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NHS
Gloucestershire Health and Care
NHS Foundation Trust

Information Governance: Records

ACCESS TO HEALTH RECORDS POLICY

Policy Number:	**IGR-01**
Version:	7
Purpose:	This document sets out the policy for giving access to health records, including subject access requests.
Consultation:	Information Governance Group
Approved by:	Information Governance Group
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Author:	Head of Health Records
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Executive Lead:	Sandra Betney, Director of Finance
Audience:	All Trust employees
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Impact Assessments:	This policy has been equality impact assessed using the Trust's agreed process, and the assessment has not identified any significant adverse impact on people with one or more protected characteristic.

Version History

Version	Date	Reason for Change
1	February 2013	New Policy
2	October 2015	Rewrite in the light of experience.
3	February 2017	Rewrite in the light of experience.
4	May 2018	Rewrite to reflect new legislation.
5	March 2019	Rewrite in the light of experience.
6	February 2020	Rewrite in the light of experience and to reflect new Trust.
7	April 2023	Rewrite in the light of experience.

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PART 1

SUMMARY

Individuals have a right of access to seek access to their own health information. Holders of that information must respond to such requests within a defined timescale and may restrict or prevent access in certain circumstances.

In certain circumstances individuals and organisations also have a right of access to other people's health information, with or without that person's consent, depending upon the relevant legislation and/or circumstances.

PART 2

1.0 INTRODUCTION

1.1. Individuals have a right to apply for access to health information held about them and, in some cases, information held about other people.

2.0 PURPOSE

2.1 The purpose of this policy is to enable Trust staff to provide service users and other individuals/organisations with access to health records in line with their obligations under the following legislation and guidance:

The General Data Protection Regulation (UK GDPR) – a regulation from the European Parliament, the Council of the European Union and adopted by the United Kingdom government after leaving the EU. It is intended to strengthen and unify data protection for all individuals. It includes rights for individuals to have access to their personal data.

The Data Protection Act 2018 (DPA) –updates data protection laws in the UK, supplementing the UK GDPR, as well as extending data protection laws to areas which are not covered by the UK GDPR. It also includes rights for individuals to have access to their personal data.

The Access to Health Records Act 1990 – rights of access to deceased service user health records by specified persons.

The Medical Reports Act 1988 – right for individuals to have access to reports, relating to themselves, provided by medical practitioners for employment or insurance purposes.

The Mental Health Act 1983 – rights for certain people and bodies – including the Care Quality Commission, SOADs, First-tier Tribunals, independent mental health advocates and those authorised to convey a patient to hospital (or anywhere else) under the Act, to find and return a patient who has absconded from legal custody or who is absent without leave or to transfer responsibility for a patient subject to the Act from one hospital to another – to access confidential information about a patient, even if the patient does not consent.

The Mental Capacity Act – a statutory framework to empower and protect people who may lack capacity to make some decisions.

NHS Code of Practice on Confidentiality

Guidance for Access to Health Records Requests

3.0 SCOPE

3.1 This policy applies to all staff with contact with service users and/or health records and involved in the provision of health records to service users, their representatives and other individuals and bodies.

4.0 DUTIES

4.1 The Director of Finance is the Trust's executive lead for Information Management & Technology and is responsible for overseeing all IM&T developments and implementation programmes across the Trust. The Director of Finance is also the Senior Information Risk Owner (SIRO) and Chief Information Officer (CIO). As such, the Director of Finance also has overall responsibility for ensuring the security of all information assets and that the reporting of Information Governance and Cyber Incidents is carried out appropriately.

4.2 The Medical Director is responsible for acting as the Trust's Caldicott Guardian and Chief Clinical Information Officer (CCIO) and, as such, has an advisory role in order to ensure the optimum confidentiality of service user information and to enable appropriate information sharing with partner organisations. The Caldicott Guardian will also monitor local arrangements to ensure that they consistent with national requirements and guidance.

4.3 The Head of Governance is responsible for:

- acting as the Trust's Deputy Senior Information Risk Owner;
- the Trust's records management function (including policy, strategy and audit);
- the processing of requests for information under the UK GDPR, DPA 18, Access to Health Records Act 2000 and Freedom of Information Act 2000 (FOI). and,
- the management and supervision of the Information Governance function. The role is also responsible for the reporting of IG security and cyber-crime related risks and incidents, and will act as the Trust's nominated cyber-crime advocate.

4.4 The Head of Health Records has delegated responsibility for this policy and, with Health Records Department staff, has delegated responsibility to coordinate the handling of subject access requests and to document them.

4.5 All staff who have contact with service users and/or health records (both manual and computerised) are responsible for using this policy correctly to ensure compliance with legislation.

5.0 MEANS OF ACCESS

5.1 Data subjects and their representatives must not have unsupervised access to original paper records or to electronic record systems. Staff must not give their own smartcards to any other person.

5.2 Original paper health records should not leave the Trust without the agreement of the Caldicott Guardian.

5.3 Copy records/printouts of electronic records should be provided in a way that maintains confidentiality and is in line with the Information Management System Policy.

5.4 Some Care Quality Commission officials (including Mental Health Act Commissioners), SOADs, Tribunal medical members and legal representatives of detained patients may ask to view an electronic record on a PC themselves. (MHA Commissioners, SOADs and Tribunal members are entitled to access relevant parts of a health record without the service user's consent[1]). If such an individual already holds a smartcard which has been issued by GHC or by another NHS organisation or a body registered with Connecting for Health, they may use it on a GHC PC. If one of these individuals does not have their own smartcard, staff may give supervised access to the relevant electronic records or provide a printout of them. (See the relevant paragraph(s) below.)

6.0 SERVICE USERS' INFORMAL ACCESS TO THEIR HEALTH RECORDS

6.1 Health professionals may share their own professional information on an informal basis with service users under their care, provided that there is no possibility that access would:

- be harmful to any person's mental or physical health; or
- involve the disclosure of information about or provided by a third party who has not consented to its disclosure.

6.2 If informal access is not appropriate or possible, access should be given in line with relevant legislation.

7.0 SUBJECT ACCESS REQUESTS – FORMAL APPLICATIONS BY SERVICE USERS AND THEIR AUTHORISED REPRESENTATIVES FOR ACCESS TO LIVING SERVICE USERS' HEALTH RECORDS (GDPR & DATA PROTECTION ACT)

7.1 **The General Data Protection Regulation (GDPR) (Articles 12 & 15 and Recital 63)**

7.1.1 *Under the GDPR, individuals have the right to obtain:*

- *confirmation that their data is being processed; and*
- *access to their own data.*

7.1.2 *The reason for allowing individuals to access their personal data is so that they are aware of and can verify the lawfulness of the processing.*

7.1.3 *Where a large quantity of information about an individual is held, the organisation may ask the individual to specify the information to which the request relates.*

7.1.4 *However, where a request is manifestly unfounded or excessive, in particular because it is repetitive, a reasonable fee, taking into account the administrative costs of providing the information, may be charged. The organisation may also refuse to respond, in which case it must, without undue delay and at the latest within one month, explain why to the individual, informing them of their right to complain to the supervisory authority and to a judicial remedy.*

[1] Mental Health Act Code of Practice, chapter 10

7.1.5 *Information must be provided without delay and at the latest within one month of receipt. However, this can be extended by a further two months where requests are complex or numerous. If this is the case, the individual must receive an explanation of the necessity of the extension within one month of receipt of the request.*

7.1.6 *The organisation must verify the identity of the person making the request, using reasonable means.*

7.1.7 *If the request is made electronically, the information should be provided in a commonly-used electronic format.*

7.2 **The Data Protection Act 2018**

7.2.1. *The Data Protection Act states that a data subject is entitled to obtain from the controller:*

- *confirmation as to whether or not personal data concerning him or her is being processed; and*
- *where that is the case, access to the personal data.*

7.2.2 *Where a data subject makes a request, the information to which the data subject is entitled must be provided in writing without delay and in any event within one month.*

7.2.3 *The controller may restrict, wholly or partly, the above rights under certain circumstances.*

7.2.4 *In this case, the controller must inform the data subject in writing without undue delay:*

- *that the rights of the data subject have been restricted;*
- *of the reasons for the restriction;*
- *of the data subject's rights to make a request to the Commission to check that the restriction is lawful and to lodge a complaint with the Commissioner; and*
- *of the data subject's right apply to a court.*

However, these do not apply if the provision of the information would undermine the purpose of the restriction.

7.2.5 *The controller must:*

- *record the reasons for a decision to restrict (whether wholly or partly) the rights of a data subject; and*
- *if requested to do so by the Commissioner, make the record available to the Commissioner.*

7.2.6 *A controller is not obliged to disclose information to the data subject to the extent that doing so would involve disclosing information relating to another individual who can be identified from the information. However, the controller's obligation is not removed where:*

- *the other individual has consented to the disclosure of the information to the data subject; or*

- *it is reasonable to disclose the information to the data subject without the consent of the other individual.*

7.2.7 *In determining whether it is reasonable to disclose the information without consent, the controller must have regard to all the relevant circumstances, including:*
- *the type of information that would be disclosed;*
- *any duty of confidentiality owed to the individual;*
- *any steps taken by the controller with a view to seeking the consent of the other individual;*
- *whether the individual is capable of giving consent; and*
- *any express refusal of consent by the other individual.*

7.2.8 *'Information relating to another individual' includes information identifying the other individual as the source of information. An individual can be identified from information to be provided to a data subject by a controller if the individual can be identified from:*
- *that information; or*
- *that information and any other information that the controller reasonably believes the data subject is likely to possess or obtain.*

7.2.9 *It is to be considered reasonable for a controller to disclose information to a data subject without the consent of the other person where:*
- *the health data test is met;*
- *the social work data test is met; or*
- *the education data test is met.*

7.2.10 *The health data test is met if:*
- *the information in question is contained in a health records; and*
- *the other individual is a health professional who has compiled or contributed to the health record or who, in his or her capacity has been involved in the diagnosis, care or treatment of the data subject.*

7.2.11 *The social work data test is met if the other individual is employed by a local authority in connection with its social services functions or meets the other criteria in Schedule 2, paragraph 3.*

7.2.12 *The education data test is met if the other individual is an education-related worker.*

7.2.13 *The DPA clarifies a number of aspects of the GDPR in relation to accessing of health data.*
- *The GDPR provisions do not apply in the following circumstances:*
  - *The data subject is an individual aged under 18 and the person making the request has parental responsibility for the data subject.*
  - *The data subject is incapable of managing his or her own affairs and the person making the request has been appointed by a court to manage those affairs.*
  - *Complying with the request would disclose information which:*

- *was provided by the data subject in the expectation that it would not be disclosed to the person making the request;*
- *was obtained as a result of any examination or investigation to which the data subject consented in the expectation that the information would not be so disclosed;*
- *or the data subject has expressly indicated should not be so disclosed.*
  (These do not apply if the data subject has expressly indicated that he or she no longer has the expectation mentioned there.)

