Gloucestershire Health and Care
NHS Foundation Trust

Processing Subject Access Requests (SAR) – June 2024

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Processing a Subject Access Request (SAR)

A subject access request does not have to be in any particular form or media, nor does it have to include the words “subject access” or refer to the UK General Data Protection Regulations (UK GDPR). The person making the request does not need to tell you the reason for their request (although it may help us find the information they are requesting), or what they intend to do with the information.

1. Recording a SAR

Requests may be received in the following format:

- On an application form
- In writing
- By email
- Verbal (and documented in health record by recipient)

The above list is not exhaustive.

Once a SAR is received create a patient folder in the O-Drive (O:\Executive Management\Information Governance\10 SARs). See Appendix A for folder structure and naming conventions. Copy/save all emails and documents received into this folder.

There is one Excel spreadsheet for recording and tracking the progress of all SARs. This spreadsheet is accessed in Microsoft Teams.

The spreadsheet is used to record all actions, telephone conversations, and any relevant notes for each SAR. The spreadsheet needs to be updated at every stage of the process. See Appendix B for guidance on completing the SARs spreadsheet.

2. Acknowledging a SAR

Send an appropriate acknowledgement email to the requestor within 3 days of receipt (by letter if requested or no email address provided). This can be done even if you do not know what records are available. There are different acknowledgement templates in the “O” Drive in the SAR folder (O:\Executive Management\Information Governance\10 SARs\Letter and Email Templates). Chose the most appropriate template depending on who the request is received from, and whether any additional information is requested to progress the SAR. See Sections 3-6 to identify which acknowledgement is required.

If no records are held send the requester an acknowledgement email advising no records held.

Once all documents required have been received, SARs for living patients need to be processed within one calendar month. Records for deceased patients need to be processed within 21 days (if the records have been added to within the last 40 days), or 40 days from receipt of of the request.

3. SAR received from a Solicitor

Adult or Child - Has the solicitor provided sufficient information to be able to verify their client's identity?

- If you are unable to find the patients records, inform the solicitor that their client cannot be found with the information supplied, ask them to check their client's details and resend another letter/consent with correct details.

Adult or Child - Has the solicitor provided a consent document allowing them access to their client's records, which has been signed and dated within the last 6 months?

- If not request an up to date consent form from the solicitor.

Child - Has the solicitor provided a copy of the child's full birth certificate?

(Solicitors need to provide evidence that the person who signed the medical consent form has parental responsibility for the child).

- If no, request a copy of the child's full birth certificate – send acknowledgment requesting birth certificate, once you have check to see what medical records are available.

- Depending on the child's circumstances they could live with a guardian, you would then need to request a copy of the court order or care order stating parental responsibility.

4. SAR received from Patient / Parent/Guardian / Patients Representative

If a completed application form has not been received send the relevant application form out to the requestor with the acknowledgement email. There are different application forms in the "O" Drive (O:\Executive Management\Information Governance\10 SARs\Application Forms and Letters).

You cannot make someone complete a SAR application form, (completing an application form is preferred as it has all the information you need to be able to process a SAR), but you must ensure you have enough of the patient's personal information to be able identify the person to process the request, and a copy of their identification documentation;

- Name
- Date of birth
- Address
- Type of records requested
- Copy of proof of identify
- Copy of proof of address

The above information and identification documents must be requested, received and verified before a SAR is processed.

Patients who are an inpatient on a ward at a GHC hospital may also request records. A letter or completed application form is required from the patient. The staff on the ward will verify the patient's identity, identification documents are not required if the patient does not have any with them.

Child - SAR received from Parent/Guardian

Has the parent/guardian provided two official documents with the completed application form proving their identity, with a copy of the child's full birth certificate?

- Ensure all identification documents received are in the parent/guardian's name, if not request missing document.

- Ensure all addresses match on identification document.

