

ACCESS TO HEALTH RECORDS POLICY & PROCEDURES

Version 2.0

Purpose:	To advise and inform all Trust staff of Access to Health Records Policy and Procedures
For use by:	All Trust staff
This document is compliant with /supports compliance with:	Data Protection Act 1998 Freedom of Information Act 2000 Access to Health Records Act 1990 Trust Records Policy
This document supersedes:	Access to Health Records Policy v1.0
Approved by:	Information Governance Group
Approval date:	4 February 2009
Ratified by:	Trust Management Team
Date Ratified:	9 February 2009
Implementation date:	23 March 2009
Review date:	1 March 2012
In case of queries contact: (Responsible Officer)	Information Governance Manager
Directorate and Department:	Information, Information Governance
Archive Date: (ie date document no longer in force)	<i>To be inserted by Information Governance Department when this document is superseded. This will be the same date as the implementation date of the new document.</i>
Date document to be destroyed: (ie 10 years after archive date)	23 March 2019

Version and document control:

Version number	Date of issue	Change Description	Author
0.1	January 2008	First draft	IG Manager
0.1		First approved version	IG Manager
1.0		First ratified version	IG Manager
1.1	January 2009	Review and update	IG Manager
1.1	4 February 2009	Approved by IGG	IG Manager
2.0	9 February 2009	Ratified by TMT	IG Manager

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SECTION 1 - INTRODUCTION

1.1 Policy Statement and Rationale

As a prerequisite for complying with standards of the Connecting for Health Information Governance Toolkit standards (standard 205), the Data Protection Act 1998 (DPA), the Access to Health Record Act 1990 (AHRA), and the Freedom of Information Act 2000 (FOIA), this document sets out the Trust's policy and procedures to be followed in relation to requests from patients to access their health records, or requests to access the health records of a deceased patient.

1.2 Key Principles

- All data subjects, or in certain circumstances someone acting on their behalf, can request a copy of their personal data held by the Trust.
- Requests from patients, their family, agents or other parties for copies of patient health records must be made in writing to the Access to Health Records Team.

1.3 Definitions

- AHRA - Access to Health Records Act (1990)
- DPA - Data Protection Act (1998)
- FOIA - Freedom of Information Act (2000)

1.4 Background Information

1.4.1 The DPA governs access to both computerised and manual health records of living people.¹ It gives people the right to access information held about them by organisations and outlines eight data protection principles governing how organisations can use the personal information that they hold - including how they acquire, store, share or dispose of it.

1.4.2 The DPA is not confined to health records held for the purposes of the National Health Service (NHS). It applies equally to the private health sector and to health professionals' private practice records. It also applies to the records of employers who hold information relating to the physical or mental health of their employees if the record has been made by or on behalf of a health professional in connection with the care of the employee.

1.4.3 The DPA became effective from 1st March 2000, and superseded the Data Protection Act 1984 and the AHRA, though the AHRA still governs access to the health records of deceased people.

1.4.4 All manual and computerised health records about living people are accessible under the Data Protection Act (DPA) 1998. If a request for someone's own personal information is received by the Trust as a Freedom of Information request, it will fall under FOIA exemption Section 40(1): Personal Information and the applicant will be sent an FOIA refusal notice within 20 working days, and advised to make a Subject Access Request under the DPA.

1.4.5 Requests made by a third party for the records of another living person fall under the FOIA and are protected from release under FOIA exemption Section 40(2): Personal Information. In these cases, the subject of the data requested must give written consent for its release to the applicant.

¹ <http://www.dca.gov.uk/foi/datprot.htm>

- 1.4.6 Requests for records of deceased patients are diverted from the FOIA to the Access to Health Records Act 1990 by means of the FOIA exemption Section 21: information available by other means.² (Proof of entitlement to access the records will be required from the applicant.)
- 1.4.7 If the Trust is refusing a request for access to health records, the Access to Health Records Team must issue a refusal notice within 20 working days (in accordance with FOIA) and state which FOIA exemption the Trust is using and why. The applicant must also be given an indication of how to complain (Section 17(1) of the FOIA).

SECTION 2 – DUTIES AND RESPONSIBILITIES

2.1 All Trust staff

All Trust staff should forward requests for copies of patient health records to the Access to Health Records Team, managed by the Information Governance Manager.

