THE SCOTTISH OFFICE

National Health Service in Scotland
Management Executive

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Edinburgh EH1 3DG

5 June 1995

NHS MEL(1995)31

Dear Colleague

CODE OF PRACTICE ON OPENNESS IN THE NHS IN SCOTLAND

Summary

1. This letter relates to the Code of Practice on Openness in the NHS in Scotland which came into effect on 1 June 1995. Attached to the letter are guidance notes on the implementation of the Code, and a letter from the Health Service Commissioner (Ombudsman) outlining how he intends to tackle his responsibilities to investigate complaints relating to the Code.

Action

2. You are asked to take the action indicated in the Annex to this letter:

- securing wide distribution of copies of the Code;
- publicising the Code and local arrangements for implementation;
- identifying a named individual accountable to you for local arrangements;
- briefing members of your board/council and staff on their obligations under the Code;
- reviewing your procedures to enable your organisation to meet its obligations under the Code;
- setting up arrangements for monitoring the operation of the Code.

3. Please ensure that the attached guidance notes and Health Service Ombudsman's letter are also circulated to those responsible for implementing the Code.

CLASS Ref
ACC. IP-10 : 3136
Date — Price —

Yours sincerely

DAVID R STEEL
Director of Corporate Affairs

Addressees

For action:
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Chief Executives, NHS Trusts

General Manager, Common Services Agency

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General Manager, Health Education Board for Scotland

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IMPLEMENTATION OF THE CODE OF PRACTICE ON OPENNESS IN THE NHS IN SCOTLAND

1. Action

1.1 Distributing the Code of Practice

You should have received a supply of copies of the Code of Practice. Please arrange for their distribution as widely as possible. In the case of Health Boards, sufficient copies have been distributed to allow one to be provided to each GP practice, dental practice, community pharmacy and optician. Further copies may be obtained on application to Mrs Elaine Young, Room 147, St Andrew's House, 0131-244 2382.

1.2 Publicising the Code of Practice Locally

You are asked to make arrangements to ensure that local people are aware of the existence of the Code, for example, through articles in the local press, posters on NHS display boards and notices in local clinics and practices. These should include information about where to apply for information and the handling of local complaints relating to the Code.

1.3 Identifying a Named Individual Responsible for the Code of Practice

The Code (page 8) requires you to publish the name of a senior officer who is accountable to yourself to take responsibility for local implementation of the Code. Further guidance is provided in paragraph 6 of the attached guidance notes.

1.4 Briefing Members of Your Board and Staff

As the Minister indicated in his letter to Chairmen, he looks to boards to take a lead in ensuring that the principles of the Code are adopted throughout the NHS in Scotland, and requests for information are dealt with positively.

1.5 Reviewing Your Procedures

Whilst much of the Code represents existing practice, there are some areas where you may need to review existing procedures in order to bring them into line with the requirements of the Code. In addition, one of the main purposes of the Code is to encourage you to extend the range of information made available.

1.6 Monitoring

The Code of Practice requires all Health Boards and NHS Trusts to nominate one individual to be responsible for its operation locally. The nominated individual will wish to maintain his/her own appropriate records for monitoring purposes. It will be useful, for example, to keep local records of the number of requests made for information covered by the Code of Practice, how many are refused, which exemptions are most frequently invoked, the frequency and scale of charging, and the numbers and reasons for complaints. The Management Executive will not be seeking regular statistical returns.

However, after the first year of the Code's operation the Management Executive will undertake a review of the Code and Health Boards and NHS Trusts will be asked to contribute to this review by providing feedback on local use of the Code.

2. Guidance Notes

The guidance notes are intended to assist NHS organisations in interpreting the Code of Practice. They explain the intentions behind the Code and amplify its specific provisions. In the light of experience, the notes will be reviewed and consideration will be given to providing equivalent guidance on the annexes to the Code.

The guidance notes are not confidential. They should be made available to any individual or organisation seeking a copy.

3. Health Service Commissioner (Ombudsman)

The letter from the Health Service Commissioner (Ombudsman) outlines the complaints relating to the Code that he will accept for investigation and the time limits that will apply for responses by the NHS organisation concerned and for completion of the investigation. It also includes an Annex setting out the key provisions governing his powers and actions and their application to his procedures.

GUIDANCE ON IMPLEMENTATION OF THE CODE OF PRACTICE ON OPENNESS IN THE NHS IN SCOTLAND

1. Introduction

1.1 The Code of Practice on Openness in the NHS in Scotland was published on 25 May 1995 to take effect from 1 June 1995. (See page 11 the Code and Guidance paragraph 11.1.)

1.2 The Code is supported by 4 annexes designed to supplement the Code with examples: they must not be considered as fully comprehensive. This Guidance has been written to assist staff responsible for responding to requests for information under the Code: it is not expected to cover all possible circumstances, but is advisory and designed to complement the Code and to assist in its development. The Guidance will be supplemented and amended as experience of operating the Code develops.

1.3 The Code draws attention to the ultimate responsibility of the Health Service Commissioner (Ombudsman) for considering complaints where - after representations have been made to the General Manager/Chief Executive of the appropriate NHS organisation - the applicant for information under the Code is dissatisfied with the response. The role of the Ombudsman should be seen as a significant sign to the public of the importance of the Code, and the objectivity and thoroughness with which any complaints made about its operation will be investigated. (See pages 10 and 11 of the Code and Guidance paragraphs 10.5-10.8.)

1.4 The approach taken by NHS staff to the release of information under the Code should always be positive. The interpretation of the Code should be based on the assumption that information should be made available, unless it is exempt under one or more of the categories defined on pages 9 and 10 of the Code.

1.5 The first paragraph of the Introduction to the Code refers to 4 important documents:

- **Code of Practice on Access to Government Information**

  This applies to all Government departments, agencies and public bodies within the jurisdiction of the Parliamentary Commissioner for Administration. The Scottish Office, including the NHS in Scotland Management Executive, is covered by this Code.