- *The serious harm test is met, i.e. if the application of Article 15 of the GDPR would be likely to cause serious harm to the physical or mental health of the data subject or another individual.*

- *A controller who is not a health professional may not rely on the serious harm test to withhold data unless the controller has obtained an opinion from the person who appears to the controller to be the appropriate health professional to the effect that the serious harm test is met with respect to the data. An opinion does not count if:*
  - *it was obtained before the relevant period (six months ending with the day on which the opinion would be relied upon); or*
  - *it was obtained during that period but it is reasonable in all the circumstances to re-consult the appropriate health professional.*

- *A controller who is not a health professional is not permitted to disclose data concerning health unless the controller has obtained an opinion from the person who appears to the controller to be the appropriate health professional to the effect that the serious harm test is not met with respect to the data. This does not apply to the extent that the controller is satisfied that the data concerning health has already been seen by, or is within the knowledge of, the data subject. An opinion does not count if:*
  - *it was obtained before the relevant period (six months ending with the day on which the opinion would be relied upon); or*
  - *it was obtained during that period but it is reasonable in all the circumstances to re-consult the appropriate health professional.*

- *The 'appropriate health professional' in relation to a question as to whether the serious harm test is met with respect to data concerning health means:*
  - *the health professional who is currently or was most recently responsible for the diagnosis, care or treatment of the data subject in connection with the matters to which the data relates;*
  - *where there is more than one such health professional, the health professional who is the most suitable to provide an opinion on the question; or*
  - *a health professional who has the necessary experience and qualifications to provide an opinion on the question where there is no health professional available falling within the above paragraphs.*

7.3 **Procedure for Dealing with a Subject Access Request**

Receiving a subject access request

7.3.1 A subject access request does not have to include the words 'subject access request' or 'Article 15 of the GDPR', as long as it is clear that the individual is asking for their own personal data. A request can be made to the Trust in any of the following ways:

- on the appropriate application form (within the leaflets at Appendices 1 & 2);
- in writing;
- by email; and
- verbally. The member of staff receiving the request must document the request in the appropriate health record and immediately inform the Health Records Department.

7.3.2 An application form is the preferred method of application, but the Trust cannot insist upon its use. If the request has not been made on this form and has not provided sufficient information to identify the applicant/service user or records being sought, the applicant may be asked to complete a form.

7.3.3 The Health Records Department handles all requests. In the event of a subject access request being directed to another member of staff or department, it should be forwarded on the same working day to the designated email address: SubjectAccess@ghc.nhs.uk.

7.3.4 If a subject access request has not made on an application form but does enable the individual(s) and records to be identified, the acknowledgement letter should include one for the applicant's information, so that they are aware of the process outlined in it, although there is no expectation that the applicant will complete and return it.

7.3.5 The Information Commissioner's Office advises: 'If you have any doubts about the identity of the person making the request, you can ask for more information. However, it is important that you only request information that is necessary to confirm who they are. The key thing is proportionality. You need to let the individual know as soon as possible that you need more information from them to confirm their identity before responding to the request. The period for responding to the request begins when you receive the additional information'. If there is any doubt about the applicant's identity, the Health Records Department should request appropriate further evidence. Any further concerns should then be raised with the Information Governance Manager and/or Caldicott Guardian.

7.3.6 If a subject access request is made on behalf of the data subject with the data subject's explicit consent and full understanding, this provides the legal basis for disclosure. The Health Records Department must be satisfied that the applicant has the authority to make the subject access request and that the data subject has given informed consent. If there is any doubt about consent and if the data subject is open to a GHC service, a health professional should attempt to speak to the data subject to clarify their wishes. If the data subject is closed to GHC services, their GP or a health professional in another organisation might be in a position to do this. The discussion with the data subject should include:

- the reason for the request;
- the part(s) of the record likely to be of relevance; and

- the way in which the applicant might use and share any records disclosed to them.

The wishes of the data subject should be recorded in the health record and, if different, could override consent given previously to the applicant.

7.3.7 Data subjects living outside of the UK who had treatment in the UK have the same rights under the DPA to apply for access to their UK health records. These requests should be treated the same as those from someone within the UK.

7.3.8 The Health Records Department may ask the applicant to specify whether they are seeking access to the entire health record or to certain parts only.

7.3.9 If a subject access request is considered manifestly unfounded or excessive, the Trust may charge a fee, based on the administrative cost of dealing with it, or refuse to respond to it.

The ICO guidance is that '*a request may be manifestly unfounded if:*

- *the individual clearly has no intention to exercise their right of access. For example an individual makes a request, but then offers to withdraw it in return for some form of benefit from the organisation; or*
- *the request is malicious in intent and is being used to harass an organisation with no real purposes other than to cause disruption. For example;*
- *the individual has explicitly stated, in the request itself or in other communications, that they intend to cause disruption;*
- *the request makes unsubstantiated accusations against you or specific employees;*
- *the individual is targeting a particular employee against whom they have a personal grudge; or*
- *the individual systematically sends different requests to you as part of a campaign, eg once a week, with the intention of causing disruption.*

This is not a simple tick list exercise that automatically means a request is manifestly unfounded. You must consider a request in the context in which it is made, and you are responsible for demonstrating that it is manifestly unfounded.

Also, you should not presume that a request is manifestly unfounded because the individual has previously submitted requests which have been manifestly unfounded or excessive or if it includes aggressive or abusive language.

The inclusion of the word 'manifestly' means there must be an obvious or clear quality to it being unfounded. You should consider the specific situation and whether the individual genuinely wants to exercise their rights. If this is the case, it is unlikely that the request will be manifestly unfounded.'

If it is decided not to comply with the request, the applicant should, within one month of receipt, receive an explanation of the decision and information about the right to complain to the Information Commissioner's Office and their ability to enforce this right through a judicial remedy.

Access to children's health records

7.3.10 The law regards young people aged 16 or 17 to be adults in respect of their rights to confidentiality.

7.3.11 Even if a child is too young to understand the implications of subject access rights, it is still the right of the child, rather than of anyone else, such as a person with parental responsibility. It is therefore the child who has a right of access to the information held about them, although in the case of young children, these rights are likely to be exercised by those with parental responsibility. A person with parental responsibility is:

- the natural mother;
- the father, if married to the mother or if he registered the birth with the mother after 1st December 2003;
- the unmarried father by agreement or court order;
- the local authority under a care order; or
- the court.

7.3.12 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. However, good practice dictates that the child should be encouraged to involve parents or other legal guardians in their healthcare.

7.3.13 Before responding to a subject access request for information held about a child, the Trust should consider whether the child is mature enough to understand their rights; if the child is aged 12 years or over, this will be assumed, unless the contrary is shown.

7.3.14 If the Trust is confident that the child can understand their rights, the Trust should usually respond directly to the child. However, it will allow the person with parental responsibility to exercise the child's rights on their behalf if the child authorises this or if it is evident that this is in the best interests of the child.

7.3.15 The issue for health professionals to consider is whether the child is able to understand (in broad terms) what it means to make a subject access request and how to interpret the information received as a result of doing this. When considering borderline cases, the following should be taken into account:

- the child's level of maturity and their ability to make decisions like this;
- the nature of the personal data;
- any court orders relating to parental access or responsibility that may apply;
- any duty of confidence owed to the child or young person;
- any consequence of allowing those with parental responsibility access to the child's or young person's information. This is particularly important if there have been allegations of abuse or ill treatment;
- any detriment to the child or young person if individuals with parental responsibility cannot access this information; and
- any views the child or young person has on whether their parents should have access to information about them.

7.3.16 On receipt of a request from a child consenting to the disclosure of their information to a person with parental responsibility, if there is any doubt about

whether that consent is informed, a health professional should attempt to speak to the child to clarify their wishes.

7.3.17 On receipt of a request with the consent of a person with parental responsibility, but not the child:

- if the child is open to a GHC service, the Health Records Department should consult with a health professional whether the child is likely to have the competence to consent;
- if so, a health professional should advise on the most appropriate way of seeking that consent, bearing in mind that it may not be appropriate for that consent to be sought via the parent and that it may be more appropriate for a health professional to have a confidential conversation with the child so that they can freely express their wishes;
- if the child does give valid consent, the subject access request should be processed in the normal way, taking into account any wishes expressed by the child;
- if the child does not consent, it may be necessary to seek the advice of the Caldicott Guardian, in case disclosure is considered in the child's best interests. It should still be possible to disclose any information in the health record about the parent, if not the child.

Access to the health records of people lacking the capacity to consent

7.3.18 If a data subject is unable to give consent or to communicate a decision, the health professionals concerned must take decisions about the use of information. This needs to take into account the data subject's best interests and any previously expressed wishes and be informed by the views of relatives or carers as to the likely wishes of the service user. If a data subject has made his or her preferences about information disclosures known in advance, this should be respected.

7.3.19 Health professionals should always consult people close to the data subject to agree the best course of action or treatment, unless the data subject has made it clear in the past that they do not want a particular individual involved. This may involve sharing part of the health record, if the health professional considers this in the data subject's best interest. However, it does not necessarily mean full disclosure.

7.3.20 There may be occasions covered by the Data Protection Act whereby an individual could request access to the data subject's records without the data subject's consent if it is necessary in order to pursue the legitimate interests of a third party, except where the release of such records could prejudice the rights and freedoms or legitimate interests of the data subject. An individual could also state that disclosure is in the vital interests of the data subject, or another person, where consent cannot be given on behalf of the data subject.