2.2 Sexual Health staff

Sexual Health staff are responsible for the following:

- Forwarding requests for copy records to the Access to Health Records Team
- Copying the patient health notes
- Forwarding the copied notes to the Access to Health Records Team together with signed consent from the Sexual Health Consultant for release of the copy records.

2.3 Diagnostic Imaging Directorate Administrator

The Diagnostic Imaging Directorate Administrator is responsible (if the request is for x-rays only) for logging the request in a database and organising copies. The Access to Health Records Team logs any incoming requests it receives for x-rays only in its database and forwards the request to the Diagnostic Imaging Directorate Administrator for the x-ray request to be dealt with by Diagnostic Imaging.

2.4 Human Resources

If a member of staff requires a copy of his/her personnel data, the request should be made directly by the member of staff to Human and Corporate Services. The Access to Health Records Team does not get involved with these requests.

2.5 Occupational Health

If an individual requires access to his/her Occupational Health records, the request should be made to the Occupational Health Systems Co-ordinator. The Access to Health Records Team does not get involved with these requests.

2.6 Clinical Staff

Before copies of any health records are released to private individuals, the clinicians in charge of care of the patient who is the subject of the access request must check the copy records to remove information that may be harmful or distressing, and sign to authorise release. (This does not apply to copy records sent to solicitors, insurers, or government agencies.)

- 2.7 The Lead Director for this Policy is the Director of Information Management & Technology.

² BMA – Access to health records by patients www.bma.org.uk/ap.nsf/content/accesshealthrecords

- 2.8 The Responsible Officer for this Policy is the Information Governance Manager who is ultimately responsible for monitoring compliance with the contents of this document and for reviewing it after 3 years.
- 2.9 The Information Governance Group will approve this document and is responsible for monitoring compliance with and the effectiveness of this guidance and agreeing any remedial action. The Trust Management Team will ratify this document.

SECTION 3 – ACCESS TO HEALTH RECORDS POLICY & PROCEDURES

3.1 Entitlement to Personal Data

- 3.1.1 Individuals are entitled to apply for access to their total health record as it stands at the time the request was received. The information provided may, however take account of any amendment or deletion which is made to the record in the period between the request having been received and dealt with, being an amendment or deletion that would have been made regardless of the receipt of the request.
- 3.1.2 Individuals have a right to apply for access to records irrespective of when they were compiled. Whereas the Access to Health Records Act 1990 (which relates to deceased patients records) does not provide individuals with a statutory right of access to records compiled prior to November 1991, under the Data Protection Act 1998 (which relates to living patients records) there is no such limitation.
- 3.1.3 An individual who makes a subject access request is entitled to:
- be told by the Trust whether any personal data is held about him/her, and
 - be supplied with a copy of the information that forms any such personal data.
- 3.1.4 A request to access patient records must be made in writing to the Access to Health Records Team, by using one of the following methods:
- Letter
 - Fax
 - Application Form provided in the Trust booklet 'Our Responsibilities under the Data Protection Act 1998 And How You Can Access Your Health Records'.

Email applications are not accepted, as an email address does not prove identity and signed consent must be provided in any case.

- 3.1.5 The applicant has the right to:
- Obtain a copy of the record in permanent form (subject to fees, see below), and
 - View a record without obtaining a copy
 - To have information explained where necessary eg medical abbreviations.

No reason need be given for an application (unless the application is for the records of a deceased patient – please see below) and staff should be ready to assist applicants in making subject access requests.

- 3.1.6 The applicant must confirm that he/she is legitimately entitled to access the personal data requested. Therefore, the applicant must meet one of the following criteria:
- The applicant is the patient

- The applicant has been asked by the patient to apply and attaches his/her written consent
- The applicant is acting in *loco parentis* and the patient is under the age of 16
- The applicant may have a claim arising from the patient's death
- The applicant has been granted Power of Attorney over the patient's affairs.

3.1.7 The Information Governance Team submits a quarterly report to the Information Governance Group regarding the number of requests received and comparing the information with previous years.