- **Patient's Charter**

  The Patient's Charter: A Charter for Health, which was circulated widely to the NHS and the general public in September 1991, sets out the rights of patients and standards of service they can expect to receive from the NHS in Scotland.

- **Code of Practice on Confidentiality of Personal Health Information**

  The Code of Practice on Confidentiality of Personal Health Information, issued in June 1990, provides a framework for the handling of personal health information designed to protect its confidentiality other than with the consent of the patient or in certain specific circumstances.

- **Codes of Conduct and Accountability for NHS Boards**

  The Codes of Conduct and Accountability for NHS boards, were adopted by all Health Boards and NHS Trusts in 1994, and acceptance of their provisions is now a condition of appointment to an NHS board. They set out the basis on which board members and the organisations they lead fulfil the duties and responsibilities conferred upon them by the Secretary of State.

1.6 Ministers look to every NHS organisation to ensure that this Code is publicised widely, with specific reference to where local information can be found, and to whom a request for information should be made.

1.7 NHS staff must similarly be made aware of their organisation's obligations under the Code and that appropriate priority must therefore be given to meeting requests for information.

1.8 Each NHS organisation should establish, by its behaviour, good practice, and ability to respond to requests for information, that the Code is meaningful and important to the way it manages its services for the benefit of the public it serves. NHS organisations should not re-write the Code to meet local circumstances, but instead adapt appropriately their response under what is a national Code to meet the demands of their local public. This Guidance is intended to assist a consistent interpretation throughout Scotland (equivalent guidance is being issued in the other parts of the UK).

2. Scope

2.1 The following NHS organisations and practitioners in Scotland are governed by the Code:

Health Boards

NHS Trusts

Special Health Boards (Health Education Board for Scotland, State Hospitals Board for Scotland, Scottish Council for Postgraduate Medical and Dental Education)

Common Services Agency

Scottish Dental Practice Board

General Medical Practitioners (including GP Fundholders)

General Dental Practitioners

Community Pharmacists

Opticians (optometrists and ophthalmic medical practitioners)

Local Health Councils

The Mental Welfare Commission for Scotland has agreed to operate within the terms of the Code.

3. Aims

3.1 The aims of the Code are positive, plainly emphasising the responsibility of NHS organisations to ensure that people may easily obtain an understanding of all the services provided by the NHS, and particularly changes to those services that may affect them or their families.

3.2 Public concern about the need for disclosure is expected to be particularly strong where the information being requested may assist the understanding of an issue that is currently the subject of national or local debate, or where disclosure may improve understanding of the reasons for decisions and therefore the accountability of NHS organisations. The Code does not exclude requests for retrospective information - ie information about matters prior to 1 June 1995.

3.3 The Code does not provide for access to details of the process underlying the organisation's preparation of proposals. The right for space to deliberate and think in private is protected by exemption (see 'Internal Discussion' exemption on page 9 of the Code), except where failure to disclose would be considered to be outweighed by the public interest.

3.4 The Code is not designed for the purposes of assisting historical research for its own sake.

3.5 The Code does not require NHS organisations to obtain information they do not possess. While the emphasis of the Code is on access to available information, even where there is agreement to pay, NHS organisations do not have to go to great or expensive lengths to analyse, collate and print information which they do hold, but not in the form requested. Whether the offer of payment influences the decision is a local matter. There is a clear obligation on NHS organisations to publish, and regularly update, guidance on what information is available, and details of where people may obtain it (see page 5 of the Code).

4. General Principles

4.1 The intention of the Code is to encourage the practice of responding positively to all requests for information. Speedy, courteous responses to requests for information; comprehensive advice about what information is available and where it can be easily obtained; and the actual provision of the information requested in a well presented, understandable form; will all assist in establishing a climate of willingness to be open.

4.2 It is imperative that every NHS organisation appoints a named person to be responsible for the arrangements for implementing the Code locally (see page 8 of the Code).

4.3 Any refusal to respond to a request for information should refer specifically to the appropriate exemption (see pages 9 and 10 of the Code). There should always be a reason given for not providing the information requested.

4.4 The procedure for handling complaints relating to matters governed by the Code is not the same as that relating to patient care, because of the different nature of the decision making process involved.

- Complaints relating to patient care will continue to be handled under present complaints procedures which will remain in force until the new arrangements flowing from the Government's response in Scotland to the Wilson Committee Report are implemented from 1 April 1996. Further guidance will be issued in due course.

- The Code lays down a different procedure for dealing with complaints relating to problems of accessing information. There needs to be a simple and clearly understood mechanism for handling local complaints and concerns about any matters relating to the Code (see pages 10 and 11 of the Code).

4.5 It is for NHS organisations to decide how to monitor the effectiveness of their arrangements for managing the Code; see MEL(1995)31, which covers the publication of this Guidance.

5. Information Which Must be Provided

5.1 This section of the Code commits NHS organisations to make certain information available as a matter of course, and to be ready to release other information in response to specific requests, in a manner that is seen to be open and transparent.

5.2 The annexes to the Code give examples of good practice in providing information, and what information may be published. NHS organisations should recognise that the Code may raise expectations in the mind of the public that the examples of information cited will be made available on request. These examples are not exclusive.

5.3 While the Code is about access to information, not specific documents, it may often be simplest to provide an existing document, or it may be sufficient to advise the applicant of the title of a published document and where it may be obtained. Copies of whole documents may be provided if this is simplest. Where part of the information is restricted or confidential, it is reasonable to provide an expurgated version of the document.

5.4 The implications of the Code are that information to be provided about services should be comprehensive. The public should be helped to a knowledge of all the services that are available to them.

5.5 NHS organisations should be diligent and proactive in their communications with the public. It is important for NHS organisations to make clear any proposed changes to policies or the way services are delivered locally, and the reasons for these proposals. A clear distinction should be drawn between proposed changes, upon which views are being sought, and decisions on changes, where a clear statement of the reasons for the changes should always be available if an explanation has not already been publicised.

5.6 Health Boards and NHS Trusts have been issued with detailed advice in respect of their obligations to provide information about the way in which they manage local health services (see pages 12 and 13, and 17 and 18 of the Code).