7.3.21 The Mental Capacity Act provides a statutory framework to empower and protect people (generally aged 16 or over) who may lack capacity to make some decisions. The MCA set up a new Court of Protection, which is permitted to appoint a deputy to deal with property and affairs and/or personal welfare

decisions. Whilst they still have capacity, people can appoint a lasting power of attorney, also for property and affairs and/or personal welfare decisions. Personal welfare deputies/attorneys can ask to see information concerning the person they are representing as long as the information applies to decisions they have the legal right to make. Although property and affairs deputies/attorneys are not permitted to make health decisions, they may be entitled to certain information held within a health record in order to manage the person's property and affairs. An Independent Mental Capacity Advocate (IMCA) may access any health record which the Trust considers may be relevant to their investigation. The Information Governance Manager/Caldicott Guardian are available to advise on the appropriateness of disclosure.

7.3.22 If the deputy/attorney is seeking limited information (such as when the person they are representing needs to take medication), it may be appropriate for ward staff to give it verbally or to provide a hard copy (a printout and/or photocopy). The disclosure of this information should be documented in the health record. Otherwise, the deputy/attorney should be asked to make a formal subject access application.

Litigation Friends

7.3.23 A person can be appointed as litigation friend to make decisions about a court case for either:

- an adult who lacks the mental capacity to manage their own court case either with or without a solicitor; or
- a child.

The court case can be:

- a civil case, except a tribunal;
- a family case; or
- a Court of Protection case.

7.3.24 Applications by or on behalf of a litigation friend should include their consent and evidence of their appointment to that role.

Processing the subject access request

7.3.25 On receipt of the subject access request the Health Records Department will acknowledge it and identify all relevant electronic and paper health records. If the Health Records Department has reason to believe that an electronic system to which it does not have access holds relevant information about the data subject, the appropriate Information Asset owner should be asked to provide it.

7.3.26 When the applicant has provided the necessary information to identify the health records to which access is being sought, the Health Records Department will record the request on the Subject Access Requests log. The request should then be responded to within one month of receipt. If this is not possible due to the complexity of the subject access request, the response may be delayed for up to two more months. In this case an explanation should be sent to the applicant within one month of receipt and the Head of Health Records informed.

Advice from health professional(s) on serious harm

7.3.27 The Health Records Department will seek clinical advice on whether the serious harm test is met (i.e. disclosure of the record would be likely to cause serious harm to the physical or mental health of the data subject or another individual and should therefore be withheld from the applicant). Advice will be sought from:

- the health professional who is currently or was most recently responsible for the diagnosis, care or treatment of the data subject in connection with the matters to which the data relates;
- where there is more than one such health professional, the health professional who is the most suitable to provide an opinion on the question; or
- a health professional who has the necessary experience and qualifications to provide an opinion on the question where there is no health professional available falling within the above paragraphs.

The advice must have been obtained within the previous six months.

The health professional will also be asked to:

- identify any third party information of which they are aware and which may not be suitable for disclosure; and
- advise whether, if any redactions are necessary on either serious health or third party grounds, the applicant should be informed of them, and, if so, whether this should be in writing or given in person by a particular health professional.

7.3.28 If the health professional identifies any part of the health record as meeting the serious harm test, the Health Records Department will consult the Caldicott Guardian, who will review this advice, nominate a colleague to do so or commission an appropriate risk assessment.

7.3.29 If clinical advice on the serious harm test in relation to the same health records has already been provided within the previous six months, it is not necessary to re-seek it, unless the Health Records Department considers it necessary to do so in the circumstances.

7.3.30 The Trust will not disclose information with the potential to cause serious harm to an individual unless the Caldicott Guardian has specifically directed this and is able to outline the reason and rationale for disclosure. Where such information is approved by the Caldicott Guardian, a review will take place by members of the executive team prior to disclosure. Justification for disclosure should not include that the information is freely available within the public domain; although this may be the case, the Trust still maintains a duty of care when considering the disclosure of such information.

Third party information

7.3.31 The Health Records Department will identify any third party (i.e. information which would disclose information relating to another individual who can be identified from the information). If appropriate, the Health Records Department will contact the third party to seek their consent to disclose the information. If this is not possible or practicable and if there are any other concerns about the

disclosure of the third party information, the health Records Department will consult the Information Governance Manager and/or Caldicott Guardian. Where it can be demonstrated that consent is not practicable, the Trust should weigh up whether the third party information should be fully released or removed. All disclosures of information about a third party need to be considered on a case-by-case basis. Lack of consent from third parties should not prevent the information from being provided where this would place the data subject's human rights in jeopardy. Four helpful things to consider are:

- any duty of confidentiality owed to the third party;
- any steps taken with a view to seeking the consent of the third party;
- whether the third party is capable of giving consent;
- any express refusal of consent by the third party.

7.3.32 As documents received from other organisations become part of the data held by the Trust, the Trust is able to decide on its disclosure. There is no requirement to seek the consent of health professionals in other organisations, nor from social care and education professionals. However, there may be occasions when it is considered appropriate to seek the advice of the organisation providing the document, although the Trust is not obliged to follow it.

Responding to subject access requests

7.3.33 The Health Records Department will consider whether it is appropriate to inform the applicant of any third party which has not been disclosed, as this knowledge could be harmful to either the data subject or another person.

7.3.34 Once the above checks have been completed and any redactions made, a copy of the health record should be provided to the service user or their representative. Alternatively, a date should be set for the relevant records to be viewed. If copy records are to be provided, it is preferable for the data subject or representative to collect them in person and for a Trust staff member to record that they have done so. Alternatively, the copies should be sent by recorded delivery post or as an encrypted email.

7.3.35 The Health Records Department will retain:

- a copy of the request and of the clinical advice in the health record;
- a copy of the information being disclosed to the applicant;
- a copy of any information not being disclosed to the applicant; and
- the reason for restricting/withholding access.

7.3.36 Where information is not readily intelligible to the data subject, an explanation (e.g. of abbreviations or medical terminology) must be given.

7.3.37 If it is agreed that the applicant may directly inspect paper health records, it should be considered whether access should be supervised by a health professional or a lay administrator. A lay administrator is a neutral person who can oversee the viewing and ensure that the record remains safe. In these circumstances the lay administrator must not comment or advise on the content of the record. If the applicant raises queries, an appointment with a health professional should be offered.

8.0 REQUESTS TO AMEND HEALTH RECORDS AND COMPLAINTS

8.1 Credible records are an important aid in providing safe healthcare to service users. Records should reflect the observations, judgements and factual information collected by the contributing health professional. The DPA fourth principle requires that information should be accurate and kept up-to-date. This provides the legal basis for enforcing correction of factual inaccuracies. An opinion or judgement recorded by a health professional, whether accurate or not, should not be deleted. Retaining relevant information is essential for understanding the clinical decisions that were made and to audit the quality of care

8.2 If a data subject feels that information recorded on their health record is incorrect, they should first make an informal approach to the health professional concerned to discuss the situation in an attempt to have the records amended. Where both parties agree that information is factually inaccurate, it should be amended to clearly display the correction whilst ensuring that the original information is still legible. An explanation for the correction should also be added.

8.3 Where the health professional and data subject disagree about the accuracy of the entry, the Department of Health recommends that the data subject should be allowed to include a statement within their record to the effect that they disagree with the content.

8.4 If the issue remains unresolved, the service user should be informed that they have a right to make a formal complaint to the Trust through the NHS Complaints Procedure.

8.5 The service user should also be informed that they also have the right to complain directly to the Information Commissioner's Office if they believe that the Trust is not complying with their request in accordance with the DPA and to seek legal independent advice.

8.6 Service users may also apply to the Trust for the correction or deletion of their information under section 10 of the DPA where the processing of the information is causing substantial and unwarranted damage or distress. The Trust should respond within 21 days to such requests, confirming compliance or non-compliance and reasons why they believe the request is unjustified.

8.7 If the service user is dissatisfied with the Trust's decision to reject a section 10 request, they may apply to the courts to have their request upheld.

9.0 FORMAL APPLICATIONS FOR ACCESS TO THE HEALTH RECOORDS OF DECEASED SERVICE USERS (ACCESS TO HEALTH RECORDS ACT)

9.1 The Access to Health Records Act 1990

9.1.1 The Access to Health Records Act 1990 (AHRA) originally related to all health records but, having been superseded by Data Protection Acts for living individuals, now relates to the health records of deceased people only. It

provides a small cohort of people with a statutory right to apply for access to information contained within a deceased person's health record.

9.1.2 *An application for access to a health record, or to any part of a health record may be made to the holder of the record by the person's personal representative (the executor or administrator of the deceased person's estate) and any person who may have a claim arising out of the patient's death.*

9.1.3 *Where an application is made, the holder shall, within the requisite period, give access to the record, or the part to which the application relates:*

- *by allowing the applicant to inspect the record or an extract setting out as much of the record as is not excluded; and*
- *if the applicant so requires, by supplying a copy of the record or extract.*

9.1.4 *Where any information contained in a record or extract is expressed in terms which are not intelligible without explanation, an explanation of those terms shall be provided with the record or extract, or supplied with the copy.*

9.1.5 *No fee shall be required for giving access except:*

- *where access is given to a record, or part of a record, none of which was made after the beginning of the period of 40 days immediately preceding the date of the application, a fee not exceeding £10; and*
- *where a copy of a record or extract is supplied to the applicant, a fee not exceeding the cost of making the copy and (where applicable) the cost of posting it.*

9.1.6 *The requisite period is:*

- *where the application relates to a record, or part of a record, none of which was made before the beginning of the period of 40 days immediately preceding the date of the application, the period of 21 days beginning with that date; or*
- *in any other case, the period of 40 days beginning with that date.*

9.1.7 *Where an application does not contain sufficient information to enable the holder of the record to identify the patient or to satisfy the holder that the applicant is entitled to make the application and within the period of 14 days beginning with the date of the application, the holder of the record requests the applicant to furnish such further information as may reasonably be required for that purpose, the requisite period commences when that further information is so furnished.*

9.1.8 *Access shall not be given to any part of a health record which:*

- *in the opinion of the holder of the record would disclose:*
    - *information likely to cause serious harm to the physical or mental health of any individual; or*
    - *information relating to or provided by an individual who could be identified from that information (unless the individual has consented to the application or where that individual is a health professional who has been involved in the care of the patient);*
    - *information provided by the patient in the expectation that it would not be disclosed to the applicant; or*