3.2 When the Police approach Trust staff for information

3.2.1 The Trust will release patient information to the police under the following circumstances:

- With the patient's consent.
- Where the patient is incapable of giving/withholding that consent and it is in his best interests to release the information. This may apply to a victim of crime. If the patient's incapability is transitory it may be appropriate to let it pass and then ask for his consent. In this situation the importance of the information to the police, the need for them to have it urgently and the likely period of incapability will have to be considered.
- Where there is an overriding public duty. This should only be considered where there has been a serious crime and the information is necessary to prevent it happening again.

3.2.2 Please refer to the Trust's Police Information Sharing Policy for further details.

3.3 Exemptions

3.3.1 There are specific reasons why access to personal data may be denied including:

- Where the data released may cause serious harm to the physical or mental health or condition of the patient, or any other person.
- Where access would disclose information relating to or provided by a third party (where consent had not been received by that third party to release his/her data).³
- Where the consultant in charge of a patient's care assesses that a patient under the age of 16 cannot understand the implications of accessing his/her records (the Gillick competency test').
- Where the patient expressly stated the information must not be revealed.
- Where the information relates to, or has been given by, anyone except a clinician involved in the patient's care, unless his/her consent has been given.

The Trust must be prepared to justify decisions to withhold information.

3.3.2 Record holders are free to advise applicants of the grounds on which information has been withheld but are not obliged to do so. If it is thought likely to cause undue distress, the record holder may not wish to volunteer the fact that information has been withheld.⁴

³ NB. This does not include information recorded by Trust employees as part of their normal duties.

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http://www.dh.gov.uk/PolicyAndGuidance/InformationPolicy/PatientConfidentialityAndCaldicottGuardians/AccessHealthRecordsFAQ/fs/en?CONTENT_ID=4039714&chk=iOJNGp#5145299

3.3.3 There may be other occasions when either an entire record or part of the record is not released to the applicant:

- Where an access request has previously been complied with, the Data Protection Act permits record holders not to respond to a subsequent identical or similar request unless a reasonable interval has elapsed since the previous compliance. When considering what is a 'reasonable interval' the Trust should consider the nature of the information, how often it is altered and the reason for its processing. The reason for the request(s) may also be relevant.
- The obligation to provide a copy may be waived where the patient agrees otherwise or it is not possible to supply a copy of the material sought, or to do so would involve disproportionate effort (for example because papers have been destroyed, or are spread around the country). However, cost alone is not sufficient grounds on which to refuse to provide a copy.⁵
- There is no obligation to comply with an access request unless the Trust has such information as needed to identify the applicant and locate the information, and the required fee has been paid.
- Releasing deceased patient information or records to people not entitled to it could lead to the Trust being sued for breach of confidence by the personal representatives. Next of kin do not have an automatic right to see a deceased patient's health records. When a patient has died, only his/her personal representative, or executor or administrator, or anyone having a claim resulting from the death (this could be a relative or another person), has the right to apply for access to the deceased's health records. Only those records directly relevant to the claim should be released. Thus a personal representative or executor can access information to benefit the deceased's estate, as can an individual who was a dependant of the deceased and who has a claim relating to that dependency which has arisen from the death. The request should give details of the applicant's right to access the records.⁶
- No records may be released to the personal representatives of the deceased where there is a note in the records that patient has specifically requested he/she did not wish access to be given. If a deceased person had indicated that he/she did not wish information to be disclosed, or the record contains information that the deceased person expected to remain confidential, then it must remain so. In addition the record holder has the right to deny or restrict access if it felt that disclosure would cause serious harm to the physical or mental health of any other person, or would identify a third person.

3.4 Fees

3.4.1 A fee of £10 may be charged for access to the health records, where the record has not been added to in the 40 days preceding the application. An additional fee may be charged for copying and posting the records. There is no limit on this charge, but it should not result in a profit for the record holder.

3.4.2 The fees⁷ to access and copy information are:

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http://www.dh.gov.uk/PolicyAndGuidance/InformationPolicy/PatientConfidentialityAndCaldicottGuardians/AccessHealthRecordsFAQ/fs/en?CONTENT_ID=4039714&chk=iOJNGp#5145299

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http://www.dh.gov.uk/en/Policyandguidance/Informationpolicy/Patientconfidentialityandcaldicottguardians/FAQ/DH_065886

⁷ Set by Lord Chancellor – see Information Commissioner's web site at <http://www.informationcommissioner.gov.uk/eventual.aspx>

- Up to £50 dependent on volume of copies required and complexity of the request:
 - £10 maximum for computer records only
 - £50 maximum for part computer and part manual records
 - £50 maximum for manual records only

3.4.3 The fees to view records are:

- £10 maximum for either manual or computer records or a combination of both, unless the record has been added to in last 40 days (in which case, access is free of charge).
- If the applicant views the records and then requests a copy, this must be treated as one request and a maximum of £50 can be charged.

