating decisions or
- understanding decisions or
- retaining the memory of decisions

The cause of the incapacity must be mental disorder or inability to communicate because of a physical disability. Mental disorder includes mental illness, personality disorder, learning disability and other causes of mental impairment. You should be aware that this definition includes adults who are unconscious and on a ventilator in Intensive Care Units because of illness or injury.

There are many people with a learning disability who may have varying degrees and levels of understanding and who would not in any way regard themselves as having a mental disorder. Many people with a learning disability also have very complex health needs, including

physical disability. This can affect both their understanding and the ability to communicate effectively, unless careful and planned assistance is given to help them.

If you can overcome or improve on the disability by human or mechanical support, then it is a requirement of the Act to do so. This can include simple measures such as ensuring the adult is wearing their glasses and hearing aid or providing a quiet and distraction-free environment. You may need to involve other people, including speech and language therapists, signers or interpreters, to help bridge the communication gap.

People with a learning disability can often achieve a level of understanding which you might not have expected, providing that information is well-presented by experienced people. Sometimes mechanical aids are also helpful here.

Before the Act was introduced, health professionals who wished to examine, investigate or treat people lacking the capacity to take healthcare decisions for themselves had no lawful means of doing so, unless an application was made to the Court and its permission was granted. Apart from giving emergency treatment in life-threatening situations, health professionals ran the risk of facing allegations of assault, negligence or professional misconduct for acting in the absence of consent.

Principles

The Act sets out principles which must be observed. All decisions made on behalf of an adult with incapacity must:

- benefit the adult
- take account of the adult's present and past wishes and feelings
- take into account the wishes of the nearest relative, primary carer, proxy and relevant others, where it is reasonable and practicable to do so
- restrict the adult's freedom as little as possible while achieving the desired benefit

You should note that capacity is specific to the situation. This means that an adult may be capable of reaching a decision on some aspects of their healthcare, but incapable in terms of handling decisions about its more complex aspects.

Authority to treat

Medical treatment is defined widely in Section 47 of the Act as "any procedure or treatment designed to safeguard or promote physical or mental health". The Act sets out what must be done to obtain the general authority to treat, including observing the principles, assessing the adult's capacity and completing the appropriate certificate (sometimes called a Section 47 certificate or a certificate of incapacity). This process is likely to include speaking not only with the adult but also with the nearest relative, primary carer, their healthcare proxy if they have one and others, as set out in the Act, where it is reasonable and practicable to do so. Several members of the healthcare team may be involved in the assessment process. See the *Code of Practice for Part 5* of the Adults with Incapacity (Scotland) Act for more information.

You should note that, at present, only a fully registered medical practitioner can complete and sign the certificate. However, the Act allows for the general authority to treat to be delegated to other members of the healthcare team so that they can do what is necessary to safeguard or promote the physical or mental health of the adult. The certificate can last for a maximum of 12 months at present and is usually kept in the adult's healthcare record.

The Act, therefore, not only enhances access to healthcare by your adult patients lacking capacity to make some or all of their decisions for themselves but also it enables you to deliver care lawfully to them.

Excepted treatments

The Act contains additional safeguards for patients. For example, the general authority to treat is not enough to permit certain procedures to be undertaken. There are additional criteria which must be satisfied before electro-convulsive therapy, sterilisation (including any medical treatment likely to lead to sterilisation as an unavoidable result), termination of pregnancy or implantation of hormones or drug treatment to reduce sexual drive can be carried out. The Adults with Incapacity (Scotland) Act 2000 cannot be used to treat patients detained against their wishes for treatment of mental disorder: The Mental Health (Scotland) Act 1984 or the Mental Health (Care and Treatment)(Scotland) Act 2003 (once it comes into effect) should be invoked if necessary.

Research

The Act also sets out criteria, including rigorous ethical and scientific scrutiny, which must be satisfied before research can be carried out on adults lacking the capacity to decide whether or not to participate.

Codes of Practice on the Adults with Incapacity (Scotland) Act 2000 have been published and further information about the Act can be found on the Scottish Executive Justice Department's website (www.scotland.gov.uk/justice/incapacity).

The Mental Health (Scotland) Act 1984

The principles of consent also apply to people suffering from mental disorder who are detained under the provisions of Part X of the Mental Health (Scotland) Act 1984. The treatment provisions in the Mental Health Act apply only to patients detained on short term or long term detention. They do not apply to voluntary patients or those on emergency detention nor do they apply to treatment for physical disorders. The Code of Practice accompanying the 1984 Act provides detailed guidance on when you are permitted to override patients' wishes.