- If the child is over the age of 12, ensure they have signed the application form (if they have capacity to understand what they are signing). If the child has not signed the application form, check child's competence with health professional and request consent if appropriate.

- Children under 12; copy of full birth certificate required or care order / court order stating parental responsibility.

Adult - SAR received from a Patient

Has the service user provided two official documents with the completed application form proving their identity?

- Ensure all identification documents received are in the patient's name, addresses match etc.

- If identification documents are incorrect or not received, request relevant documents

5. <u>SAR received from the Patient's Representative</u>

Has the patient's representative provided two official documents with the completed application form proving their identity, and a signed / dated consent from the service user allowing the service users representative access to their medical, or provided a copy of a Power of Attorney?

- Ensure all identification documents received are in the service user's representative's name.

- If identification documents are incorrect or not received, request relevant documents.

- If the service user's representative cannot provide a power of attorney, they must provide written / dated consent from the service user allowing them access to their records.

6. <u>SAR received from the Patients Representative requesting access to deceased records</u>

Has the patient's representative completed an access to deceased patient's application form?

- If a completed application form has not been received send the relevant application form.

Has the service user's representative provided two official documents with the completed application form proving their identity and a copy of the deceased Will showing they are executor of the will, or documents proving they have a claim arising from the patient's death?

- If identification documents are incorrect or not received request relevant documents.

- If a copy of the Will showing the Executor of the Will or claim documents not provided request.

- If the Courts have appointed a person as Administrator of the deceased Estate, proof will need to be provided.

Has a solicitor requested access to a deceased patient's record?

The majority of solicitors do not provide a copy of the deceased patient's Will showing who the Executor of the Will is, you will need to request a copy. Once received check the Executor to the Will is the same as the person who has signed the medical records consent form. If it isn't the solicitor will need to provide a medical records consent form signed by the Executor of the Will. If there is no Will, then the solicitor can be asked to provide the lawful basis for requesting the information.

7. SAR received from the Police and Court Orders

Police requests are processed by the Legal Services Team. All Police requests received should be forwarded to legalservices@ghc.nhs.uk.

Court Order requests are processed by the Records Team, but treated as a priority. Clinical authorisation is not mandatory for Court Orders, and no redactions are required.

8. Locating Records

Locate the medical records as requested in the SAR, or request copies of records if held by a different department.

Mental Health Records

- Electronic records are downloaded from Rio.
- Older paper records are downloaded from CITO.
- Electronic records may also be held on IAPTUS. These need to be requested from the MHICT team. [redacted] attaching the SAR and consent for the release of the records.
- Paper records not scanned onto CITO are stored with Iron Mountain, and will need to be requested.

Physical Health records

- Electronic records are downloaded from SystemOne.

- Paper records are stored with Crown and will need to be requested.
- Dental records need be requested from the Dental Service. Email [redacted] attaching the SAR and consent for the release of the records.
- Sexual Health records including GUM, SARC and counselling records email [redacted] and [redacted] attaching the SAR and consent for the release of the records.
- Gloucestershire Wheelchair Service may have more recent records on SystemOne, but always email Wheelchair Service for copies of older records, and to request BEST records – [redacted]

Once records are downloaded or received save a copy to the patient's folder on the O-Drive (See Appendix A).

When downloading records from RIO and SystemOne, only save from referral date to discharge, or enough/sufficient information to satisfy the request.

Guidance on downloading records RIO and SystemOne can be found in the O-Drive (O:\Executive Management\Information Governance\10 SARs\Processes and Flowcharts).

- Saving Records from RIO – Case Record Menu – Check List
- Saving Records from RIO - Mental Health Records
- Saving Records from SystemOne - Physical Health Records

9. Redacting Records

We are obliged to give full access to the health record unless:

- access is considered likely to cause serious harm to the physical or mental health or condition of the patient or any individual lawfully requesting; and/or,
- access would disclose information relating to or provided by a third person (excluding a health, social care or education professional) who has not consented to the disclosure.