All the maximum charges are inclusive of copying and postage and packing costs.

3.4.4 Following a costing exercise, it has been established that most applications would cost over £50 for the Trust to handle. It is therefore Trust's policy to charge a fee of £50, with the exception of applications relating to the following, for which no fee will be charged:

- Complaints
- Deceased patients
- Government Agencies (Court Orders, Benefits Agency, Police, etc)
- GPs or other NHS hospitals

3.4.5 The Access to Health Records Team will use their discretion to reduce or waive the fee on a case by case basis.

3.5 Timescales

3.5.1 Access can be given by allowing the applicant to inspect the records or extract (in the company of the health professional who had charge of the patient's care), or by supplying a copy if this is requested. If the records are held by a health service body, access cannot be given before advice has been obtained (ie authorisation of the health professional that had charge of the patient's care).

3.5.2 Once the Access to Health Records Team is satisfied that the person requesting the information is entitled to it, access must then be given within specified time limits. The Trust has 40 calendar days (including weekends and public holidays) to comply with a request under the Data Protection Act 1998 and the Access to Health Records Act 1990, with the exception of Court Orders (7 days) and Government agency requests (10 days).

3.5.3 However, guidance for access to health records requests under the Data Protection Act 1998 published by the Department of Health in June 2003 recommends that Subject Access Requests should be complied, where possible, within 21 days but by no later than 40 days.

3.5.4 Where the application concerns access to records, *any* of which were made in the 40 day period immediately preceding the date of application, access must be given within 21 days.

3.5.5 Where the information concerns information all of which was recorded *more* than 40 days before the date of application, access must be given within 40 days.

3.5.6 Appointments to attend the Trust and view medical records must be made with the clinician in charge of care of the patient, as the Access to Health Records Team are not clinically trained and are therefore unable to answer any questions that may arise.

3.6 Access to Deceased Patient Records

3.6.1 When a patient dies, Trust health records remain at the Trust, or may be sent to a local archive for storage where they are retained for the recommended retention period. The Department of Health recommends that health records are kept for a minimum of 8 years following the end of any treatment, or the patient's death. At the end of that specified time, the Trust Records Manager will decide whether to retain the records further or destroy them. For further details, see the 'NHS Records Management: Code of Practice March 2006'.

3.6.2 The Access to Health Records Act (AHRA) came into force on 1 November 1991, therefore records created before that date do not have to be made available in response to a subject access request for a deceased patient.⁸

3.6.3 Health records relating to deceased people do not carry a common law duty of confidentiality and the DPA does not make provision for deceased people. However, the Trust's duty of confidentiality to patients survives beyond their death. It is Department of Health and General Medical Council policy that records relating to deceased people should be treated with the same level of confidentiality as those relating to living people. Access to the health records of a deceased person is governed by the AHRA. Under this legislation when a patient has died, his/her personal representative or executor or administrator or anyone who may have a claim resulting from the death (this could be a relative or another person), has the right to apply for access to the deceased's health records. Please see paragraph 3.2.3 above for details of when records may/may not be released.

3.6.4 A request for access should be made in writing to the record holder ensuring that it contains sufficient information to enable the correct records to be identified. The request should also give details of the applicant's right to access the records.

3.6.5 If the deceased person had indicated that he/she did not wish information to be disclosed, or the record contains information that the deceased person expected to remain confidential then it must remain so. In addition the record holder has the right to deny or restrict access if it felt that disclosure would cause serious harm to the physical or mental health of any other person, or would identify a third person.

3.7 Access to Medical Reports

3.7.1 The Access to Medical Reports Act 1988 governs access to medical reports made by a patient's normal clinician for insurance or employment purposes.

3.7.2 Specific provision is made in the Access to Medical Reports Act 1988 for a patient's medical practitioner to supply a third party, such as an employer or an insurance company with a medical report about the patient.