- *information obtained as a result of any examination or investigation to which the patient consented in the expectation that the information would not be so disclosed;*
  - *was made before the commencement of this Act (1st November 1991) (unless the giving of access is necessary in order to make intelligible any part of the record to which access is required to be given under the Act); or*
  - *is not relevant to any claim which may arise out of the patient's death.*

9.1.9 *A health body shall take advice from the appropriate health professional before they decide whether they are satisfied as to any matter for the purposes of this Act. The 'appropriate health professional' means:*

- *where one or more medical practitioners are available who have been responsible for the clinical care of the patient, that practitioner or, such one of those practitioners, as was most recently responsible: or*
- *where this does not apply, a health professional who has the necessary experience and qualifications to advise on the matter in question.*

9.1.10 *There may be circumstances where individuals who do not have a statutory right of access under the AHRA request access to a deceased service user's record. Current legal advice is that the courts would accept that confidentiality obligations owed by health professionals continue after death. The Department of Health, General Medical Council and other clinical professional bodies have long accepted that the duty of confidentiality continues beyond death and this is reflected in the guidance they produce.*

9.1.11 *In these circumstances the general rules that apply to the disclosure of confidential service user information should have effect to determine whether a disclosure is appropriate and lawful. Requests should be considered on a case-by-case basis and not simply rejected. Paragraphs17.2.3-4 below provide more detail on the considerations that apply where there is no statutory right of access.*

9.1.12 *There are also a range of public bodies that have lawful authority to require the disclosure of health information. These include the courts, legally-constituted public inquiries and various regulators and commissions e.g. the Audit Commission and the Care Quality Commission. In these cases the common law obligation to confidentiality is overridden.*

9.2 Procedure for Dealing with an application for the health records of a deceased person

Receiving an application

9.2.1 A request for access should be made in writing ensuring that it contains sufficient information to enable the correct records to be identified. The use of the form at Appendix 3 is preferred. Applicants may wish to specify particular dates or parts of records which they wish to access. This may help to reduce the fee that is payable for copies provided. The request should also give details of the applicant's right to access the records.

9.2.2 The Health Records Department handles all applications. In the event of an application being directed to another member of staff or department, it should be forwarded on the same working day to the designated email address: SubjectAccess@ghc.nhs.uk.

9.2.3 If an application has not been made on an application form, one should be sent to the applicant for their information, so that they are aware of the process outlined in it, although there is no expectation that the applicant will complete and return it.

9.2.4 The personal representative (ie the executor or administrator of the deceased person's estate) is the only person who has an unqualified right of access to a deceased service user's record and needs give no reason for applying for access to a record. The personal representative may be asked to provide evidence of who they are and their relationship with the deceased. Examples of evidence include:

- copy of marriage certificate;
- copy of the relevant part of the deceased person's will or probate (grant of representation).

If there are any concerns about evidence provided, further concerns should be raised with the Information Governance Manager and/or Caldicott Guardian.

9.2.5 Individuals other than the personal representative have a legal right of access under the Act only where they can establish a claim arising from a service user's death and they should therefore be asked to provide evidence to support their claim and to prove their identity. There is less clarity regarding which individuals may have such a claim. Whilst this is accepted to encompass those with a financial claim, determining who these individuals are and whether there are any other types of claim is not straightforward. The decision as to whether a claim actually exists lies with the record holder. In cases where it is not clear whether a claim arises, the Information Governance and/or Caldicott Guardian should be consulted and, if necessary, legal advice sought.

9.2.6 All requests for further information about the identity of the patient or for evidence of entitlement to make the application should be made within 14 days of receipt of the application.

Processing the application, timescale and fees

9.2.7 On receipt of the application the Health Records Department will identify all relevant electronic and paper health records. If the Health Records Department has reason to believe that an electronic system to which it does not have access holds relevant information, the appropriate Information Asset Owner should be asked to provide it.

9.2.8 Once the Health Records Department has the relevant information and fee (or agreement to pay), it should comply with the request promptly and within 21 days where the entire record (or part requested) has been made to in the last 40 days, and within 40 days otherwise. The Health Records Department should provide a regular update on the progress of their application if access has not been given

after 21 or 40 days. The applicant should be informed of any delays of more than 40 days and the reasons for them.

9.2.9 The fee structure under the AHRA is:

- **Records held manually** - where an applicant is permitted to view a record which is held manually and has been added to in the forty days preceding the application, access is free of charge. Where the record has not been added to in the preceding forty days, a charge of £10 may be made to view the record.

- **Records held wholly or partially on computer** - where an applicant is permitted to view a record which is held wholly or partially on computer, a fee of £10 may be made.

- **Hard copies of information** – if an applicant wishes to obtain a copy of the record, they may be charged a fee. There is no limit on this charge, but it should not result in a profit for the record holder. This fee is over and above the £10 for the initial access.

Advice from health professional(s) on serious harm

9.2.10 The Health Records Department will seek clinical advice on whether disclosure of any part of the health record is likely to cause serious harm to the physical or mental health of any individual and should therefore be withheld from the applicant. Advice will be sought from the last health professional responsible for the deceased person's care or, if that person is not available, the Caldicott Guardian. The health professional will also be asked to identify any information which the patient expected not to be disclosed and third party information which may not be suitable for disclosure.

9.2.11 If the health professional identifies any harmful information within the health record, the Health Records Department will consult the Caldicott Guardian.

9.2.12 The Trust will not disclose information with the potential to cause serious harm to an individual unless the Caldicott Guardian has specifically directed this and is able to outline the reason and rationale for disclosure. Where such information is approved by the Caldicott Guardian, a review will take place by members of the executive team prior to disclosure. Justification for disclosure should not include that the information is freely available within the public domain; although this may be the case, the Trust still maintains a duty of care when considering the

Third party information and information which the patient expected not to be disclosed

9.2.13 The Health Records Department will identify any third party information (i.e. information which would disclose information relating to another individual who can be identified from the information and has not consented to its disclosure) or information which the deceased person had indicated that they did not wish to be disclosed. If advice is required, it can be sought from the Trust Secretary and/or Caldicott Guardian.

Responding to applications

9.2.14 Once the above checks have been completed and any redactions made, a copy of the health record should be provided to the service user or their representative. Alternatively, a date should be set for the relevant records to be viewed. If copy records are to be provided, it is preferable for the data subject or representative to collect them in person and for a Trust staff member to record that they have done so. Alternatively, the copies should be sent by recorded delivery post or as an encrypted email.

9.2.15 The Health Records Department will retain:

- a copy of the request and of the clinical advice in the health record;
- a copy of the information being disclosed to the applicant;
- a copy of any information not being disclosed to the applicant; and
- the reason for restricting/withholding access.

9.2.16 Where information is not readily intelligible to the data subject, an explanation (e.g. of abbreviations or medical terminology) must be given.

9.2.17 If it is agreed that the applicant may directly inspect paper health records, it should be considered whether access should be supervised by a health professional or a lay administrator. A lay administrator is a neutral person who can oversee the viewing and ensure that the record remains safe. In these circumstances the lay administrator must not comment or advise on the content of the record. If the applicant raises queries, an appointment with a health professional should be offered.

Disclosure in the absence of a statutory basis

9.2.18 Disclosures in the absence of a statutory basis should be in the public interest, proportionate and judged on a case-by-case basis. The public good that would be served by disclosure must outweigh both the obligation of confidentiality owed to the deceased individual, any other individuals referenced in a record, and the overall importance placed in the health service providing a confidential service. Key issues for consideration include any preference expressed by the deceased prior to death, the distress or detriment that any living individual might suffer following the disclosure, and any loss of privacy that might result and the impact upon the reputation of the deceased. The views of surviving family and the length of time after death are also important considerations. The obligation of confidentiality to the deceased is likely to be less than that owed to living service users and will diminish over time.

9.2.19 Another important consideration is the extent of the disclosure. Disclosing a complete health record is likely to require a stronger justification than a partial disclosure of information abstracted from the record. If the point of interest is the latest clinical episode or cause of death, then disclosure, where this is judged appropriate, should be limited to the pertinent details. If a right of access is established due to a claim arising from a service user's death, only information relating to this claim should be disclosed to the applicant. There is no right of access to any information which is not relevant to the claim being made.

9.2.20 In some cases the decision about disclosure may not be simple or straightforward and the Trust Secretary and/or Caldicott Guardian should be consulted. In the

most complex cases it may be necessary for them to seek advice from the Trust's legal advisors.

9.2.21 There are no prescribed fees for health information disclosed for the deceased in the absence of a statutory basis. Any fees should be reasonable and proportionate to cover the cost of satisfying a request. The Department of Health recommends that the fee structure established for the AHRA above is followed.

10.0 SHARING HEALTH RECORDS WITH ANOTHER HEALTHCARE PROVIDER FOR HEALTHCARE PURPOSES

10.1 A written request must be received from the requesting organisation explaining the reason for the request.

10.2 The request should include the written consent of the service user (or the person with parental responsibility). If consent cannot be provided, this should be explained so that a Health Records Manager can decide on access or seek further advice from a health professional, Caldicott Guardian, Information Governance Manager or legal advisor.

10.3 Only relevant parts of the health record should be provided. A Health Records Manager will normally be able to determine this but on some occasions may need to seek further advice as in 18.2 above.

10.4 Annex B1 in *Confidentiality: NHS Code of Practice* may also be referred to.

11.0 INSURANCE COMPANIES

11.1 The Information Commissioner's Office is understood to have advised that the practice of insurance companies using the right of subject access to obtain health records is likely to breach the Data Protection Act third principle that information must be adequate, relevant and not excessive in relation to the purpose for which it is processed.

11.2 If a subject access request is received in the name of an individual but directly from an insurer, the letter at Appendix 4 should be sent to the insurer suggesting that they request a medical report seeking only that information which is relevant to the insurance application and which is compliant with the provisions of the Access to Medical Reports Act 1998 (see paragraph 25 below).

12.0 POLICE

12.1 This is set out in *Guidelines for Dealing with Requests from the Police for Personal Information*.

13.0 CORONERS

13.1 It is the Department of Health's view that public interest served by Coroners' inquiries will outweigh considerations of confidentiality unless exceptional circumstances apply. When the Trust considers that there are reasons why full

disclosure is not appropriate, e.g. due to confidentiality obligations or Human Rights considerations, the following steps should be taken:

- the coroner should be informed about the existence of information relevant to an inquiry in all cases;
- the concern about disclosure should be discussed with the Coroner and attempts made to reach an agreement on the confidential handling of records or partial redaction of record content;
- where agreement cannot be reached, the issue will need to be considered by an administrative court.