Once records are downloaded and saved in the patient's folder in the O-Drive they need to be reviewed and marked for redaction if required.

Physical Health Redactions

- Mothers Health Visiting records – check to ensure no information regarding child's (or other members of the family) health details has been added to the mum's record.

- Check any patient identifiable numbers (eg NHS No) printed on any communications or attachments match the service user that you are processing the SAR for.

- All safeguarding information which has been entered onto a child's records to be redacted up to the point where parent/guardian has been notified.

- Take out "Signs of Safety" documents from all children's records and redact all information relating to the signs of safety in the tabbed journal – this is third party information.

- Children's records that mention "Fabricated Illness" – this can be redacted from the records if not known to the parent/guardian.

- All records – must redact staff mobile numbers which are not know to the patient.

- Information within the record which have been given by the patients relative/carer/parent etc that may not be known to patient, and may cause harm if disclosed to a patient.

- Attached Documents – Police MARAC – Multi Agency Risk Assessment Conference, and reference to these documents in the tabbed journal

- Attached Documents – Police DARP – Domestic Abuse Risk Assessment, and reference to these documents in the tabbed journal

Mental Health Redactions

- Progress Notes – any notes which have been struck through in red / show as deleted (notes enter in error / notes added to wrong patients record etc).

- Progress Notes - any progress notes marked with confidential

- Progress Notes – any progress notes added which relate to / reference added Police documents below (MARAC / DARP)

- Attached Documents – Police MARAC – Multi Agency Risk Assessment Conference

- Attached Documents – Police DARP – Domestic Abuse Risk Assessment

- All safeguarding information which has been entered onto a child's records to be redacted up to the point where parent/guardian has been notified.

- Conversations held with / information given by a patients relative / carer / third party which would be unknown to patient, and would cause harm to the patient if shared with them.

- Check through every document / core and risk assessment / AMHP (Approved Mental Health Professional) reports etc for third party. Sometimes there is third party next of kin information within these documents.

10. Approval for Disclosure of Mental Health Records

Once records have been reviewed (and marked for redaction if required) they need to be emailed to the appropriate health professional for authorisation prior to disclosure. Contact the current Care Co-ordinator or the clinician who had most recent contact with the subject, irrespective of how recent that contact was. It is the responsibility of that person (or if none identified, then the team of the clinician) to consider the records and advise on:

- whether disclosure of all or part is likely to cause serious harm to physical or mental health of data subject, and advise on the need for redaction;

- and third-party information of which they are aware and not suitable for disclosure

The authoriser for Mental Health records can be found in one of the following areas on RIO:

- Clients View - If an inpatient it will state on left hand side by Care Co- Ordinator. If outpatient check in community referrals, then check in progress notes for clinician's name.

- If you cannot find a consultant check clinical documents for the latest review / appointment etc.

The only exception to this is for CAMHS records. If the most recent team responsible for the clinical care of the patient was CAMHS, the records are sent to [redacted] and [redacted] for review and approval.

The records are sent by email to the appropriate professional with a copy of the letter/consent or application form/identification documents received from requester. The template email 'MH-SAR Email Approval' should be used, with the relevant sections completed (found in O:\Executive Management\Information Governance\10 SARs\Letter and Email Templates). An email from the authorising professional saying "happy for the records to be disclosed" will suffice, and must be saved to the patient's folder on the "O" Drive.

11. Approval for disclosure of Physical Health Records

Once records have been reviewed (and marked for redaction if required) they need to be emailed to the appropriate health professional for authorisation prior to disclosure. The list of authorisers can be found on the "O" drive (O:\Executive Management\Information Governance\10 SARs\Contacts). It is the responsibility of that person to consider the records and advise on:

- whether disclosure of all or part is likely to cause serious harm to physical or mental health of data subject, and advise on the need for redaction;

- any third-party information of which they are aware and not suitable for disclosure

The records are sent by email to the appropriate professional with a copy of the letter/consent or application form/identification documents received from requester. The template email 'PH-SAR Email Approval' should be used, with the relevant sections completed (found in O:\Executive Management\Information Governance\10 SARs\Letter and Email Templates). An email from the authorising professional saying "happy for the records to be disclosed" will suffice, and must be saved to the patient's folder on the "O" Drive.