When someone refuses examination

You may be faced with someone who refuses to be examined and you think that their refusal may be because of a mental disorder. This can be a difficult situation to deal with because it may happen without much warning and in surroundings such as the person's home or an Accident and Emergency Department. Sometimes you may become involved after the person has been taken into police custody.

If the person refuses to talk to you, or to be examined, it may be because they are seriously mentally ill and are a potential risk to themselves and to others. If so, you may have to consider whether it is appropriate to use the Mental Health Act. If the person is unwilling or unable to consent to examination then you may have to obtain information about the patient from other sources. This could include relatives and friends of the person, police officers or

other people involved in the current situation. Part V of the Mental Health Act describes the conditions which must be satisfied before emergency detention can take place.

The Mental Health (Care and Treatment)(Scotland) Act 2003

This Act will come into effect on a staged basis. In relation to consent, it updates mental health legislation in Scotland in two important ways. The first change lies in the area of urgent treatment in emergencies. Part X of the 1984 Act does not give authority to treat a patient detained on a Section 24 (Emergency) Order. By contrast, Section 2(4)3 of the 2003 Act does allow for medical treatment to be given to a patient who does not consent or is incapable of consenting to that treatment even where that patient is detained because of an Emergency Detention Certificate (issued under Section 36 of the 2003 Act).

Urgent treatment can only be provided where the purpose of the treatment is to

- save the patient's life
- prevent serious deterioration in the patient's condition
- alleviate serious suffering on the part of the patient
- prevent the patient from behaving violently or from being a danger to himself or others

This treatment must not be hazardous or irreversible. The second important way in which the 2003 Act updates Scottish mental health legislation is through the introduction of a set of principles known as the Millan Principles which you should apply when carrying out functions under the Act. From the point of view of consent, the most relevant principles are non-discrimination, informal care and participation. The Millan Principles will have an impact on many health professionals in NHSScotland whether or not you are working in the field of mental health.

You will be able to find more details in the Explanatory Notes and Code of Practice on the Act to be published before it comes into effect. For further details see the Executive's website www.scotland.gov.uk/health/mentalhealthlaw

Chapter 4 Disclosure of Healthcare Information

All personal health information in NHSScotland is held under strict legal and ethical obligations of confidentiality. Information obtained in the course of delivery of healthcare should not be used or disclosed in a form that might identify a patient without their consent.

What is meant by Patient Identifiable Information?

Examples include information containing:

- the patient's name
- the patient's address
- the patient's full post code
- the patient's date of birth
- pictures, photographs, videos, audio tapes or other images of the patient
- anything which could be used to identify someone directly or indirectly
- the Community Health Index (CHI) which contains the person's date of birth and a number to indicate their sex

This list is not exhaustive.

A combination of these items would increase the chance of patient identification and a breach of your duty of confidentiality.

There are some important exceptions to this rule which are described later, but patients should be involved in decisions about the use of their personal health information and normally their consent is required before you disclose it.

Guidance is available from SEHD on protecting patient confidentiality in NHSScotland - see www.show.scot.nhs.uk/confidentiality for more information.

Obtaining consent from patients about use of their information

You must ensure that as far as possible you disclose information only after effective involvement of patients and with their consent. To be valid, that consent should be informed and freely given. Patients can change their minds and withdraw their consent to disclosure.

Consent may be explicit, when the patient gives verbal or written agreement. It may sometimes be implied, by the patient's acceptance of a service. You should ask your local Data Protection Officer or Caldicott Guardian for advice if in doubt.

Anonymisation

Data are said to be anonymised when details such as name, address, post code, date of birth and other identifiers are removed, the recipient of the data cannot identify the patient and the possibility of the patient's identity being discovered is extremely small. Wherever appropriate, you should consider anonymisation. Although the Data Protection Act 1998 does not restrict the use of information that does not identify patients, it is good practice to let patients know when you intend to anonymise information held about them. The extent of data anonymisation may be an important aspect of gaining consent for research.

Exceptions

There are exceptions to the normal rule that a patient's consent is required before you disclose identifiable healthcare information. You may encounter some of the situations set out below.