5.7 All NHS organisations should support their Local Health Council by widely publishing the details of office location, personnel, and public meetings. Details of how the Health Service Ombudsman can be contacted should similarly be widely published, particularly in relation to local complaints procedures. It is good practice to display prominently appropriate leaflets and posters and their promotion and updating should, where possible, be the responsibility of one person in the organisation.

5.8 Information about how people may exercise their right to access their personal health records must be well publicised, alongside the fact that all NHS staff have a duty to keep a patient's health records confidential. (See pages 8 and 9 of the Code, and associated Guidance).

6. Response to Requests for Information

6.1 While the Code emphasises, as a matter of good practice, that there should always be a prompt response to requests for information, it also recognises that from time to time it may not be possible to meet the target date. Where the reason for delay is not a difficulty with the request itself, but an unexpected general pressure of work, then it would be appropriate for a summary of information or an interim response to be made, together with an explanation of why more time is needed to provide further details. Targets can legitimately be extended when significant search or collation of material is required, but the circumstances should be fully explained to the applicant in advance.

6.2 Reasons for refusing information need to be given in sufficient detail to explain the refusal adequately. If the information requested falls under an exemption the response should indicate which exemption category the organisation considers relevant, with any additional explanation which might be helpful. (See pages 9 and 10 of the Code.)

6.3 It is not sufficient for the organisation simply to publish the title of the individual who is responsible for the operation of the Code. It is important that a name, as well as title, contact address, telephone and facsimile numbers, are published widely. Most appropriately this should be done alongside the local publicity given to the Code itself.

6.4 The senior officer responsible for local implementation of the Code will be accountable to the General Manager/Chief Executive. Where the role is in practice to be delegated to a lower tier of management in the organisation, it is essential that this work is clearly carried out in the name of the nominated individual who is responsible to the General Manager/Chief Executive for implementing the Code.

7. Charging for Information

7.1 The intention of the Code is to encourage the availability of information to the public as part of the normal process of business and accountability of NHS organisations.

7.2 For example, information explaining the availability of services; quality standards of treatment; rights and entitlements, including information about making complaints about services; the reasons for administrative decisions made in a particular individual's case; should all normally be made available free of charge. There may be occasions when information requested causes additional work. In these cases it may be appropriate to make a charge.

7.3 The Code cites specific bodies that are excluded from being charged. Any charging should therefore be exceptional and is a matter for each NHS organisation to decide.

7.4 The Code specifies no charge for the first hour, and suggests a maximum charge of £20 for each whole hour thereafter. Provision of such information is exempt from VAT.

7.5 Charges should not exceed the additional cost to the organisation of the work created by the request, although some charge for on-costs may be included, but only up to the maximum charge. Organisations may ask for payment of the estimated charge before work is carried out, but should not charge more than the estimated amount without notice and without confirmation that the applicant is willing to make payment.

7.6 Organisations should take steps to record carefully the volume, time, and cost of work involved in a particular case for which a charge is to be made, since the exceptional nature of charging is likely to be an arena for complaint. Unreasonable charges are one of the matters on which the public may complain to the Ombudsman.

7.7 The Code can apply retrospectively, but it is not one of its prime intentions to be a means by which historical research can be assisted. While it does not exclude this purpose, there may be considerations of cost for the applicant. The Code refers (on page 9) to requests for information which are 'manifestly unreasonable', and to requests which may require 'unreasonable resources' to be diverted to obtain an answer. Nevertheless, it would be reasonable for information to be requested about past matters, where the events or issues are a matter of continuing public concern, or the request concerns some continuing injustice or matter which appears to need remedy.

7.8 The Code is not intended to obstruct requests for information to assist health related research and development projects, provided

the law relating to access to personal files and health records and to data protection, and the general principles of confidentiality, are complied with. There should be no barrier to the free-flow of information supporting the development of medical, dental, and allied sciences. Where evidence can be supplied in support of a bona-fide project which is being funded from public funds, approval should be given to access appropriate information, subject to any necessary approval by a research ethics committee. While the view of the researchers may be that there should be no charge where their project is being supported by public funds, nevertheless where an NHS organisation is required to carry out extra work caused by the request, then it would not be unreasonable for a charge to be made in accordance with the Code, provided this is discussed and agreed with the researcher in advance. (Guidance on matters relating to possible waiver of exemptions is given in association with the relevant section of the Code.)

8. Personal Health Records

8.1 This section applies also to all the Family Health Service Practitioners.

8.2 The principle that patients should be allowed to see what has been written about them has been well established. In addition to any informal arrangements, patients have statutory rights of access, subject to certain safeguards. The Data Protection Act 1984 gives patients right of access to information which is held about them on computer. Detailed guidance on the 1984 Act is available, free of charge, from the office of the Data Protection Registrar. The Access to Health Records Act 1990 gives a right of access to health records compiled on or after 1 November 1991 that are not kept on computer. People applying for access to health records may be charged a fee of £10, and the cost of postage and photocopying may be recovered. Separate guidance has been issued to the NHS in relation to both these Acts.

8.3 A Code of Practice on Confidentiality of Personal Health Information was issued in June 1990. This sets out the main principles which should be followed in maintaining the confidentiality of personal health information and is therefore a statement of good practice to which all involved in the NHS are expected to conform. It is supported by separate guidance covering various specific areas such as contracting.

9. Information Which May Be Withheld

9.1 The Code states explicitly that NHS organisations must provide the information requested unless it falls within one or more of the 9 exempt categories that allow information to be withheld.

9.2 There is however just as strong a duty on organisations to protect information which is properly exempt from release - including private personal information and commercially sensitive information, and to guard against inadvertent disclosure or unauthorised access - as there is under the rest of the Code to be positive in providing access to information.

9.3 It is recognised that decisions on disclosure will require judgement and discretion. Because the Code is not statutory, it cannot set aside restrictions on disclosure which are based in law. These will include those statutory provisions restricting disclosure which leave no discretion to disclose in the public interest. Where there is a duty of confidentiality this will also apply, unless that duty has been overridden by a court or because a statute requires it, or because the obligation of confidence has been waived by the person to whom that confidence is owed.