12. Sending Medical Records to the Requestor

Depending on how a SAR request is received, or what instructions you received from the requester with determine how you send the records. Most requests are processed electronically, and will be disclosed electronically (this is the preferred option).

All records to be converted to PDF file in Adobe, watermarked with "Subject Access Request", and password protected before sending by email. If the file is too big, send it using a link from Microsoft 365 files.

If hard copies of the records are requested, IG and Records Team must either:

- arrange for collection from a Trust site
  or
- sends by recorded/special delivery

If the requestor wishes to view original paper records, or wishes to discuss the contents of their records, the most appropriate clinician / member of staff to arrange a meeting or telephone conversation with patient will need to be identified.

13. Additional Information

Hereford SARS & Hereford patient records

If the patient has had no contact with services after 01/04/2020, it is GHC's responsibility to complete the request.

If the patient has had contact after 01/04/2020, it is Herefordshire & Worcestershire NHS Health & Care Trust's responsibility to complete the request, and the requestor needs to be directed to [redacted]

Check Hereford case note tracker for records.

Historic Minor Injuries & Illness Unit Records

Some MIiU records (also called CAS Cards - paper records) in Crown from Lydney/Stroud/Dilke and North Cotswolds are archived by box and are not indexed on to Crown. To find these records in Crown search for box description and type in CAS or Hospital name.

Patient First records can be accessed by and requested from the Deputy Head of Information Governance and Records

Radiology & Fracture Clinic Records

The X-ray departments at GHC Community Hospitals are run by Gloucestershire Hospitals NHS Foundation Trust, so any requests for X-Rays and also any requests for Fracture Clinic records need to be directed to;

> *Access to Health Records Office (Radiology), Gloucestershire Hospitals NHS Foundation Trust, Gloucestershire Royal Hospital, Great Western Road, Gloucester, GL1 3NN, Tel No: 0300 422 5746, email: ghn-tr.accessoffice@nhs.net*

Out of Hours GP Records

On some occasions a request will be received asking for MIU records, and no MIU records can be found. The Out of Hours GP service use the MIU departments in Gloucestershire Care Services Community Hospitals. Unfortunately, there is no way of find out whether the service user has attended the Out of Hours GP service.

- Up until April 2015 the Out of Hours GP service was run by Gloucestershire Care Services NHS Trust. These records can be obtained from the BI Team by sending a request to the following email address; [redacted]

- From April 2016 the Out of Hours GP service was run by South Western Ambulance Services NHS Foundation Trust. The requester will need to redirect their request to:

  Information Governance Team, South Western Ambulance Services NHS Foundation Trust, Abbey Court, Eagle Way, Exeter, Devon, EX2 7HY or Telephone 01392 261 514

- From June 2017 to present the Out of Hours GP service is run by Care UK, the requester will need to redirect their request to:

  Admin and Governance Manager, Gloucestershire OOH Service, Care UK, Unit 10, Hignham Business Park, Hignham, Gloucestershire, GL2 8DN or Telephone 01452 687 000.