14.0 MEMBERS OF PARLIAMENT AND OTHER ELECTED REPRESENTATIVES

14.1 The term 'elected representative' covers members of parliament (UK, Scotland, Wales and Northern Ireland), local authority councillors and mayors (and their equivalents in the devolved countries). Specific legislation under the Statutory Instrument, 2002, No. 2905, The Data Protection (Processing of Sensitive Personal Data) (Elected Representatives) Order 2002 enables information to be disclosed to elected representatives without contravening the Data Protection Act. However, it does not remove the constraints of the common law duty of confidentiality and as such the common law should still be satisfied (normally by consent) before information is disclosed. However, where an MP states, in writing, that they have a person's consent for disclosure, this may be accepted without further resort to that person. [2]

15.0 COURT ORDERS

15.1 A court may order the release of information without the consent of the data subject or representative. All court orders must be reported to the Health Records Department, who will liaise with the current/most recent health professional to ensure that there are no concerns about full disclosure. Any such concerns should then be raised with the Information Governance Manager and/or Caldicott Guardian.

16.0 MENTAL HEALTH ACT COMMISSIONERS

16.1 The Care Quality Commission is the independent regulator of health care and social care services. It monitors the operation of the Mental Health Act and protects the interests of people whose rights are restricted under it. Section 120 places a duty on the CQC to review and, where appropriate, investigate the exercise of powers and the discharge of duties. For these purposes a person authorised by the CQC may at any reasonable time:

- visit and interview in private any patient in a hospital;
- if the authorised person is a registered medical practitioner or approved clinician, examine the patient there; and
- require the production of and inspect any records relating to the detention or treatment of any person who is or has been detained under the Act or who is or has been a community patient or a patient subject to guardianship.

2 Section 13 of Model B3 in *Confidentiality: NHS Code of Practice* provides more information about disclosure to MPs.

16.2 Commissioners make an annual visit to all wards on which patients are detained, normally without prior notice. A member of the ward staff should identify with the commissioner the information which they wish to see and provide them with any case notes containing some or all of it. Much, if not all, of this information is likely to be on RiO only. The commissioner may apply to the Trust for their own smartcard or may use one which has already been issued to them by another organisation. If so and if the visit takes place during office hours, Appendix 6 should be referred to. Otherwise, ward/MHA Administration/Health Records staff should either show the relevant records to the commissioner on RiO or provide a printout of them.

17.0 INDEPENDENT MENTAL CAPACITY ADVOCATES (IMCAS)

17.1 The Mental Capacity Act Code of Practice refers to section 35(6) of that Act and states that the powers of IMCAs to carry out their duties include the rights:

- *to have an interview in private with the person who lacks capacity; and*
- *to examine, and take copies of, any records that the person holding the record thinks are relevant to the investigation.*

17.2 An IMCA wishing to view records should contact the ward to arrange a suitable time to view them, if possible giving at least 48 hours' notice. This should provide ward staff with sufficient time to print off the electronic records or to ask the Health Records Department to do so. If ward staff have any concerns about the appropriateness of the IMCA accessing the complete health record (in light of the criteria at 8.3.25), they should seek advice from the health professional responsible for the data subject's clinical care, Caldicott Guardian and/or Information Governance Manager.

17.3 On arrival on the ward, the IMCA must provide ward staff with evidence that they are authorised to view the records.

17.4 A member of the ward staff should identify with the IMCA the information which they need to see and provide them with any case notes containing some or all of it. However, much, if not all, of this information is likely to be on an electronic health record only. Ward staff should either show the relevant records to the IMCA or provide a printout themselves or through the Health Records Department.

18.0 INDEPENDENT MENTAL HEALTH ADVOCATES (IMHAS)

18.1 Chapter 6 of the Mental Health Act Code of Practice states the following.

- *Where the patient consents, IMHAs have a right to see any clinical or other records relating to the patient's detention or treatment in any hospital, or relating to any after-care services provided to the patient.*(6.30)

- *Where the patient does not have the capacity (or in the case of a child, the competence) to consent to an IMHA having access to their records, the holder of the records must allow access if they think that it is appropriate and that the records in question are relevant to the help to be provided by the IMHA.* (6.31)

- *When an IMHA seeks access to the records of a patient who does not have the capacity or competence to consent, the person who holds the records should ask the IMHA to explain what information they think is relevant to the help they are providing to the patient and why they think it is appropriate for them to be able to see that information.. (6.32)*

- *The Act does not define any further what it means by access being appropriate, so the record holder needs to consider all the facts of the case. But the starting point should always be what is in the patient's best interests and not (for example) what would be most convenient for the organisation which holds the records. (6.33)*

- *In deciding whether it is appropriate to allow the IMHA access, the holder of the records needs to consider whether disclosure of the confidential patient information contained in the records is justified. (6.34)*

- *The key consideration will therefore be whether the disclosure is in the patient's best interests. That decision should be taken in accordance with the Mental Capacity Act 2005 (or, for children under 16, the common law). (6.35)*

- *Record holders should start from a general presumption that it is likely to be in the patient's interests to be represented by an IMHA who is knowledgeable about their case. But each decision must still be taken on its merits, and the record holder must, in particular, take into account what they know about the patient's wishes and feelings, including any written statements made in advance. (6.36)*

- *Records must not be disclosed if that would conflict with a decision made on the patient's behalf by the patient's attorney or deputy, or by the Court of Protection. (6.37)*

- *If the record holder thinks that disclosing the confidential patient information in the records to the IMHA would be in the patient's best interests, it is likely to be appropriate to allow the IMHA access to those records in all but the most exceptional circumstances. (6.38)*

18.2 Department of Health supplementary guidance on IMHAs' rights to information which patients themselves would have no right to see and whether IMHAs may share that information with patients is available at:

http://www.dh.gov.uk/en/publicationsandstatistics/publications/publicationspolicyandguidance/DH_098828

18.3 An IMHA wishing to view records should contact the ward to arrange a suitable time to view the records, if possible giving at least 48 hours' notice. If the service user does not have capacity to consent, the health professional in charge of care should be asked to advise on access on 'best interest' principles. If ward staff have any concerns about the appropriateness of the IMCA accessing the complete health record (in light of the criteria at 8.3.25), they should seek advice from the responsible clinician and/or the Caldicott Guardian.

18.4 A member of the ward staff should identify with the IMHA the information which they need to see and provide them with any case notes containing some or all of it. However, much, if not all, of this information is likely to be on an electronic health record only. Ward staff should either show the relevant records to the IMHA on RiO or provide a printout themselves or through the Health Records Department.

19.0 MEDICAL TRIBUNAL MEMBERS

19.1 The Mental Health Act Code of Practice states:
In certain categories of case a medical member of the Tribunal may be asked to examine the patient at some time before the hearing. Hospital managers must ensure that the medical member can see patients who are in hospital in private, where this is safe and practicable, and make provision for the member and the Tribunal panel at the hearing to be able to examine the patient's medical records, if necessary. It is important that the patient is told of any visit in advance so that they can be available when the medical member visits. (12.23)

19.2 The medical member should contact the ward (or community team if the patient is on long term section 17 leave or a community treatment order) to arrange to meet with the patient and to view relevant health records held by the ward/team.

19.3 A member of the ward/community team/MHA Administration/Health Records staff should identify with the medical member the information which they wish to see and provide them with any case notes containing some or all of it. Much, if not all, of this information is likely to be on RiO only. The visiting Tribunal doctor may apply to the Trust for their own smartcard or may use one which has already been issued to them by another organisation. If so and if the visit takes place during office hours, Appendix 6 should be referred to. Otherwise, staff should either show the relevant records to the medical member on RiO or provide a printout of them.

20. DETAINED PATIENTS' LEGAL REPRESENTATIVES AND INDEPENDENT DOCTORS

20.1 The Mental Health Act Code of Practice states:

- *Hospital managers and professionals should enable detained patients to be visited by their legal representatives at any reasonable time. This is particularly important where visits are necessary to discuss a Tribunal application. Where the patient consents, legal representatives and independent doctors should be given prompt access to the patient's medical records. Delays in providing access can hold up Tribunal proceedings and should be avoided. (12.8)*

- *In connection with an application (or a reference) to the Tribunal, an independent doctor or approved clinician authorised by (or on behalf of) a patient has a right to visit and examine the patient in private. Those doctors and approved clinicians also have a right to inspect any records relating to the patient's detention, treatment and (where relevant) after-care under section 117. where nearest relatives have a right to apply to the Tribunal, they too*

may authorise independent doctors or approved clinicians in the same way. The patient's consent is not required for authorised doctors or approved clinicians to see their records, and they should be given prompt access to the records they wish to see. (12.9)

20.2 Under Rule 14 of the Tribunal Procedure (First-tier Tribunal) (Health, Education and Social Care Chamber) Rules 2008, the Tribunal can withhold from a patient information which is likely to cause serious harm to the patient or another person but disclose it to the patient's solicitor on the basis that they do not disclose it to anyone else, including the client. More information is at http://www.lawsociety.org.uk/support-services/advice/practice-notes/representation-before-mental-health-tribunals/ (Paragraph 5.3.3)

20.3 The Mental Health Lawyers Association Code of Conduct (https://www.mhla.co.uk/about/code-of-conduct/) states that 'representatives will comply with any lawful hospital procedures such as those relating to … access to medical records'.

20.4 A legal representative who has been instructed by a patient should provide the patient's written consent to the MHA Administration/Health Records Department for scanning and uploading to RiO. If the legal representative has been appointed by the Tribunal because the patient has been deemed not to have capacity to appoint one, the legal representative should provide evidence of their appointment.

20.5 The RC/ward/community team will be aware if a patient has a forthcoming Tribunal. If they know of any sensitive information within the record which it may be inappropriate for the legal representative/independent doctor to see (in light of the criteria at 10.3.25), they should inform the MHA Administrator/Health Records Department so that appropriate advice can be sought.

20.6 The legal representative/independent doctor should contact the ward (or patient/community team if the patient is on long term section 17 leave or a community treatment order) or MHA Administration/Health Records Department to arrange to meet with the patient and to view any relevant health records held by the ward/team.