9.4 There is no intention in the Code to change the present arrangements by which the courts decide what disclosure is necessary in the interests of justice in criminal and civil proceedings.

9.5 Where an exemption refers to 'harm' or 'prejudice' it is not necessary to prove that actual harm or prejudice is certain to result from disclosure: risk - or reasonable expectation - of harm can be taken into account. The weight to be attached to risk depends on the nature of the harm that could occur. Where harm arising from disclosure could be extremely serious - for example with certain security risks - it would not be necessary to show that harm is likely to occur to take it into account. Where risk is neither likely nor grave, it should be given less weight. 'Reasonable' may be taken to mean 'not irrational, absurd, or ridiculous'.

9.6 The public interest in disclosure cannot always be decided solely on the basis of the effect of a specific disclosure. The exemption excluding disclosure which would harm 'frank internal debate' is based on the general need for assurance that such discussion will be private, and not primarily on whether disclosure of a particular piece of information would cause harm. Where any of the exemptions refer to 'harm' or 'prejudice' it should be considered whether any 'harm' or 'prejudice' arising from disclosure is outweighed by the public interest in making the information available.

9.7 Exemptions should not be interpreted in a way which causes injustice to individuals. The Code should not be interpreted in any way which undercuts the existing functions of the Ombudsman in investigating maladministration leading to injustice. Where the Ombudsman would be unlikely to find that failure to give particular information amounted to maladministration causing injustice, nothing in the Code restricts his ability to reach such a finding.

Personal Information

9.8 The Code of Practice on the Confidentiality of Personal Health Information provides the framework in Scotland for issues surrounding the maintenance of confidentiality of such information. Existing legislation gives people a right of access to their own health records, but not to information about others. This exemption relates to individual privacy. It is separate from considerations of confidentiality - commercial or otherwise - of firms, institutions and organisations, but has links with general confidentiality covered by the 'Confidential Information' exemption.

9.9 This exemption may be overridden, and information may be provided, when the subject of the information has given consent to its disclosure, preferably in writing, or because of a statutory requirement, or a court order.

9.10 This exemption relates to any information held concerning the personal affairs of an individual, whether that information has been obtained from the individual or from another source. If information is confidential, then it remains as such unless there is some justification for its disclosure. Even where disclosure would not cause harm, if that information is confidential - and there is no justification - any disclosure would in fact be a breach of confidence. However, it only applies to information which identifies an individual, and can readily be associated with that person.

9.11 This exemption relates not only to information which is provided on an explicit condition of confidentiality, but also information provided in circumstances where there is a reasonable expectation or assumption of confidentiality.

9.12 If the subject gives consent, and no other exemptions come into play, there should be no bar to releasing the information. However, if the subject objects to the release of the information, this can only be overridden where the public interest outweighs that of the individual, or there is a requirement by statute or a court. While there may be possibility of public interest considerations overriding those of privacy these will be extremely rare, and will relate mainly to national security, public safety, the protection of health, or to the protection of the rights and freedoms of others (see Code of Practice on Confidentiality of Personal Health Information). Legal advice should be sought in these circumstances.

9.13 Information relating to a deceased person is equally confidential and private, and must be treated as such. It should be subject to the need for care where a statutory guarantee of confidentiality applies, for example the hundred year rule relating to confidentiality of Census returns. There are exceptional circumstances where personal information should not be disclosed, even on occasions to the subject: guidance associated with the Access to Health Records Act 1990 and the Data Protection Act 1984 provides advice on this.

9.14 In operating this exemption there are a number of judgements that need to be made, particularly where the motives of the third party seeking the personal information are not clear. For example:

- information should not automatically be given to relatives, even in cases of deceased persons; proof of executorship may also be necessary;

- enquiries by the police, where careful thought has to be given as to whether it is appropriate to release information in the public interest, to assist the police in their duties;

- information being sought by the media and public bodies should be protected unless specific consent has been given by the individual;

- information about an individual being sought by friends and the wider family should also be protected, unless specific consent has been given by the individual; the conventional practice of providing reports over the telephone to close members of the family needs to be handled with care, so as not to break confidence to unauthorised persons inadvertently.

Unreasonable Requests

9.15 There are 2 strands to this exemption. The first relates to the amount of information being sought, and the second to difficulties involved in identifying, locating, or collating the information requested.

9.16 In each case, the test should be whether these factors would mean that meeting a request for access would require an unreasonable diversion of resources, or otherwise undermine the work of the organisation: for example that staff have to be diverted for a large amount of time from what is considered to be more urgent work relating to the purposes of the organisation. Even where an applicant agrees to cover the full costs of providing a voluminous amount of information, it might still be reasonable to reject it on the grounds that the diversion of staff resources from other important work is unreasonable. The same consideration might apply where repeated requests are made by the same person, which in total amounted to an unreasonable diversion of resources.

9.17 'Manifestly unreasonable' requests would include those which are framed in such a way as to request access to a very large volume of information, or that are so general as to make it difficult to identify the information sought. NHS organisations should positively assist applicants to focus their request more narrowly and help clarify what information is really required.

9.18 Access may be refused where the information requested is difficult to identify or locate. This may be because finding it would require extensive searches in historical files, or because the information is physically not easily accessible, or because it would require a significant amount of processing before it could be released. A related problem arises when an unreasonable degree of effort would be required to collate the information requested. Organisations are not required to carry out what may amount to research work, but may be able to give access to raw research data if this can be done without risk of exposing exempt material.

Internal Discussion and Management Information

9.19 The 'Planned Publication' exemption should be studied in conjunction with this exemption.

9.20 The Code is not intended to change or undermine long established conventions for protecting the confidentiality of internal decision-making processes.

9.21 There is an important distinction between the process by which a decision or policy has been reached, which remains confidential, and the explanation of the basis of the decision once reached, which

should be given as fully and openly as possible. The Code recognises that there is a place for private deliberation in coming to an agreed position or in developing proposals. This should be seen as quite separate from the obligation placed on Health Boards to consult on policy options and proposals for change, for which there is existing guidance.