3.7.3 The Access to Medical Reports Act 1998 only applies to a report prepared by the medical practitioner who usually looks after the clinical care of the person. Reports prepared by other medical practitioners, such as those contracted by the employer or insurance company are not covered by the Act. Reports prepared by such medical practitioners are covered by the Data Protection Act 1998.

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http://www.dh.gov.uk/PolicyAndGuidance/InformationPolicy/PatientConfidentialityAndCaldicottGuardians/AccessHealthRecordsFAQ/fs/en?CONTENT_ID=4039714&chk=iOJNGp#5145299

- 3.7.4 The Access to Medical Reports Act 1988 provides that a person cannot ask a patient's medical practitioner for a medical report on him/her for insurance or employment reasons without the patient's knowledge and consent. Patients have the option of declining to give consent for a report about them to be written.
- 3.7.5 The patient has the right to see the report (subject to certain safeguards – see below) before it is supplied, and to ask for any part that she/he thinks incorrect to be amended. If a patient request an amendment to a report, the medical practitioner should either amend the report accordingly, or at the patient's request, attach to the report a note of the patient's views on the part of the report which the doctor is declining to amend. Patients should request amendments in writing.
- 3.7.6 Medical practitioners are not required to give copies of reports to patients under certain, specific circumstances. The medical practitioner may refuse to give access to the report if it would reveal information about a third person, or if it would reveal the identity of a third person who had given the medical practitioner information about the patient for the report (unless the person has consented, or is a doctor). If access is refused to part of a report, the doctor should tell the patient this.
- 3.7.7 Patients can be supplied with a copy of the report before it goes to the employer. They have to notify the medical practitioner of this wish. When a patient requests to see a copy of the report before it is supplied to the employer, the medical practitioner who wrote the report must comply with this (unless 21 days have passed since the patient has communicated with the doctor about making arrangements to see the report).
- 3.7.8 A medical practitioner may make a reasonable charge for supplying the patient with a copy of the report. When a patient has been given access to the report, the report cannot be passed on to the employer without the patient's consent.
- 3.7.9 Doctors should keep copies of reports they supply for 6 months. A medical practitioner should provide a copy of a report supplied to an employer in the previous 6 months, if a patient requests it. There may be a reasonable charge for this.
- 3.7.10 The medical practitioner must seek the patient's consent before he or she supplies the report to the person who applied for it. If the patient requests a copy of the report and access is refused to part of a report, the doctor cannot supply the full report to the employer without the patient's consent.
- 3.7.11 A Court may order a person to comply with this Act if it feels that the person has not been compliant.
- 3.7.12 Please refer to the Police Information Sharing Policy for details about releasing children's medical reports to the Police.

3.8 Children's records

- 3.8.1 As a general rule, a person with parental responsibility will have the right to apply for access to a child's health record. Parental responsibility for a child is defined in the Children's Act 1989 as "all the rights, duties, powers, responsibilities and authority which by law a parent of a child has in relation to the child and his property". Although not defined specifically, responsibilities therefore would include:
- Safeguarding and promoting a child's health, development and welfare.
 - Financially supporting the child.
 - Maintaining direct and regular contact with the child.

- 3.8.2 Included in the parental rights which would fulfil the parental responsibilities above are:
- Having the child live with the person with responsibility or having a say in where the child lives.
 - If the child is not living with her/him, having a personal relationship and regular contact with the child.
 - Controlling, guiding and directing the child's upbringing.
- 3.8.3 A parent not living with the child may have access to the child's health record if they have parental responsibility for the child eg a separated/divorced parent.
- 3.8.4 Children of 16 years or older must make application for copies of their own medical records. The law regards young people aged 16 or 17 to be adults for the purposes of consent to treatment and right to confidentiality. Therefore if a 16 year old wishes a medical practitioner to keep the treatment confidential then that wish should be respected. For example, children under the age of 16 who have the capacity and understanding to take decisions about their own treatment are also entitled to decide whether personal information may be passed on and generally to have their confidence respected, for example if they were receiving counselling or treatment about something they did not wish their parent to know.
- 3.8.5 Case law has established that such a child is known as 'Gillick Competent', ie where a child is under 16 but has sufficient understanding in relation to the proposed treatment to give, or withhold consent, consent or refusal should be respected. However, good practice dictates that the child should be encouraged to involve parents or other legal guardians in any treatment.
- 3.8.6 As a child grows older and gains sufficient understanding, he/she will be able to make decisions about his/her own life. Where a child is considered capable of making decisions about his/her medical treatment, the consent of the child must be sought before a person with parental responsibility can be given access. Where, in the view of the appropriate health professional, the child patient is not capable of understanding the nature of the application, the holder of the record is entitled to deny access if it were not felt to be in the patient's best interests.⁹ Therefore, in the case where an applicant is under the age of 16, the appropriate clinician may withhold the information if it is felt that the applicant would not understand what the implication of seeing his/her records means.