20.7 Before a legal representative accesses a record, staff should satisfy themselves that a patient with capacity has consented to this or, if the patient lacks capacity, the Tribunal has appointed the solicitor to act on the patient's behalf.

20.8 A member of the ward/community team/MHA Administration/Health Records staff should identify with the legal representative the information which they wish to see and provide them with any case notes containing some or all of it. Much, if not all, of this information is likely to be on RiO only. Staff should either show the relevant records to the legal representative on RiO or provide a printout of them.

21.0 SECOND OPINION APPOINTED DOCTORS (SOADS)

21.1 The Mental Health Act (section 119) states that a registered medical practitioner or other person appointed by the Commission 'may visit and interview and, in the case of a registered medical practitioner, examine in private any patient detained and require the production of and inspect any records relating to the treatment of the patient'.

21.2 The Mental Health Act Code of Practice states that:

- *SOADs have a right of access to records, without the patient's consent if necessary and may ask hospital managers to provide the clinical notes to help inform their decision. Managers are responsible for ensuring that such requests can be fulfilled promptly. (25.50*)

21.3 The SOAD should contact MHA Administration/Health Records Department, ward or community team (if the patient is on long term section 17 leave or a community treatment order) to arrange to meet with the patient and to view any relevant health records.

21.4 A member of the ward/community team/MHA Administration/Health Records staff should identify with the SOAD the information which they wish to see and provide them with any case notes containing some or all of it. Much, if not all, of this information is likely to be on RiO only. The SOAD may apply to the Trust for their own smartcard or may use one which has already been issued to them by another organisation. If so and if the visit takes place during office hours, Appendix 6 should be referred to.

Otherwise, staff should either show the relevant records to the medical member on RiO or provide a printout of them.

22.0 FREEDOM OF INFORMATION

22.1 The Freedom of Information Act 2000 (FOI) is an act to make provision for the disclosure of information which is held by public authorities and those who provide services to public authorities.

22.2 FOI and Access to Health Records

22.2.1 The FOI is not intended to allow people to gain access to private sensitive information about themselves or others, such as information held in health records. Those wishing to access personal information about themselves should apply under the DPA. The Information Commissioner has provided guidance to the effect that health records of the deceased are exempt from the provisions of FOI due to their sensitive and confidential content.

22.2.2 There are specific exemptions in the FOI Act to stop disclosure of personal health information. The following two sections of the FOI Act are the most relevant.

- **Section 40 –** Information which constitutes ''personal information'' under the DPA is exempt from the provisions of FOI if its disclosure would contravene any of the DPA principles. Although the DPA applies only to living individuals, there are some cases where information about a deceased service user is also personal information relating to or identifying a living individual.

- **Section 41** – Information that has been provided in confidence is exempt from the provisions of the FOI. There is a general agreement that information provided for the purposes of receiving healthcare is held under a duty of confidence. This exemption applies with regards to access to deceased service user records.

23.0 MEDICAL REPORTS ACT 1988

23.1 Access to Medical Reports Act 1988

23.1.1 The Access to Medical Reports Act 1988 governs access to medical reports made by a medical practitioner who is, or has been, responsible for the clinical care of the service user for insurance or employment purposes. 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.

23.1.2 A person cannot ask a service user's medical practitioner for a medical report on him/her for insurance or employment reasons without the service user's knowledge and consent. Service users have the option of declining to give consent for a report about them to be written.

23.1.3 The service user can apply for access to the report at any time before it is supplied to the employer/insurer, subject to certain exemptions. The medical practitioner should not supply the report until this access has been given, unless 21 days have passed since the service user has communicated with the doctor about making arrangements to see the report. Access incorporates enabling the service user to attend to view the report or providing the patient with a copy of the report.

23.1.4 Once the service user has had access to the report, it should not be supplied to the employer/insurer until the service user has given their consent. Before giving consent, the service user can ask for any part of the report that they think is incorrect to be amended. If an amendment is requested, the medical practitioner should either amend the report accordingly, or, at the service user's request, attach to the report a note of the service user's views on the part of the report which the doctor is declining to amend. Service users should request amendments in writing. If no agreement can be reached, service users also have the right to refuse supply of the report.

23.1.5 A medical practitioner may make a reasonable charge for supplying the service user with a copy of the report.

23.1.6 Medical practitioners must retain a copy of the report for at least 6 months following its supply to the employer/insurer. During this period service users continue to have a right of access, for which the medical practitioner may charge a reasonable fee for a copy.

23.1.7 The medical practitioner is not obliged to give access to any part of a medical report whose disclosure would in the opinion of the practitioner:

- cause serious harm to the physical or mental health of the individual or others,
- indicate the intentions of the medical practitioner towards the individual, or
- identify a third person, who has not consented to the release of that information or who is not a health professional involved in the individual's care.

PART 3

24.0 DEFINITIONS

24.1 A **health (medical) record is defined by the** Data Protection Act as a record which consists of data concerning health and has been made by or on behalf of a health professional in connection with the diagnosis, care or treatment of the individual to whom the data relates. A health record can be recorded in electronic or manual form (paper case notes) or in a mixture of both. It may include such things as: hand-written clinical notes, letters to and from other health professionals, laboratory reports, radiographs and other imaging records, e.g. x-rays and not just x-ray reports, printouts from monitoring equipment, photographs, videos and tape-recordings of telephone conversations.

24.2 A **data controller** is the legal entity which determines the purposes for which and the manner in which any personal data are, or are to be, processed. The Trust is a data controller.

24.3 A **data subject** is a living and identifiable individual about whom a data controller holds personal and sensitive information.

24.4 **Subject access rights** are the rights of data subjects or their authorised representatives to apply to see certain personal data held about them, including health records.

24.5 A **service user** is any person receiving a service from the Trust.

24.6 A **patient** is a person who is, or appears to be, suffering from a mental disorder and is the terminology used in the Mental Health Act.

24.7 A **First-tier tribunal** is a judicial body which has the power to discharge patients from detention, supervised community treatment, guardianship and conditional discharge under the Mental Health Act. Any detained patient who makes an application or is referred to the Tribunal is entitled to legal representation through Legal Aid.

24.8 **A second opinion appointed doctor (SOAD)** is an independent doctor appointed by the Care Quality Commission who gives a second opinion on whether certain types of medical treatment for mental disorders should be given without the patient's consent.

24.9 An **independent mental capacity advocate (IMCA)** provides support and representation for a person who lacks capacity to make specific decisions, where the person has no one else to support them. The IMCA service is established under section 35 of the Mental Capacity Act and its functions are set out under section 36. It is not the same as an ordinary advocacy service.

24.10 An **independent mental health advocate (IMHA)** is an advocate available to offer help to patients under arrangements which are specifically required to be made under the Mental Health Act.

26.0 PROCESS FOR MONOTORING COMPLIANCE

26.1 The Head of Health Records will provide the Information Governance Steering Group with an annual summary of all Data Protection Act/Access to Health Records Act applications. This will highlight all occasions when access has been limited or denied and any deviations from the stipulated timescales.

26.2 Any occasions when information has been disclosed inappropriately will be reported by Datix. The Information Governance Steering Group will be informed and will ensure that appropriate action is taken.

27.0 TRAINING

27.1 Health Records Department staff who deal with subject access requests receive appropriate training.

27.2 Information Governance is included in the Corporate Induction and in ongoing mandatory training.

28.0 REFERENCES

- *Access to Health Records Act 1990*
- *Access to Medical Reports Act 1988*
- *Data Protection Act 2018*
- *Mental Health Act 1983 and Code of Practice*
- *Mental Capacity Act 2005 and Code of Practice*
- *NHS Code of Practice on Confidentiality*
- *Guidance for Access to Health Records Requests (2010) Department of Health*
- *Independent Mental Health Advocates – Supplementary guidance on access to patient records under section 130B of the Mental Health Act (2009) Department of Health*
- *Representation before Mental Health Tribunals (2009) The Law Society*

Gloucestershire Health and Care NHS Foundation Trust policies

- *Freedom of Information Policy*
- *Guidelines for Dealing with Requests from the Police for Personal Information*
- *Health and Social Care Records Policy and Procedures*
- *Information Security Policy*

APPENDIX 1

Gloucestershire Health and Care
NHS Foundation Trust

Seeing your Health Records

This leaflet explains what to do if you wish to have access to your health records held by Gloucestershire Health and Care NHS Foundation Trust

Can I ask to see my health records?
The Data Protection Act gives every living person, or an authorised representative, the right to apply for access to health records. You can use the form in this leaflet to apply for access to your health records held by Gloucestershire Health and Care NHS Foundation Trust.

When you complete the form, it would be helpful if you could state whether you require specific time periods or services within your records.

This Trust provides a range of services:

- **Mental Health**, including Charlton Lane and Wotton Lawn Hospitals, Community Mental Health Teams, Crisis Resolution & Home Treatment Teams, Later Life Teams, Let's Talk, Memory Service, Recovery Teams
- **Learning Disability**, including Berkeley House and Community Learning Disability Team
- **Physical health**, including Community Hospitals, Community Dental, Nursing, Occupational Therapy & Physiotherapy Services, Minor Injury Units, Podiatry, Speech & Language Therapy and Sexual Health

Although this information is optional, it can help us to ensure that we give you the information you want and can help to save NHS time and resources.

Can anyone else ask to see my health records?
With your signed agreement, another person (such as a solicitor) can apply on your behalf. Please be aware that your representative may gain access to all health records about you, some of which may not be relevant to the purpose for which your representative needs them. If this is a concern to you, you should inform your representative of what information you wish them to request.

Can I see my child's health records?
The law regards young people aged 16 or 17 to be adults in respect of their rights to confidentiality. A parent of such a person may not make an application without the young person's signed consent. There is a separate leaflet if you wish to apply to the records of children aged under 16, for whom you have parental responsibility.

Can I see the health records of a person who has died?
Some people (such as the executor) can apply to see the health records of a deceased person. There is a separate leaflet for this.

Must I prove my identity?
If we are not sure about your identity, we will ask for more information. In order to prevent a delay, please provide proof of your identity and address with your application, if you are not currently in contact with one of our services.

What happens after I have asked to see my health records?
In some circumstances the Data Protection Act requires us to withhold information held in your health record. We therefore have to make the following checks.