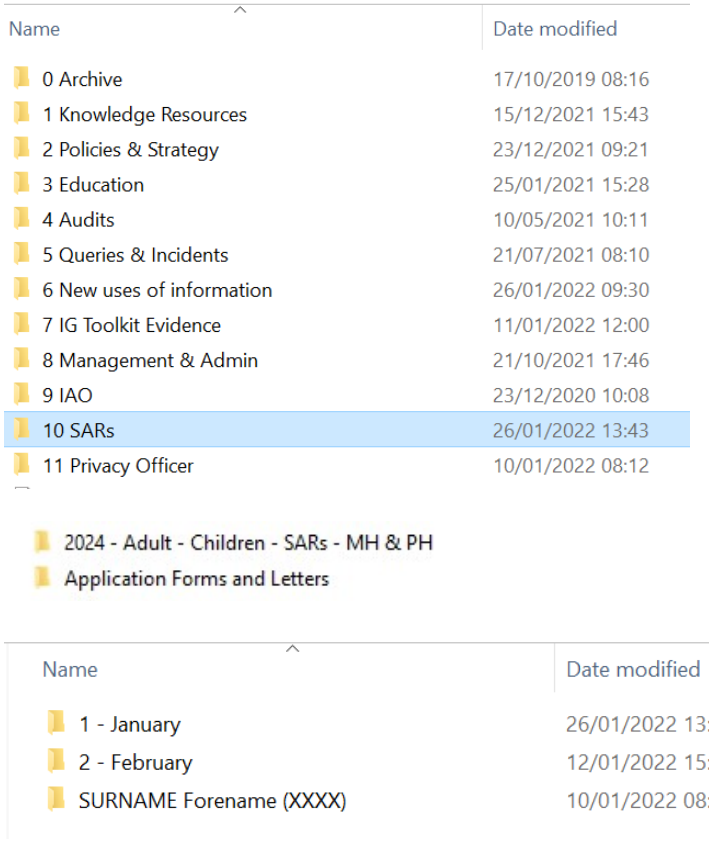
MSKAPS MRI Records

MRI scans and MRI medical reports are owned by the Cobalt Unit, Cheltenham. Patient's will need to request copies of these directly from the Cobalt Unit.

Appendix A – SAR Folder Structure & Naming Conventions

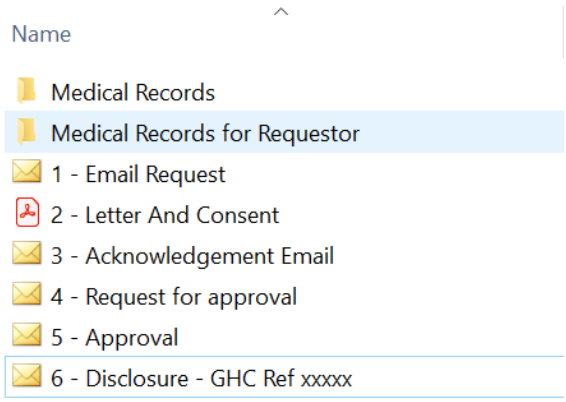
Once a SAR is received create a patient folder in the '2024 Adult - Children – SARs' folder (O:\Executive Management\Information Governance\10 SARs) under the month SAR received.

Follow the format; surname (capitals), forename, then reference number i.e. BLOGGS Joe (JB0122SAR), or copy the template folder below called SURNAME Forename (XXXX) and paste it into the correct year/month and change the name of the folder.



The reference number is a combination of the patients initials, month and SAR. For example, a subject access request received from Joe Bloggs for a copy of his records in May 2024 would be reference number JB0524SAR. Ensure all references used in the same month are different, for example if you received a SAR for a Josephine Anne Biggs in May 2024, the reference would be JAB0522SAR, not JB0522SAR.

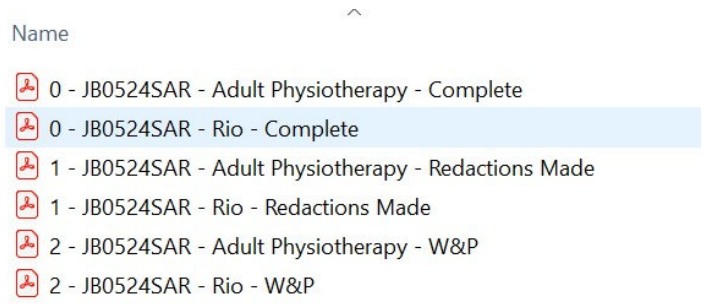
Within the patient's folder all documents and emails need to be saved, and numbered at receipt in numerical order. Additionally, two sub-folders need to be created to save medical records into – 'Medical Records' and 'Medical Record for Requestor'.