3.9 Patients living abroad

- 3.9.1 In cases where a patient moves abroad, their GP health records are sent to the local Primary Care Trust and their Trust records are stored in the Trust or sent to a local archive. They are retained for the minimum period. Trust records are kept for a minimum of 8 years following the end of treatment and GP records for 10 years, though please note that certain types of records are kept for longer. At the end of the minimum retention period the Records Manager at the Trust/hospital/archive will decide whether to retain further or destroy the records. Under the UK Data Protection Act 1998, a patient has the right to apply for access to copies of their health records. The request should be made in writing to the record holder(s), and a fee will be payable, with the maximum that can be charged set at £50.

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3.9.2 A person cannot take their health records with them for their new doctor if they are living outside the UK. However, patients can make a subject access request for copies of their records, and then take the copies with them.¹⁰

3.10 Rectifying medical records

If a patient feels information recorded on their health record is incorrect then he/she should firstly make an informal approach to the health professional concerned to discuss the situation in an attempt to have the records amended. If this avenue is unsuccessful then he/she may pursue a complaint under the NHS Complaints procedure in an attempt to have the information corrected or erased. They could further complain to the Information Commissioner, formerly the Data Protection Commissioner, who may rule that any erroneous information is rectified, blocked, erased or destroyed.¹¹

3.11 Procedures for processing a request

3.11.1 The Access to Health Records Team processes the requests in the following order:¹²

1. Check the validity of the written consent or ask for further information to locate the records/proof of legitimacy of request/consent if necessary.
2. Check that the required fee has been sent in advance.
3. Log the request onto the Access to Health Records database.
4. Request x-rays, physiotherapy notes etc if required by passing a copy of the request to them.
5. Trace the records via the Patient Administration System (PAS) and collect them for photocopying.
6. Pay in fees received.
7. Copy and review the information requested (eg full set of case notes or details of one episode) to decide if access is appropriate (eg the existence of any 3rd party data, harmful information - see Exemptions section), redacting any third party names from the copies.
8. In the case of applications from a patient for copies of his/her own records, send the copy records to the appropriate consultant for authorisation to send them to the patient. If the applicant requires an explanation of the medical records (eg of abbreviations or medical terminology), or requests an appointment to come in and view the medical records, the Access to Health Records Team will direct the applicant to the appropriate consultant's secretary for an appointment between the patient and that consultant to be made. Lay administrators must not comment or advise on the content of the record.¹³
9. Send the copy records by Recorded (Signed for) delivery.
10. Record progress on the Access to Health Records database.

3.11.2 The Access to Health Records Team regularly monitors the 'live' requests (those which have not yet been completed). The Team reminds colleagues of the requirement to answer specific queries about the requests, within the timescales prescribed by the Acts, where appropriate.

¹⁰

http://www.dh.gov.uk/PolicyAndGuidance/InformationPolicy/PatientConfidentialityAndCaldicottGuardians/AccessHealthRecordsFAQ/fs/en?CONTENT_ID=4039714&chk=iOJNGp#5145299

¹¹

http://www.dh.gov.uk/PolicyAndGuidance/InformationPolicy/PatientConfidentialityAndCaldicottGuardians/AccessHealthRecordsFAQ/fs/en?CONTENT_ID=4039714&chk=iOJNGp#5145299

¹²

<http://www.foi.gov.uk/guidance/proguide/chap02.htm>

¹³

http://www.dh.gov.uk/PolicyAndGuidance/InformationPolicy/PatientConfidentialityAndCaldicottGuardians/AccessHealthRecordsFAQ/fs/en?CONTENT_ID=4039714&chk=iOJNGp#5145299

3.12 Processing Of Sensitive Personal Data (Elected Representatives) Order 2002

This Order¹⁴ provides Elected Representatives with certain rights over the disclosure of patient's personal data. The Trust has decided that all requests for information will be dealt with via the Access to Health Records Team to ensure appropriate disclosure of personal data, in accordance with the Data Protection Act 1998 and this Order.