Statutory requirement

Births and deaths, termination of pregnancy and certain infectious diseases must be reported to the appropriate authority. (Notification of births and deaths is dealt with by the Registration of Births, Marriages and Deaths (Scotland) Act 1965, abortion under the Abortion Act 1967 and the Abortion (Scotland) Regulations 1991 and infectious diseases under the Infections Diseases (Notification) Act 1889 and the Public Health (Notification of Infectious Diseases)(Scotland) Regulations 1988). The Road Traffic Act 1988 and the Terrorism Act 2000 require limited disclosure of information in specific circumstances.

Please note that these are examples and not a full list of situations where there is a statutory duty to disclose information.

Court Order

In the course of legal proceedings, a court can order the disclosure of all or part of a patient's healthcare records. If you are in doubt about what to do, take advice from your manager or legal adviser.

Audit and Monitoring

In order to audit performance, maintain standards and plan services in NHSScotland, it is necessary to gather information on activity and outcomes, including clinical information. All data should be anonymised before the information is gathered and used in this way. If the data are not anonymised then the processing must comply with the data protection principles.

Multidisciplinary team working

Relevant clinical information about patients in your care may be shared with non-clinical members of a multidisciplinary team provided that the patient has been informed and consents. This is likely to be necessary, for example, when care packages are being planned to allow dependent patients to be discharged from hospitals to their own homes. It is also important to realise when you have a duty to share information across inter-agency boundaries in cases of child protection. Guidance can be found in Part 4 of the Scottish Executive publication *Getting Our Priorities Right* .

Further information on your duty of confidentiality can be found in the Code of Practice for NHSScotland on Protecting Patient Confidentiality at www.show.scot.nhs.uk/confidentiality.

QUICK REFERENCE TO KEY POINTS

A Good Practice Guide on Consent for Health Professionals in NHSScotland

(This is a good practice guide and is not intended to have any legal effect.)

Note: It is proposed that the Quick Reference would also be available as a folded A4 reminder card and as an A3 poster for notice boards etc.

KEY POINTS

When is it necessary for health professionals to obtain consent from patients?

1. Before you examine, investigate or treat patients you must have authorisation to proceed. This is often called 'getting consent'.

2. People aged 16 and over are presumed to have the capacity to make their own decisions. If you have doubts about someone's capacity, you may find it helpful to ask yourself: "Can this person understand, retain and use the information they need to make this decision?" Decisions which are unusual or unexpected do not necessarily mean that the patient lacks capacity: it may indicate a need for further information or a clearer explanation.

3. People may have the capacity to take some healthcare decisions for themselves but may lack the capacity to decide about other, more complex matters.

4. Consent is usually a process, not an event. People can change their minds and withdraw their consent at any time. If in doubt, check with your patient to ensure that they still wish to continue with the healthcare being offered.

5. In an emergency, it is acceptable for you to save life or prevent serious deterioration in someone's medical condition without obtaining consent.

Can children consent to treatment for themselves?

6. Once a person reaches the age of 16, Scots law gives them the legal capacity to make decisions for themselves. However, under the age of 16, a child in Scotland has the legal capacity to authorise medical or dental care where, in the opinion of the practitioner looking after him, he is capable of understanding its nature and possible consequences. If the child has capacity, the child's decision must be respected. When a child cannot understand, then a parent or an adult with parental responsibility can make the decision on their behalf.

Who is the right person to ask the patient for consent?

7. It is usually preferable for the health professional who will be carrying out the examination, investigation or treatment to obtain consent from the patient. However, you can ask on behalf of colleagues, if you are capable of performing the procedure in question or if you have been trained to seek consent for it.

What information should be provided?

8. People need sufficient information expressed in a way that they can understand before they can reach a decision. This should include the benefits and significant risks of the proposed intervention and any relevant options, including not having the intervention. The patient's questions must be answered truthfully. If you do not know the answers, you should identify a colleague who does know and listen when they discuss the issues with the patient.

Has consent been given voluntarily?

9. Consent to proceed must be given voluntarily, without pressure, deceit or undue influence from family, health professionals or others.

Does consent have to be in writing?

10. Not necessarily: consent can be written, oral or non-verbal, depending on the circumstances. A signature on a form is not in itself proof of valid authorisation. Its purpose is to record the decision and the discussions which have taken place beforehand. Your Board may have a policy setting out the circumstances in which you need to obtain the patient's consent in writing.

Refusing healthcare

11. People with capacity are entitled to refuse healthcare, even though you believe that it would be beneficial to them. However, an exception to this occurs where the treatment is for mental disorder and the patient is detained under the Mental Health (Scotland) Act 1984. Part X of the Act sets out the provisions for detention and treatment under the Act and the circumstances in which a patient's consent is not required.