- We will ask a health professional currently or most recently responsible for your care whether supplying you with the whole record is likely to cause serious harm to the physical or mental health or condition of you or any other person.
- We will also check whether providing you with the whole record would disclose information relating to or provided by a third person who has not consented to the disclosure. (This exemption does not apply where that third person is a health professional involved in your care.)

We may need to ask for advice on these matters from the Trust's Caldicott Guardian. (All NHS organisations are required to have a senior person, called a Caldicott Guardian, response for protecting the confidentiality of information about service users and ensuring appropriate information sharing).

What is the cost?
There is not normally a charge for this service, unless your request is considered excessive or repetitive, in which case an administrative fee may be charged.

Must I tell you the reason for my request?
You do not have to tell us why you wish to see your records, but it can be helpful if you do, so that we can address any questions or concerns which you may have about your care and treatment. If you want to see your records in order to make a complaint, it may be helpful to contact the Patient and Carer Experience Team at:

- 0300 421 8313
- experience@ghc.nhs.uk
- FREEPOST RSKC-CSKU-KRZX
  Edward Jenner Court, 1010 Pioneer Avenue
  Gloucester Business Park
  Brockworth
  Gloucester, GL3 4AW

How long will I wait to see my health records?
Once you have provided us with sufficient information about yourself, so that we can locate the correct records, we will normally comply with your request within one month. In exceptional circumstances when this is not possible, you will be informed of the delay and given a timescale for when your request is likely to be met.

How will I see my records?
If you have asked to receive a copy of your records, we will either arrange for you to collect them from one of our sites or we will send to you either by secure email or recorded delivery post.

What if I have questions or concerns after seeing my records?
If you think that you may not have received a complete copy, contact the person who provided you with the copies.

If you disagree with what you read, please talk to the health professional responsible for your care. Alternatively, or if you are unhappy with the way in which we have dealt with your request, you can contact our Patient and Carer Experience Team (contact details above).

You can also contact the Information Commissioner's Office (set up to uphold information rights in the public interest, promoting openness by public bodies and data privacy for individuals) at:
Wycliffe House
Water Lane
Wilmslow
Cheshire
SK9 5AF.
www.ico.gov.uk

1a)	Full name of patient/service user (including previous surnames)	
b)	Address now	
c)	Address at start of treatment (if different)	
d)	Date of birth	
e)	NHS number (if available)	
2	Reason for application	
3	Name (s) of Consultant (s)/health professional(s) in charge of the treatment	
4	Gloucestershire Health and Care NHS Foundation Trust provides a range of Mental Health, Learning Disability and Physical Health Services. Please indicate the service(s) to which you are seeking access.	Mental Health YES/NO Learning Disability YES/NO Physical Health YES/NO
5	Place(s) where treatment was received	

6	Date(s) for which I am requesting records	
7	A description of the treatment received	
8	I wish to: • Receive a copy of the record • View the original record	YES / NO YES / NO
9	Any other relevant information, particular requirements, or any documents not required (for example, copies of computerised records)	
10	Name and address of applicant (if not the patient/service user)	
11	Relationship of applicant to patient/service user	

Any ID documents which you send must, between them prove your identity and address.

Acceptable proof of identity

Please supply a copy of *ONE* of the following:	Please tick ✔
Passport	
HM Forces ID Card	
Bank Statement with current address	
Birth Certificate	
Driving Licence Photo Card	
Marriage Certificate	
College ID	

Acceptable proof of address

Please supply a copy of *ONE* of the following:	Please tick ✔
Utility Bill e.g. Gas, Electricity, Phone	
Inland Revenue Statement	
Council Tax Bill	
Bank Statement (if not used above)	
Local Authority Rent Card	
Driving Licence Photo Card (if not used above)	

Declaration

I declare that the information given in this form is correct to the best of my knowledge and that I am the person named below. I am making this request for copy records because:

- I am the patient/service user — YES / NO
- The patient/service user has asked me to act on their behalf and I enclose their written authorisation — YES / NO
- A court has appointed me to act on behalf of the patient/service user and I attach a copy of the court order — YES / NO

Name (BLOCK CAPITALS) …….

Address (BLOCK CAPITALS) ……

……

Telephone Number…….

Signed……. **Dated**…….

Please return to:
Information Governance and Records
Gloucestershire Health and Care NHS Foundation Trust
Edward Jenner Court
Brockworth Business Park
1010 Pioneer Avenue
Brockworth
Gloucester
GL3 4AW
or Email subjectaccess@GHC.nhs.uk

APPENDIX 2

Gloucestershire Health and Care
NHS Foundation Trust

Seeing your Child's Health Records

This leaflet explains what to do if you wish to have access to your child's health records held by Gloucestershire Health and Care NHS Foundation Trust

Can I ask to see my child's health records?
The Data Protection Act gives every living person, or an authorised representative, the right to apply for access to health records. You can use the form in this leaflet to apply for access to the health records held by Gloucestershire Health and Care NHS Foundation Trust of a child for whom you have parental responsibility.

When you complete the form, it would be helpful if you could state whether you require specific time periods or services within your records. This Trust provides a range of services:

- **Mental Health**, including Charlton Lane and Wotton Lawn Hospitals, Community Mental Health Teams, Crisis Resolution & Home Treatment Teams, Later Life Teams, Let's Talk, Memory Service, Recovery Teams
- **Learning Disability**, including Berkeley House and Community Learning Disability Team
- **Physical health**, including Community Hospitals, Community Dental, Nursing, Occupational Therapy & Physiotherapy Services, Minor Injury Units, Podiatry, Speech & Language Therapy and Sexual Health

Although this information is optional, it can help us to ensure that we give you the information you want and can help to save NHS time and resources.

Does my child have to agree that I can see their health records?
The law regards young people aged 16 or 17 to be adults in respect of their rights to confidentiality. There is a separate leaflet for adults.

If your child is aged 12 or over, we will normally require their consent also, on the assumption that they are mature enough to understand their rights.

Can anyone else ask to see my child's health records?
With your or your child's signed agreement, another person (such as a solicitor) can apply on your behalf. Please be aware that your representative may gain access to all health records about your child, some of which may not be relevant to the purpose for which your representative needs them. If this is a concern to you, you should inform your representative of what information you wish them to request.

Can I see the health records of a person who has died?
Some people (such as the executor) can apply to see the health records of a deceased person. There is a separate leaflet for this.

Must I prove my or my child's identity?
If we are not sure about the identity of the person making the application, we will ask for more information. In order to prevent a delay, please provide proof of identity, address and parental responsibility with your application, if your child is not currently in contact with one of our services.

What happens after I have asked to see my child's health records?
In some circumstances the Data Protection Act requires us to withhold information held in your health record. We therefore have to make the following checks.

- We will ask a health professional currently or most recently responsible for your child's care whether supplying you or your child with the whole record is likely to cause serious harm to the physical or mental health or condition of you, your child or any other person.
- We will also check whether providing the whole record would disclose information relating to or provided by a third person who has not consented to the disclosure. (This exemption does not apply where that third person is a health professional involved in your child's care.)

We may need to ask for advice on these matters from the Trust's Caldicott Guardian. (All NHS organisations are required to have a senior person, called a Caldicott Guardian, response for protecting the confidentiality of information about service users and ensuring appropriate information sharing).

What is the cost?
There is not normally a charge for this service, unless your request is considered excessive or repetitive, in which case an administrative fee may be charged.

Must I tell you the reason for my request?
You do not have to tell us why you wish to see your records, but it can be helpful if you do, so that we can address any questions or concerns which you may have about your care and treatment. If you want to see your records in order to make a complaint, it may be helpful to contact the Patient and Carer Experience Team at:

- 0300 421 8313
- experience@ghc.nhs.uk
- FREEPOST RSKC-CSKU-KRZX
  Edward Jenner Court
  1010 Pioneer Avenue
  Gloucester Business Park
  Brockworth
  Gloucester, GL3 4AW

How long will I wait to see my child's health records?
Once you have provided us with sufficient information about your child and yourself, so that we can locate the correct records, we will normally comply with your request within one month. In exceptional circumstances when this is not possible, you will be informed of the delay and given a timescale for when your request is likely to be met.

How will I see my child's records?
If you have asked to receive a copy of your child's records, we will either arrange collection from one of our sites or we will send them by either secure email or recorded delivery post.

What if I have questions or concerns after seeing my child's records?
If you think that you may not have received a complete copy, contact the person who provided you with the copies.

If you disagree with what you read, please talk to the health professional responsible for your child's care. Alternatively, or if you are unhappy with the way in which we have dealt with your request, you can contact our Patient and Carer Experience Team (contact details above).

You can also contact the Information Commissioner's Office (set up to uphold information rights in the public interest, promoting openness by public bodies and data privacy for individuals) at:
Wycliffe House
Water Lane
Wilmslow
Cheshire
SK9 5AF.
www.ico.gov.uk

1a)	Full name of patient/service user (including previous surnames)	
b)	Address now	
c)	Address at start of treatment (if different)	
d)	Date of birth	
e)	NHS number (if available)	
2	Reason for application	
3	Name (s) of Consultant (s)/health professional(s) in charge of the treatment	
4	Gloucestershire Health and Care NHS Foundation Trust provides a range of mental health, learning disability and physical health services. Please indicate the service(s) to which you are seeking access	Mental Health YES/NO Learning Disability YES/NO Physical Health YES/NO
5	Place(s) where treatment was received	

6	Date(s) for which I am requesting records	
7	A description of the treatment received	
8	I wish to: • Receive a copy of the record • View the original record	YES / NO YES / NO
9	Any other relevant information, particular requirements, or any documents not required (for example, copies of computerised records)	
10	Name and address of applicant (if not the patient/service user)	
11	Relationship of applicant to patient/service user	

Any ID documents which you send must, between them prove your identity and address.

Acceptable proof of identity

Please supply a copy of *ONE* of the following:	Please tick ✔
Passport	
HM Forces ID Card	
Bank Statement with current address	
Birth Certificate	
Driving Licence Photo Card	
Marriage Certificate	
College ID	

Acceptable proof of address

Please supply a copy of *ONE* of the following:	Please tick ✔
Utility Bill e.g. Gas, Electricity, Phone	
Inland Revenue Statement	
Council Tax Bill	
Bank Statement (if not used above)	
Local Authority Rent Card	
Driving Licence Photo Card (if not used above)	

Acceptable proof of parental responsibility

Please supply a copy of:	**Please tick ✔**
Child's full birth certificate	

Declaration

I declare that the information given in this form is correct to the best of my knowledge and that I am the person named below. I am making this request for copy records because:

- I am the patient/service user — YES / NO
- I have parental responsibility for this child
- The patient/service user has asked me to act on their behalf and I enclose their written authorisation — YES / NO
- A court has appointed me to act on behalf of the patient/service user and I attach a copy of the court order — YES / NO

Name (BLOCK CAPITALS) …….