9.22 The justification for retaining the confidentiality of internal deliberations, opinions, advice and recommendations, is the need to ensure that matters can be discussed candidly and frankly, and that, even where a full record is kept, this can be done without taking into account the possibility of later publication. It is not intended that internal opinion should be published. It is recognised that disclosure could undermine candour and frankness. The Government's White Paper on Open Government (paragraph 3.14) explains the reasons for retaining confidentiality of internal deliberation and advice.

9.23 This exemption should however not be seen as providing the reason for refusing to publish analyses of alternative and rejected options. It is a matter of judgement in particular circumstances as to whether it is in the public interest for the alternatives that have been explored to be published. There is no obligation to do so.

9.24 This exemption should not be seen to justify withholding expert advice, especially where its availability will enhance public debate and understanding of the issues. It might, in the public interest, be important that such advice should be open to peer assessment. It would be possible for the Ombudsman to be asked to investigate complaints concerning refusal by an NHS organisation to disclose the expert advice on which they had relied.

9.25 The annexes to the Code describe for NHS organisations the management information that is obligatory and of good practice to publish or have readily available on demand. While General Managers/Chief Executives and their boards have some discretion on these matters, the citing of this category of exemption will need to be approached with caution. Bearing in mind the intention of the Code that NHS organisations should make it easier for people to access a greater range of information, and be helped to contribute to the planning and provision of health services, the public interest factor may be seen to outweigh specific objections.

Legal Matters

9.26 The Code does not circumvent or modify existing rules or practices of disclosure in legal proceedings. The exemption is designed to protect the integrity and effectiveness of legal proceedings, including those in the civil and criminal courts, proceedings before tribunals, and certain other formal proceedings of inquiry or investigations - including planning inquiries, investigations into regulatory areas, or accident and disaster inquiries.

9.27 Pressure may arise to publish the outcome report of an internal inquiry, particularly if it is known that a 'report' has been prepared. Attention must be paid to protecting the confidentiality of individuals involved. Publication may also be prejudicial to

subsequent disciplinary or legal proceedings. It will be necessary to balance the information released in the public interest against any of these factors. (See paragraphs 9.8-9.14 and 9.25 of this Guidance.)

Personnel Management and Commercial Activities

9.28 This exemption does not apply to the release of information concerning NHS internal market contracts, as defined in Section 17A of the NHS (Scotland) Act 1978 as amended by Section 30 of the NHS and Community Care Act 1990. However, this exemption does apply to contracts with non-NHS providers, who should be treated in the same way as any other private sector supplier.

9.29 The management of personnel and assessment of staff may entail withholding information. The test should be whether disclosure would prejudice effectiveness or efficiency, or breach proper undertakings of confidentiality. Although personnel records are exempt, this does not in any way exclude good management practices, such as the disclosure to individual staff of their annual performance reports, and ensuring openness and transparency in the process of recruitment and promotion. Nor does the exemption exclude access being made available to third parties in exceptional circumstances, where the balance of public interest or natural justice requires it: for example:

- information with implications for safety;
- accident reports;
- information, provided in an anonymised or statistical form, for the purposes of monitoring or reviewing non-discrimination policies.

9.30 The exemption also applies to information concerning individuals holding, or being considered for, appointments by the Secretary of State.

9.31 There should always be a general presumption of openness and transparency on the part of an NHS organisation conducting a tendering process. Commercial good practice, while welcoming openness, demands some confidentiality to preserve the business interests of competing companies and to protect the position of the NHS organisation in current or future tendering activities. Nothing in the Code therefore requires NHS organisations to prejudice the legitimate commercial confidences of tenderers and contractors. Care must be taken, when considering disclosing commercially sensitive information, to ensure the NHS organisation's reputation as a client, and taxpayers' interests, are protected.

9.32 Where an NHS organisation is involved in commercial trading activities, information may be withheld which would damage the organisation's own competitive position. Plans for the acquisition or disposal of land, for example, could fall within this exemption, if advance knowledge might encourage speculation or raise prices. The need for commercial confidentiality should be assessed stringently, and balanced against the general presumption of openness when public money is at stake.

9.33 Transparency of costs and performance specifications is an important objective of the Government's public service reforms. It serves to expose the costs of particular functions and services, so that value for money can be assessed to promote improvements in management, reduce the risk of fraud and corruption, and generally enhance accountability. Internal markets and market testing should not lead to false commercial confidentiality requirements, which may be used to restrict the spread within the public sector of improved methods or applications, even though there may be an initial comparative advantage to the organisation which has made the development.

9.34 Competitive tendering should not lead to any loss of public accountability for public service, or loss of transparency in the spending of public money. The following information should normally be made public:

- the range of tender bids, where 3 or more are received;
- the identity of the successful tenderer (by agreement with tenderer);
- the nature of the job, service, or goods supplied;
- performance standards;
- the criteria for award of contract;
- the winning tender price (by agreement with tenderer);
- the general contract terms and conditions.

9.35 There may be circumstances where an NHS organisation is right not to disclose the winning tender price, on the grounds that it might prejudice future tendering exercises. It may on occasions also prompt unsuccessful tenderers, whose bid for example might have been at a lower figure, to ask why they were not chosen. In these cases the distinction between the lowest bid and the best value for money should be outlined in debriefing of unsuccessful tenderers.

Confidential Information

9.36 Many organisations are in possession of information, opinion, or advice which has been given by members of the public - whether as individuals, companies, or organisations - in the expectation that the information supplied will be kept confidential. Much of this would be personal information, or commercially sensitive material, in which case the relevant exemptions will apply. (See paragraphs 9.8-9.14 and 9.28-9.35 of this Guidance.)

9.37 The duty of an NHS organisation to maintain confidence is not an absolute one. It can be overridden by statute, consent, or where a court determines that the public interest favours disclosure.