3.13 Dealing with complaints

3.13.1 If the Trust receives a formal written complaint relating to the handling of a request for personal data, the complaint is handled under the Trust's Complaints Policy.

3.13.2 If a patient follows this procedure and is dissatisfied with the outcome of the investigation, he/she has the right to take the complaint to the Health Care Commission.

3.13.3 Alternatively, a person has the right to complain to the Information Commissioner, formerly the Data Protection Commissioner at Wycliffe House, Water Lane, Wilmslow, Cheshire SK9 5AF (Tel: 01625 545700).

3.13.4 The Equality Impact Assessment and the Dignity & Respect Charter are not applicable to this document.

3.13.5 The Information Governance Manager is responsible for the development of this document. Advice on the content of this document has also been sought from the Trust Records Manager, the Trust's external legal advisor, and the Trust's Legal Services Manager.

3.13.6 This document should be read in conjunction with the Trust's Data Protection Policy, Police Information Sharing Policy, Freedom of Information Policy, and Records Policy.

3.14 Equality Impact Assessment and Dignity & Respect Charter

An Equality Impact Assessment has been completed for this document, and compliance with the Trust's Dignity & Respect Charter is confirmed.

SECTION 4 – TRAINING AND EDUCATION

Access to Health Records is included in the annual mandatory Information Governance training sessions for all staff working at the Trust.

SECTION 5 – DEVELOPMENT AND IMPLEMENTATION INCLUDING DISSEMINATION

5.1 The existence of this Policy & Procedures will be broadcast by email to all Trust staff, and this document will be uploaded to the Trust Intranet.

5.2 This Policy has been written in accordance with the terms of the Development and Management of Strategies, Policies & Procedures, Protocols, Guidelines and Other Guidance Material Policy v7.0.

5.3 The following have been involved in the review of this version of this Policy:

- The Access to Health Records Team

¹⁴ <http://www.opsi.gov.uk/SI/si2002/20022905.htm>

- The Information Governance Group (includes representation from Finance, Human Resources, Information Management & Technology)
- The Information Governance Manager (Responsible Officer)
- Diagnostic Imaging
- Sexual Health

SECTION 6 – MONITORING COMPLIANCE AND EFFECTIVENESS

Compliance with this policy and procedures will be checked via the ongoing monitoring of the Access to Health Records database by the Access to Health Records Team. The Information Governance Manager will also check compliance by monitoring complaints received. The Access to Health Records database logs information about requests that take more than the statutory 40 day deadline to meet, and has a comments field in which issues and actions taken when dealing with a request can be logged and tracked. Reports generated (by the Information Governance Manager) from the database are made to the quarterly Information Governance Group meetings, at which any issues are discussed and action is taken on any proposals raised at the meetings as a result of the report and reported at the next meeting.