Address (BLOCK CAPITALS)……

……

Telephone Number…….

Signed…… **Dated**……

Children Aged 12 and Over

If you have requested information on behalf of a child aged 12 or over, please ask that person to sign below. If this is not possible, please explain the reasons.

I give permission for a copy of my personal information, as described in this document, to be sent to the person whose name appears above.

Signed…… **Dated**……

Please return to:
Information Governance and Records,
Gloucestershire Health and Care NHS Foundation Trust,
Edward Jenner Court, Brockworth Business Park,
1010 Pioneer Avenue,
Brockworth,
Gloucester,
GL3 4AW,
or email: subjectaccess@GHC.nhs.uk

APPENDIX 3

Gloucestershire Health and Care
NHS Foundation Trust

Seeing the health records of a person who has died

This leaflet explains what to do if you wish to have access to the health records held by Gloucestershire Health and Care NHS Foundation Trust of a person who has died.

Can I ask to see the health records of someone who has died?
The Access to Health Records Act gives certain people the right of access to the health records of a deceased individual. If you are the executor/administrator of a deceased person's estate or may have a claim arising from a person's death, you can use the form in this leaflet to apply for access to your health records held by Gloucestershire Health and Care NHS Foundation Trust.

When you complete the form, it would be helpful if you could state whether you require specific time periods or services within your records.

This Trust provides a range of services:

- **Mental Health**, including Charlton Lane and Wotton Lawn Hospitals, Community Mental Health Teams, Crisis Resolution & Home Treatment Teams, Later Life Teams, Let's Talk, Memory Service, Recovery Teams
- **Learning Disability**, including Berkeley House and Community Learning Disability Team
- **Physical health**, including Community Hospitals, Community Dental, Nursing, Occupational Therapy & Physiotherapy Services, Minor Injury Units, Podiatry, Speech & Language Therapy and Sexual Health

Although this information is optional, it can help us to ensure that we give you the information you want and can help to save NHS time and resources.

Can anyone else ask to see the health records of a person who has died?
Assuming that you have the right of access, with your signed agreement, another person (such as a solicitor) can apply on your behalf. Please be aware that your representative may gain access to all health records about the deceased person, some of which may not be relevant to the purpose for which your representative needs them. If this is a concern to you, you should inform your representative of what information you wish them to request.

Must I prove my identity?
If we are not sure about your identity, we will ask for more information. In order to prevent a delay, please provide proof of your identity and address with your application.

What happens after I have asked to see the health records?
In some circumstances the Access to Health Records Act requires us to withhold information held in a health record. We therefore have to make the following checks.

- We will ask a health professional most recently responsible for the care of the deceased person whether supplying you with the whole record is likely to cause serious harm to the physical or mental health or condition of you or any other person.
- We will also check whether:
    - the deceased person indicated that they did not wish certain information to be disclosed
    - the health record contains information which the deceased person expected to remain confidential, unless there is an overriding public interest in disclosing
    - providing you with access to the whole record would disclose information relating to or provided by a third person who has not consented to the disclosure. (This exemption does not apply where that third person is a health professional involved in care.)

We may need to ask for advice on these matters from the Trust's Caldicott Guardian. (All NHS organisations are required to have a senior person, called a Caldicott Guardian, response for protecting the confidentiality of information about service users and ensuring appropriate information sharing).

What is the cost?
Under the Access to Health Records Act, we may charge a fee to view the health records or to be provided with a copy of them. The maximum permitted charges are set out below.

- To allow you to view the health record (where no copy is required) - £10, but access to paper records added to within the last 40 days is free.
- To provide you with a copy of the health record - £10 and also what it costs us to copy the health record and send the copies to you.

How long will I wait to see my health records?
Once you have provided us with sufficient information about yourself and the person who has died, so that we can locate the correct records, and your agreement to pay a fee, we will aim to comply with your request within:

- 21 days (if the records have been added to within the last 40 days); or
- 40 days

How will I see the records?
If you have asked to receive a copy of the records, we will either arrange for you to collect them from one of our sites or we will send to you either by secure email or recorded delivery post.

What if I have questions or concerns after seeing my records?
If you think that you may not have received a complete copy, contact the person who provided you with the copies.

If you disagree with what you read, please talk to the health professional responsible for care. Alternatively, or if you are unhappy with the way in which we have dealt with your request, you can contact our Patient and Carer Experience Team (contact details above).

1a)	Full name of patient/service user (including previous surnames)	
b)	Last address	
c)	Address at start of treatment (if different)	
d)	Date of birth Date of death	
e)	NHS number (if available)	
2	Reason for application	
3	Name (s) of Consultant (s)/health professional(s) in charge of the treatment	
4	Gloucestershire Health and Care NHS Foundation Trust provides a range of Mental Health, Learning Disability and Physical Health Services. Please indicate the service(s) to which you are seeking access.	Mental Health YES/NO Learning Disability YES/NO Physical Health YES/NO
5	Place(s) where treatment was received	

6	Date(s) for which I am requesting records	
7	A description of the treatment received	
8	I wish to: • Receive a copy of the record • View the original record	YES / NO YES / NO
9	Any other relevant information, particular requirements, or any documents not required (for example, copies of computerised records)	
10	Name and address of applicant	
11	Relationship of applicant to patient/service user	

Any ID documents which you send must, between them prove your identity and address.

Acceptable proof of identity

Please supply a copy of *ONE* of the following:	Please tick ✔
Passport	
HM Forces ID Card	
Bank Statement with current address	
Birth Certificate	
Driving Licence Photo Card	
Marriage Certificate	
College ID	

Acceptable proof of address

Please supply a copy of *ONE* of the following:	Please tick ✔
Utility Bill e.g. Gas, Electricity, Phone	
Inland Revenue Statement	
Council Tax Bill	
Bank Statement (if not used above)	
Local Authority Rent Card	
Paper Driving Licence (if not used above)	

Declaration

I declare that the information given in this form is correct to the best of my knowledge and that I am the person named below. I am making this request for copy records because:

- I am the deceased person's personal representative and/or executor of their will and I enclose evidence of this — YES / NO
- I have a claim arising from the person's death and I enclose evidence of this. — YES / NO
- I agree to pay the fee in line with the Access to Health Records Act — YES / NO

Name (BLOCK CAPTITALS) …….

Address (BLOCK CAPITALS)……

……

Telephone Number…….

Signed…… **Dated……..**

Please return to:
Subject Access Request, Information Governance and Records, Gloucestershire Health and Care NHS Foundation Trust, Edward Jenner Court, 1010 Pioneer Avenue, Gloucester Business Park, Brockworth, Gloucester, GL3 4AW

Or Email - SubjectAccess@ghc.nhs.uk

APPENDIX 4 - Letter to Insurance Company

Dear Sir/Madam

Name of data subject

I am writing in response to your Subject Access Request for the above person in respect of an insurance application.

Following advice from the Information Commissioner's Office (ICO), we are unable to carry out this request on the basis that doing so is likely to breach a number of principles of the Data Protection Act (DPA). For example, we understand that it is the ICO's view that insurance companies which process full health records are likely to breach the DPA's principle which states that information must be 'adequate, relevant and not excessive' in relation to the purpose for which it is processed.

You may wish to consider requesting a medical report which seeks only that information which is relevant to the insurance application and which is compliant with the provisions of the access to Medical Reports Act 1988.

Yours faithfully

APPENDIX 5

1.0 Procedure when visitor already holds an NHS Care Records Service smartcard issued by another organisation

1.1 On first visit, visitor completes Registration Form 'CIS – Position Assignment Modification'

1.2 MHA Administrator/Health Records staff signs 'Sponsor Declaration'.

1.3 MHA Administrator/Health Records staff scans/emails completed form to RA Agent at Edward Jenner Court for card holder to have clinical practitioner RiO access. Original is then sent to RA Agent / HR Department in the post.

1.4 MHA Administrator/Health Records staff e-mail visitor information (Full name, role, Card UUID) to the Clinical Systems Helpdesk to have a RiO account set-up.

1.5 On the visitor's first visit with their smartcard, they must contact the Clinical Systems Helpdesk to have their card synchronised and for a brief telephone tutorial.

1.6 On completion of the visit MHA Administrator/Health Records staff to inform the RA Agent and RiO Helpdesk to ensure the card is de-activated.

1.7 On all subsequent visits during office hours the MHA Administrator/Health Records Department contacts:

- RA Agent at Edward Jenner Court with visitor's name and date/time of visit for cards to be activated/deactivated.
- Clinical Systems Helpdesk for RiO access to be activated/deactivated.

2.0 Procedure for issuing personalised smartcard to SOAD/Tribunal doctor/MHA Commissioner

2.1 Visitor contacts MHA Administrator/Health Records Department and arranges time to visit with completed Registration Form 9CIS – Create New User'' and required ID.

2.2 MHA Administrator/Health Records Department checks ID, completes 'RA Declaration' and takes digital photograph of visitor. (In manager's absence other Health Records staff may sign on his/her behalf.)

2.3 MHA Administrator/Health Records Department sends completed form and digital photograph to RA Agent, who produces the smartcard and sends it to MHA Administrator/Health Records Department.

2.4 MHA Administrator/Health Records staff e-mail visitor information (Full name, role, Card UUID) to the RiO helpdesk to have a RiO account set-up.

2.5 On next visit to the Trust, visitor collects their smartcard and contacts the Clinical Systems Helpdesk to have their card synchronised and for a brief telephone tutorial

2.6 On completion of the visit MHA Administrator/Health Records staff to inform the RA Agent and Clinical Systems Helpdesk to ensure the card is de-activated.

2.7 On all subsequent visits during office hours MHA Administrator/Health Records Department contacts:

- RA Agent at Edward Jenner Court with visitor's name and date/time of visit for cards to be activated/deactivated.
- Clinical Systems Helpdesk for RiO access to be activated/deactivated.