9.38 There must be an understanding by both sides that the information that has been supplied and received is to be kept confidential, and the recipient should make it clear that it is being received on this basis. This mutual understanding may be explicit,

particularly where a contract is involved, but often it will be implied from the circumstances without either party expressly referring to the matter.

9.39 A professional relationship may often imply confidentiality: for example the relationship between doctor and patient, social worker and client, lawyer and client. Patients and clients have an expectation that information relating to their health care, treatment, and personal circumstances are kept confidential. There is in any case a duty, which applies to all staff in the NHS, to keep personal health information confidential. (See paragraphs 8.1-8.3 and 9.8-9.14 of this Guidance.)

9.40 This exemption cannot be used where the information is generally known, or where it is contained in a public register or other document open to inspection by the public.

9.41 All employers or prospective employers may seek views on a person's medical condition to assess their fitness for a particular job. The Access to Medical Reports Act 1988 gives the subject of a report made by a medical practitioner for employment purposes a right to see it. One of the 2 exceptions allowed by this Act is that information can be withheld from the subject of that report if its disclosure would harm the health or welfare of the subject. The author of a medical report may sometimes be reluctant for the report to be provided direct to the subject, not because the content is intrinsically injurious, but because there is a risk that it might be misunderstood if offered without supporting medical explanation or advice. Organisations are not obliged under the Code to provide the original report, but they can have the report recast in an accessible way. Reports can also be made available to the subject through a third person with relevant medical expertise, perhaps their GP, who can interpret appropriately to the subject. The Act does not provide for access by a third party.

9.42 It is important to stress that the public interest in disclosure must clearly override that interest in preserving the confidentiality. For example, disclosure might be envisaged where there would be some serious breach of the law or other wrongdoing, or exposure of a significant risk to public health or to the environment or public safety. Other than in exceptional circumstances, the person or body concerned should be consulted, or at least informed, and legal advice should be sought.

Planned Publication

9.43 NHS organisations are committed to provide information on their own account, without waiting for access requests. The general purpose of this exemption is to avoid damaging existing mechanisms for providing information, which are often the most cost-effective way of meeting a regular demand for particular types of information

9.44 Information which is soon to be published need not be provided under the Code. The applicant should be informed of the position, and given an indication of the expected publication date. How far ahead an announcement or publication is planned should not be decisive. If this exemption is to be exercised, it would normally be appropriate to provide evidence that release of the information being

requested before the planned date would diminish its impact; or would not be appropriate because of some particular sensitivity; or some other factor - such as the need to assemble all the facts and have all the appropriate agreements in place - which would make earlier disclosure undesirable.

Incomplete Information

9.45 This exemption has some overlaps with the previous exemption (paragraphs 9.43-9.44 of this Guidance). In general, analysis, research information, and statistics should be made available under the Code. Indeed it is assumed that such information will often be volunteered as part of regular reports and policy announcements by an organisation. This exemption however recognises the difficulties of releasing incomplete information, particularly where it could lead to confusion or a misleading impression.

9.46 Information may be misleading in the sense that it would give a one-sided version of a particular case. It is for organisations to decide whether this type of information should be released on a discretionary basis, and whether the information is accompanied by a statement explaining where it is defective.

9.47 Where the preparation of the data is incomplete, or has been aborted, or where there has been a diversion of resources which has not allowed an exercise to be completed, then it would be reasonable for this exemption to be exercised. A full explanation should always be given to the applicant.

9.48 The concept of 'priority of publication' is intended to protect information due to be published by a public body, where that body wishes to retain copyright, including information to be published as a result of research, where importance would be attached to the particular individual or organisation who publishes it first.

9.49 This exemption is related to the 'Confidential Information' exemption (paragraphs 9.36-9.42 of this Guidance) insofar as it is designed to protect information held by organisations which act in a commercial manner, and where revealing the information would damage the organisation's commercial position. This more narrow exemption should only be invoked where disclosure would affect a planned use of the information at issue for commercial gain. For example, gaining access to an organisation's research work could prejudice the plan to sell the information to customers or to use it in a future consultancy capacity. (See paragraphs 9.28-9.35 of this Guidance.)

10. Complaining About the Provision of Information under this Code

10.1 The handling of complaints should be sympathetic, thorough, and sensitive. The period of '3 months' should not be interpreted rigidly to the exact day. Since the Code provides no similar period by which time a complaint must be made to a General Manager/Chief Executive, it would be advisable to use a similar period, but not prescriptively. The Ombudsman will not normally consider a complaint if it is made more than a year after the cause for complaint first arose, although he does have discretion to set aside this provision if he thinks it reasonable to do so.

10.2 Where there is likely to be delay in responding to a complaint, for whatever reason, an interim response, explaining the nature of the difficulties in giving a full response, should be sent to the complainant.

10.3 Health Boards and NHS Trusts may wish to consider introducing their own review mechanism, involving a non-executive director, in order to provide the General Manager/Chief Executive with a wider perspective when responding to a complaint.

10.4 Where a situation arises in respect of a complaint against a Local Health Council about the withholding of information, every effort should be made to resolve the complaint locally. Local Health Councils may wish to consider involving a nominated member in the review mechanism.

10.5 The Code makes it clear that complainants may take their complaints to the Ombudsman if they remain dissatisfied. The Code places an obligation on NHS organisations to publicise clearly how this can be done. Subject to paragraph 10.6 below, the Ombudsman has discretion to investigate any complaint about non-disclosure under the Code, or related matters. These may include requests relating to matters about which he could not otherwise investigate: for example, a complaint about non-disclosure of information about a contractual, or other commercial matter, if it was questionable whether the 'personnel management and commercial activities' exemption of the Code applied.

10.6 The Code explains that the Ombudsman does not investigate complaints about the withholding of information by GPs, dentists, community pharmacists, opticians or Local Health Councils. Where complainants remain dissatisfied with the initial response to their complaints about the withholding of information by GPs, dentists, community pharmacists or opticians, Health Boards should make every effort to resolve the complaint locally, and may want to consider the review mechanism outlined above. (See Guidance paragraph 10.3.)