SECTION 7 – CONTROL OF DOCUMENTS INCLUDING ARCHIVING ARRANGEMENTS

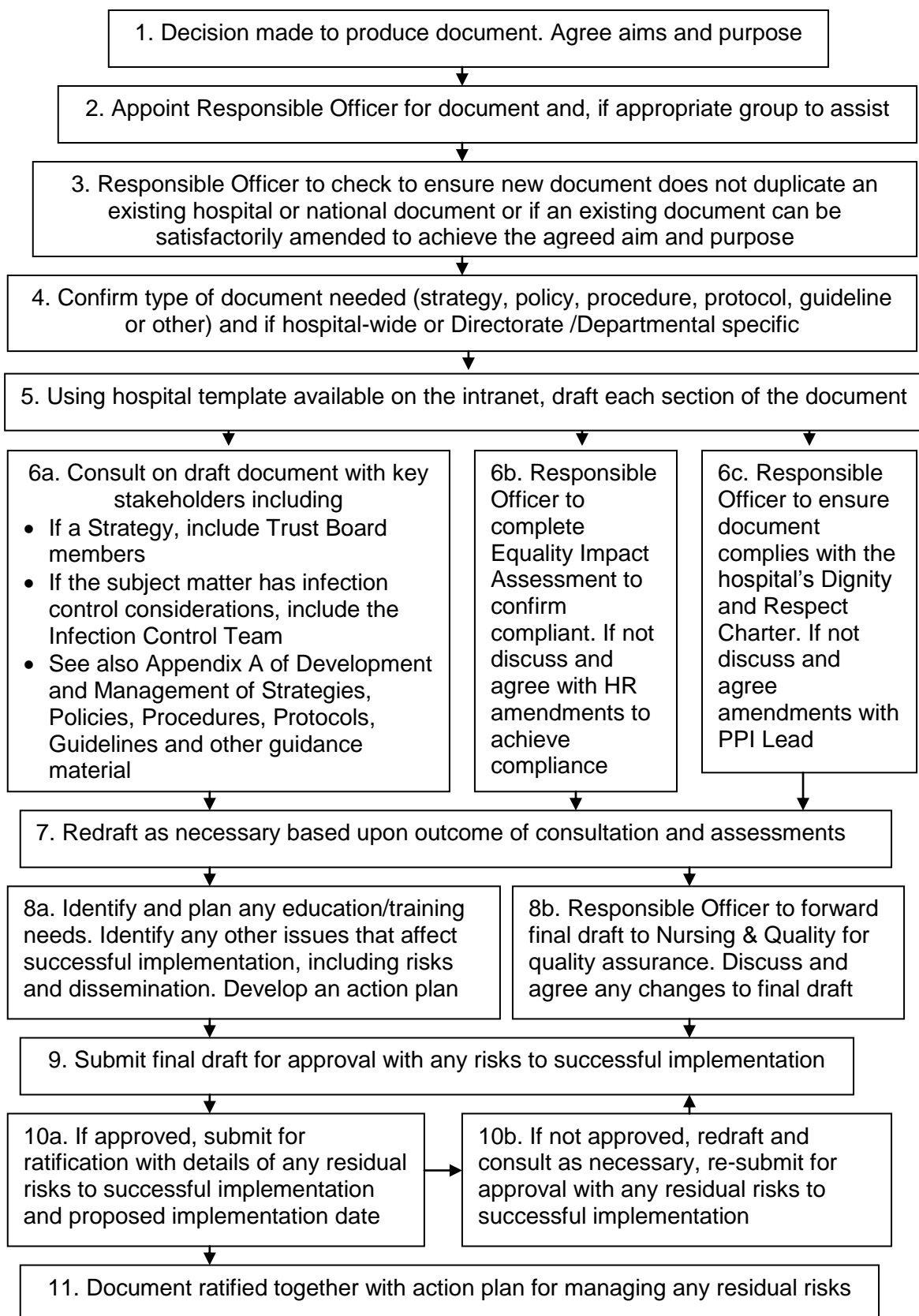
- 7.1 Once ratified by the Trust Management Team the Responsible Officer will forward this guideline to the Information Governance Department for a document index registration number to be assigned and for the guideline to be recorded onto the central Trust master index and central document library of current documentation.
- 7.2 In order that this document adheres to the Trust's Records Management Policy, the Responsible Officer will arrange for staff to be advised when this document is superseded and for arranging for this version to be removed from the Trust's intranet. The Responsible Officer will also advise the Information Governance Department who will ensure that this document is removed from the current index and library, archived and retained for 10 years from the archive date.

SECTION 8 – SUPPORTING COMPLIANCE AND REFERENCES

- 8.1 This document will support the Trust's compliance with:
- its legal obligations as set out in the Data Protection Act 1998, Access to Health Records Act 1990, and Freedom of Information Act 2000, and
 - the requirements of the Connecting for Health Information Governance Toolkit standards (standard 205).
- 8.2 The Access to Health Records Policy and Procedures has been developed in accordance with national guidance and legislation on accessing health records from the Information Commissioner and the Department of Health.

FLOWCHART FOR DEVELOPING HOSPITAL DOCUMENTATION

PRE-RATIFICATION PROCESS



FLOWCHART FOR DEVELOPING HOSPITAL DOCUMENTATION

POST-RATIFICATION PROCESS