As medical records are downloaded or received these should be saved within the 'Medical Records' folder. Combined records for each service should then be saved in the 'Medical Records for Requestor' following the below numbering format and including the SAR reference number;

- 0 Records completed
- 1 Records redacted or issues highlighted
- 2 Records watermarked and password (The one that will be sent to the requester)

Physical health records are named by service, mental health records are named as Rio, Iaptus of Paper records.



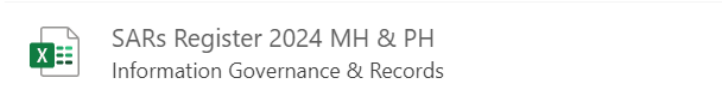
When the records have been sent to the requestor, and the email disclosure saved in the folder, the SAR is closed. The SAR may also be closed if we have requested additional information/documentation, but have not received this after 1 month. The patient's folder is renamed to add a hashtag before the patient surname, e.g. #BLOGGS Joe. When the password and receipt provided by email these emails are saved in the folder, as per other documents/emails, and numbered.

Once all the SARs for a month are completed, the folder for the month is renamed to add a hashtag before the month, e.g. #April. Additionally, once all the SARs for a year are completed a hashtag is added to the name of folder for the year, e.g. #2024 Adult - Children – SARs.

Add all documents and emails to the patient's folder as you receive/send them, to help someone else pick up the SAR if you were suddenly absent from work.

Appendix B – Completing the SAR Spreadsheet

There is one Excel spreadsheet for recording and tracking the progress of all SARs. This spreadsheet is accessed in Microsoft Teams. Click on Files, right click on the spreadsheet, select open and then select open in browser.



Each SAR must be recorded on a row of the spreadsheet, completing all columns as the SAR is progressed. Some of the columns have a drop-down list, and columns AA-AC are automatically populated via formulas. The column 'Hours spent on the request' should be updated each time the SAR is worked on.

The column 'Current Status (notes)' should be kept updated as per below;

Date - SAR received from xxxxx (requesters name/solicitors name / patient etc)
Date - Acknowledgement sent to requester
Date - Awaiting authorisation of records xxxxxx (authorisers name)
Date - Authorisation to release records received from xxxxxxx
Date - Records saved to file
Date - Records read and redacted
Date - Records disclosed to requester xxxxxx (date)

Each update should be followed by the initials of whoever completed the task/updated the spreadsheet.

The spreadsheet is colour coordinated to reflect the below;

- Row not shaded – SAR received and waiting for additional information/documentation.
- Row shaded – All required documentation provided and SAR is ready to process.
- First column of row shaded orange – work underway on SAR.
- Row shaded green – Request closed or completed.

Updates within the 'Current Status (notes)' column are highlighted red if a task is outstanding or approval is outstanding from a clinician. A SAR may be highlighted in yellow on the spreadsheet if it is urgent.

SARs are closed on the spreadsheet when the disclosure has been sent to the requestor. The password to open the records is recorded in bold in the 'Current Status (notes)' column. When a password is requested for records the spreadsheet is updated to reflect that the password has been sent.

If additional information/documentation has been requested to progress a SAR this request will be kept open until the required information is received (and progressed accordingly). Alternatively, if no contact has been made after 1 month the SAR will be closed on the spreadsheet.

The spreadsheet can be filtered to only show open SARs using the 'Completed' column. The spreadsheet is used to produce data on the number of SARs open/closed, completion time etc, so must be kept up to date. Add any information to the spreadsheet that you think would help someone else pick up the SAR if you were suddenly absent from work, to help the person know what stage of the process you have got to.