10.7 The Health Service Commissioner's statutory remit is defined by the Health Service Commissioners Act 1993 and summarised in the information leaflet, The Health Service Ombudsman for Scotland - How the Health Service Ombudsman can help you, published by his Office.

10.8 The Ombudsman has written to all NHS bodies within his jurisdiction about his role in investigating complaints about non-disclosure of information under the Code (also issued under cover of MEL(1995)31).

11. Implementation of the Code of Practice

11.1 NHS organisations have been asked to set up the procedures necessary to meet the requirements of the Code with effect from 1 June 1995, including:

- publicising the intentions of the Code;

- identifying a named individual accountable to the General Manager/Chief Executive for local arrangements;

- publicising local arrangements for implementing the Code;

- publicising where to apply for information;

- publicising the procedure for handling local complaints relating to the Code;

- briefing board members and staff on the organisation's obligations under the Code;

- reviewing the organisation's procedures to meet its obligations under the Code.

11.2 MEL(1995)31, under which this Guidance is issued, suggests possible monitoring arrangements.

Directorate of Corporate Affairs
NHS in Scotland Management Executive
June 1995

Office of the Health Service Commissioner for Scotland

(Ombudsman)

Ground Floor
1 Atholl Place
Edinburgh EH3 8HP

Telephone: 0131-225 7465
Fax: 0131-221 1940

also at 11th Floor
Millbank Tower
Millbank, London SW1P 4QP

Telephone: 0171-217- 4001
Fax: 0171-217-4000

Please reply to Edinburgh/~~London~~

To:
General Managers of Health Boards
Chief Executives of NHS Trusts
General Manager of the Common Services Agency
General Managers of Special Health Boards

Copy To:
The Chief Officers of Local Health Councils

5 June 1995

Dear Chief Executive/General Manager

Code of Practice on Openness in the NHS

1. The Code of Openness in the National Health Service (NHS) in Scotland comes into effect from 1 June 1995. I understand that copies of the Code were sent to you on 25 May and that guidance on its implementation was sent to you on 5 June under cover of NHS MEL(1995)31.

2. Complaints about refusals or delays in providing information under the Code will now come within the range of NHS complaints I investigate.

3. The Code indicates that Health Boards and NHS Trusts will provide, to those who remain dissatisfied after they have taken a grievance about the outcome of a request made under the Code to the appropriate Chief Executive or General Manager, details about how to take their complaint to me though it does not mention my address which is at the head of this letter.

4. This letter and the procedural note enclosed sets out how I intend to tackle this new responsibility (which parallels a similar responsibility I have as Parliamentary Commissioner for Administration to investigate complaints about alleged failures by Government Departments to comply with the Code of Practice on Access to Government Information, published last year). I hope it will help you in providing advice to members of the public and in your own handling of any complaints concerning your organisation which are referred to me. I shall also be publishing shortly a revised leaflet about my Office, entitled 'How the Health Service Ombudsman can help you', and it will refer to complaints relating to the Code.

Legal Basis

5. The legal basis for my investigations and reports about complaints related to the Code is the same as for other complaints within my jurisdiction. It is set out in the Health Service Commissioners Act 1993 (the Act). The key provisions governing my powers and actions, and their application to my procedures, are explained in the Annex to this letter.

What complaints would I accept for investigation?

6. Until now I have been prepared in principle to investigate complaints about denial of access to information only where the complainant could show that the denial appeared at first sight maladministrative or a failure of service and had led to some injustice or hardship to the complainant. The commitment to openness in the Code, and its indication (section 9) that 'NHS authorities and Trusts must provide the information requested, unless it falls within one of the exempted categories', means that I shall in future consider a failure to release information which, prima facie, may be disclosable under the Code as grounds for an investigation.

7. I may also investigate complaints about delays in providing information, or about the handling of such complaints or levels of charges for providing information.

8. As the Code provides for persons dissatisfied with the initial response to their request to complain to the Chief Executive of the appropriate Trust or Board, I shall not normally accept a complaint related to the Code unless it has first been put by the complainant to the Chief Executive or General Manager and a reasonable time allowed for a reply to be sent.

9. The Code explains that I do not investigate complaints about the withholding of information by family doctors, dentists, pharmacists and opticians. That is because, at present, the services which family practitioners provide for the NHS fall outside my jurisdiction. Although the Government has announced proposals for my jurisdiction to be extended to include these services, primary legislation will be needed. The Code also explains that I do not investigate complaints about the withholding of information by Local Health Councils (paragraph 10 of the Code).

10. Subject to the exclusions in the Code to which I have referred, I may exercise my discretion to consider any complaint about non-disclosure under the Code or delay or other matters relating to the handling of the request.

11. Such complaints may include requests for information about matters in respect of which I could not otherwise accept complaints for investigation.

12. For example, I am prevented by the Act from investigating complaints in respect of matters relating to contractual or other commercial transactions (except for matters relating to NHS contracts and contracts between a health service body and a non-health service body for the provision of services to patients - section 7 (2) of the Act). That exclusion will not operate to fetter my discretion to investigate complaints about non-disclosure of information about commercial contracts or transactions, for example, if I believed that, prima facie, the exemption in section 9(vi) of the Code might not apply in the case in question. It will not prevent me investigating complaints about failure to provide information about services to patients delivered, on behalf of a NHS authority, by non-NHS contractors.

Time Limits

13. Complaints which I accept for investigation will be brought to the notice of the health service body, in the same way as happens under my current jurisdiction. As the complainant

will already be known to the body concerned I shall be seeking replies to my initial letter to the relevant Chief Executive or General Manager within three weeks.

14. My letter will include a request for all the papers relating to the complaint, including the information sought by the complainant, by the end of the three week period. As with all the complaints I investigate, I require **the originals of all documents** (which will be promptly copied and returned).

15. My aim will be, with the assistance of Trusts and Boards, to complete all investigations I undertake into complaints relating to the Code within three months of the complaint being referred to me.