The Code of Practice accompanying the 1984 Act provides detailed guidance on when it is permissible to override the patient's wishes. These provisions, in the 1984 Act, will be replaced by the Mental Health (Care and Treatment)(Scotland) Act 2003.

Adults with Incapacity

12. The Adults with Incapacity (Scotland) Act 2000 sets out a framework for regulating interventions into the property, financial affairs and personal welfare of adults with impaired capacity. It protects the interests of adults who are incapable of taking a decision because of mental disorder or because of physical disability which makes them unable to communicate. (Scottish Executive guidance is available on this Act and how it affects health professionals.)

The adult may be able to reach a healthcare decision where a relatively simple and low risk procedure is being proposed. If the decision is too complex for the adult, the authority to proceed with medical treatment is given by complying with the Act.

What about consent to disclose healthcare information?

13. Usually, you need the patient's permission before identifiable information about them is shared with other people. However, there are some exceptions to this rule. Examples include the statutory requirement to report particular events (e.g. births and deaths) procedures (e.g. termination of pregnancy) or infectious diseases (e.g. tuberculosis) to the appropriate authority. There are other clinical situations where disclosure of healthcare information is required as a matter of public safety. Non-identifiable information can be used for audit and planning of healthcare services without the consent of the patient. See the Scottish Executive's guidance *NHS Code of Practice on Protecting Patient Confidentiality* for more information. Speak to your Caldicott Guardian or Data Protection Officer for advice.

APPENDICES

APPENDIX A

Abbreviations

CHI	Community Health Index
MHA	Mental Health Act
NHS	National Health Service
SEHD	Scottish Executive Health Department

APPENDIX B

List of Further Reading

Acts

Abortion (Scotland) Regulations 1991

Abortion Act 1967

Adults with Incapacity (Scotland) Act 2000

Age of Legal Capacity (Scotland) Act 1991

Children (Scotland) Act 1995

Data Protection Act 1998

Human Rights Act 1998

Mental Health (Care and Treatment) (Scotland) Act 2003

Mental Health (Scotland) Act 1984

Public Health (Notification of Infectious Diseases)(Scotland) Regulations 1988

Registration of Births, Marriages and Deaths (Scotland) Act 1965

Road Traffic Act 1988

Terrorism Act 2000

Publications

Adults with Incapacity (Scotland) Act 2000 Code of Practice for persons authorised to carry out medical treatment under part 5 of the Act Scottish Executive 2002

NHS Code of Practice on Protecting Patient Confidentiality Scottish Executive 2003

MHA 1984 Code of Practice 1990

New Directions - Report on the Review of the MHA 1984 SE/2001/56

Getting our Priorities Right , Scottish Executive 2003

Websites

www.dataprotection.gov.uk/dpr/dpdoc.nsf

www.scotland.gov.uk/health/mentalhealthlaw

www.scotland.gov.uk/justice/incapacity

www.show.scot.nhs.uk/confidentiality

A GOOD PRACTICE GUIDE ON CONSENT FOR HEALTH PROFESSIONALS IN NHSSCOTLAND

A CONSULTATION DOCUMENT

Deadline for responses: 24 June 2005

Responses should be sent to:

Miss Lucy White
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or to: **lucy.white@scotland.gsi.gov.uk**

A GOOD PRACTICE GUIDE ON CONSENT FOR HEALTH PROFESSIONALS IN NHSSCOTLAND

AN INVITATION TO COMMENT

Questions to consider when reading the draft guidelines

Q1	***Do the draft guidelines provide practical information for use by health professionals within your organisation?***
	Yes **No** **If you answered no to this question, please explain your reasons**

Q2	***Which chapters did you find most useful? Please tick all that apply***
	Principles of consent **Children** **Adults with impaired capacity** **Disclosure of health information** **Please explain what further information is required in the chapters which you did not find useful (if any)**

Q3	***Are there any areas which you had difficulty understanding?***
	Yes **No** **If you answered yes to this question, please explain your reasons**
Q4	***What would make the guide easier to use?***

Please use this section to make any additional comments on the guidelines

Thank you for taking the time to answer these questions. To ensure that we can send you a copy of the final documents, please enter your contact details below.

Name: ……..

Address: ……..

……..

……..

……..

Responses may be published on a consultation page within Scottish Health on the Web. If you do not wish your response to appear, please tick this box

	Please use this space to add any further comments about this document and feel free to continue onto a separate sheet of paper if necessary.