Arrangements in my Office

16. To prepare for and deal with this new work, and further work if Parliament approves the Government's proposed extension of my responsibilities to cover complaints related to family practitioner services and to clinical judgment, I have enlarged my staff. Complaints related to the Code of Openness will be handled by a new Directorate headed by Mr Clive Wilson in my Office in Millbank Tower, Millbank, London SW1P 4QP, (tel. no. 0171 217 4001) working to Mr Richard Oswald, Deputy Health Service Commissioner (Policy). That Directorate will be fully in touch with my office in Edinburgh.

Review

17. There will be a review of the operation of investigations related to the Code within the next two years. In the meantime I shall be glad to receive any comments from Chief Executives or General Managers based on their experience of operating the Code and responding to any investigations I may undertake.

Further information

18. I hope you will find it helpful to have this indication of how I intend to discharge my responsibilities in relation to the Code. If you have any queries or requests for further information please contact my staff as in paragraph 16 above.

Yours sincerely

William Reid

ANNEX

CODE OF PRACTICE ON OPENNESS IN THE NHS

Note by the Ombudsman

1. This note explains how the Health Service Commissioner (the Ombudsman) will handle investigations into complaints that health service bodies subject to the Code of Practice on Openness in the NHS have not observed the provisions of that Code.

2. The Code was issued to health service bodies in Scotland to which it relates on 25 May 1995. Guidance on implementing the Code was issued under cover of NHS MEL(1995)31 on 5 June.

3. Investigations will be carried out in accordance with the provisions of the Health Service Commissioners Act 1993 (the Act). This note does not describe the full provisions of that Act, nor does it bind or fetter the discretion of the Ombudsman in respect of the way in which he discharges his functions under the Act.

4. The Ombudsman will follow broadly the same procedures as for other complaints which he investigates under the Act.

(i) where he proposes to investigate a complaint about non-observance of the Code he will give the health body concerned, and any other person who is alleged to have taken or authorised the actions complained of, an opportunity to comment on any allegations contained in the complaint (section 11(1) of the Act);

(ii) where the health service body has refused to provide the information requested he will expect the body to tell him which of the exemption provisions of the Code it regards as justifying its decision, and to have the relevant considerations explained to him;

(iii) he will expect the health service body to provide him with information and documents relevant to the investigation, as required under section 12(1) of the Act;

(iv) no obligation to maintain secrecy or other restrictions upon disclosure of information, whether imposed by an enactment or any rule of law, will apply to the disclosure of information for the purpose of an investigation (section 12(3) of the Act); and the Crown will not be entitled to any privilege in respect of the production of documents or the giving of evidence as is allowed by law in any legal proceedings (sections 12(3) and (4) of the Act;

(v) the Ombudsman has full discretion to set out the facts of the investigation, to explain his reasons for finding maladministration or failure in service (if he upholds the complaint), to analyse and comment upon any disputed points about the interpretation of the Code, to recommend what information should be published, to criticise the health service body (if appropriate), and otherwise to provide a full report on his investigation in accordance with his powers under the Act;

(vi) the Ombudsman will send copies of reports of the results of his investigation to the health service body or bodies concerned and to any person who is alleged in the

complaint to have taken or authorised the action complained of. For the time being, where the health service body is not a District Health Authority a copy will also be sent to the Secretary of State (section 14(1) of the Act);

(vii) at present, where maladministration or failure in service has led to unremedied injustice, the role of the Ombudsman is to recommend redress, but the giving of redress is normally a matter for the health service body; where that body accepts that maladministration or failure in service has occurred - and even in those cases where it does not accept that charge - it is often possible for redress to be provided before the full process of investigation and report has been completed. By analogy, in cases relating to the Code of Practice a health service body may similarly be able to provide information to the satisfaction of the person making a complaint once the Ombudsman has indicated that he is going to investigate or during the course of an investigation. In cases where the information in dispute has not been so provided by the health service body the Ombudsman (in the light of sub paragraph (ix) below) will not normally look to provide the redress himself by disclosing the disputed information in his reports; if exceptionally he were minded to do so, he would first of all inform the health service body;

(viii) section 16 of the Act confers on Ministers a power to give notice in writing to the Ombudsman with respect to any document or information or class of documents or information specified in the notice, that disclosure "**would be prejudicial to the safety of the state or otherwise contrary to the public interest**" and where such a notice is given nothing in the Act shall be construed as authorising or requiring the Ombudsman or his staff to communicate to any person or for any purpose any document or information specified in the notice, or a document or information of a class so specified. Indiscriminate use of section 16 could inhibit the ability of the Ombudsman to carry out effective review of complaints relating to the Code. Without fettering the discretion of Ministers to use this power if the circumstances so demand, or of the Ombudsman to carry out his functions under the Act, he does not envisage that health service bodies or the Ombudsman will act in such a way as to make the use of section 16 the usual means of resolving differences of opinion. Normally the Ombudsman will make reasoned recommendations in his report without the specific information which is in dispute thereby being disclosed. Health service bodies will be accountable to Ministers for the actions taken or refused in the light of the Ombudsman's recommendations in the same way as they are for other decisions they take in the discharge of their functions;

(ix) the report mentioned in the second last sentence of (viii) may be:

> (a) the report of the results of the investigation the Ombudsman is required to send to the complainant and others (section 14(1) of the Act); or
>
> (b) the special report that may be made as the Ombudsman thinks fit under section 14(3) of the Act if, after conducting an investigation, it appears to him that injustice or hardship has been caused to the person aggrieved in consequence of maladministration (in these cases usually by a failure to provide information) and that the injustice or hardship has not been or will not be, remedied; or

(c) the annual and other reports made under section 14(4) of the Act.

(For the purpose of the law of defamation, all such reports are absolutely privileged).

(x) Once a report under section 14(3) or 14(4) has been laid before Parliament, it is then a matter for the House, or more usually in the first instance the Select Committee on the Parliamentary Commissioner for Administration, to consider that report and the action to be taken in the light of it.

5. The operation of these procedures will be reviewed in the light of the experience gained of them within 24 months of the coming into force of the Code of Practice.

June 1995