# Access to Patient Health Records Policy

This Policy provides guidance on the processes that are to be followed when dealing with requests for access to health records, under section 7 of the Data Protection Act 1998.

<table>
<thead>
<tr>
<th>Key Words:</th>
<th>Access, Health records, subject, data</th>
</tr>
</thead>
<tbody>
<tr>
<td>Version:</td>
<td>Version 3.0</td>
</tr>
<tr>
<td>Adopted by:</td>
<td>Quality Assurance Committee</td>
</tr>
<tr>
<td>Date adopted:</td>
<td>June 2012</td>
</tr>
</tbody>
</table>
| Name of originator/author: | Sam Kirkland  
Records Transformation & Information Governance Manager |
| Name of responsible committee: | Senior Clinical Quality Group |
| Date issued for publication: | July 2012 |
| Review date:        | July 2014                               |
| Expiry date:        | January 2015                            |
| Target audience:    | All Trust staff                         |
| Type of Policy (tick appropriate box) | Clinical | Non Clinical | √ |
| NHSLA Risk Management Standards if applicable: | | |
| State 00Relevant CQC Standards: | Outcome 21: Records |
## CONTRIBUTION LIST

### Key individuals involved in developing the document

<table>
<thead>
<tr>
<th>Name</th>
<th>Designation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Neill Bolderston</td>
<td>Healthcare Records Manager</td>
</tr>
<tr>
<td>Mary Stait</td>
<td>Information Governance Trainer</td>
</tr>
<tr>
<td>Sylvia Saunders</td>
<td>Information Governance Administrator</td>
</tr>
<tr>
<td>Vyv Wilkins</td>
<td>Equality &amp; Diversity Manager</td>
</tr>
</tbody>
</table>

### Circulated to the following individuals for comments

<table>
<thead>
<tr>
<th>Name</th>
<th>Designation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Members of IM&amp;T Strategy Group</td>
<td></td>
</tr>
<tr>
<td>Tom Towey</td>
<td>Medical Records</td>
</tr>
<tr>
<td>Angela Kher</td>
<td>Medical Records</td>
</tr>
<tr>
<td>Wendy Walker</td>
<td>Medical Records</td>
</tr>
<tr>
<td>Lesley Thornton</td>
<td>Facilities Officer</td>
</tr>
<tr>
<td>Jan Noble</td>
<td>Facilities Officer</td>
</tr>
<tr>
<td>Bernadette Williams</td>
<td>Facilities Officer</td>
</tr>
<tr>
<td>Jenny Hargreaves</td>
<td>Facilities Officer</td>
</tr>
<tr>
<td>Theresa Heffernan</td>
<td>Child Health Operational Manager</td>
</tr>
<tr>
<td>Dr Sab Bhaumik</td>
<td>Medical Director/ Caldicott Guardian</td>
</tr>
</tbody>
</table>
## CONTENTS

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Definitions that apply to this Policy</td>
<td>7</td>
</tr>
<tr>
<td>Equality Statement</td>
<td>10</td>
</tr>
<tr>
<td><strong>1.0 Summary</strong></td>
<td>10</td>
</tr>
<tr>
<td><strong>2.0 Introduction</strong></td>
<td>10</td>
</tr>
<tr>
<td><strong>3.0 Purpose</strong></td>
<td>11</td>
</tr>
<tr>
<td><strong>3.1 Principles</strong></td>
<td>11</td>
</tr>
<tr>
<td><strong>4.0 Duties within the Organisation</strong></td>
<td>11</td>
</tr>
<tr>
<td>4.1 Responsibilities of the Trust Board</td>
<td>11</td>
</tr>
<tr>
<td>4.2 Responsibility of Caldicott Guardian</td>
<td>11</td>
</tr>
<tr>
<td>4.3 Responsibility of Finance, Performance &amp; Information Directorate</td>
<td>12</td>
</tr>
<tr>
<td>4.4 Responsibility of Managers</td>
<td>12</td>
</tr>
<tr>
<td>4.5 Responsibility of all Employees</td>
<td>12</td>
</tr>
<tr>
<td>4.6 Relevant Clinician</td>
<td>13</td>
</tr>
<tr>
<td>4.7 Responsibility of Records &amp; Information Governance</td>
<td>13</td>
</tr>
<tr>
<td><strong>5.0 Rights of Access</strong></td>
<td>13</td>
</tr>
<tr>
<td>5.1 Types of Requester</td>
<td>14</td>
</tr>
<tr>
<td>5.2 Access requests by other organisations/agencies</td>
<td>17</td>
</tr>
<tr>
<td><strong>6.0 Applications to Access Personal Records – Formal Applications</strong></td>
<td>19</td>
</tr>
<tr>
<td>6.1 General principles</td>
<td>19</td>
</tr>
<tr>
<td>6.2 Exceptions to access rights</td>
<td>20</td>
</tr>
<tr>
<td>6.3 Charging – The Fee</td>
<td>20</td>
</tr>
<tr>
<td>6.4 Time Limits</td>
<td>21</td>
</tr>
<tr>
<td>6.5 Sending Copies of Records</td>
<td>21</td>
</tr>
<tr>
<td>6.6 Sending Original Records</td>
<td>22</td>
</tr>
<tr>
<td>6.7 Disproportionate Effort</td>
<td>22</td>
</tr>
</tbody>
</table>
### CONTENTS

<table>
<thead>
<tr>
<th>Section</th>
<th>Title</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>7.0</td>
<td>Applications to Access Personal Health Records – Informal Requests</td>
<td>22</td>
</tr>
<tr>
<td>8.0</td>
<td>Applications to Access Personal Health Records – Deceased Patients</td>
<td>23</td>
</tr>
<tr>
<td>8.1</td>
<td>Access to Patient Health records Fees</td>
<td>24</td>
</tr>
<tr>
<td>9.0</td>
<td>Access to CCTV records</td>
<td>24</td>
</tr>
<tr>
<td>10.0</td>
<td>Access to Audio and Digital Images</td>
<td>24</td>
</tr>
<tr>
<td>11.0</td>
<td>Mistakes and Inaccuracies</td>
<td>24</td>
</tr>
<tr>
<td>12.0</td>
<td>Complaints</td>
<td>25</td>
</tr>
<tr>
<td>13.0</td>
<td>Training</td>
<td>25</td>
</tr>
<tr>
<td>14.0</td>
<td>Dissemination</td>
<td>25</td>
</tr>
<tr>
<td>15.0</td>
<td>Monitoring Compliance and Effectiveness</td>
<td>26</td>
</tr>
<tr>
<td>16.0</td>
<td>Due Regard</td>
<td>26</td>
</tr>
<tr>
<td>17.0</td>
<td>Review</td>
<td>27</td>
</tr>
<tr>
<td>18.0</td>
<td>Standards/Key Performance Indicators</td>
<td>27</td>
</tr>
<tr>
<td>19.0</td>
<td>References</td>
<td>27</td>
</tr>
<tr>
<td>20.0</td>
<td>Associated Documentation</td>
<td>28</td>
</tr>
</tbody>
</table>

#### Appendices

<table>
<thead>
<tr>
<th>Appendix</th>
<th>Title</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Approval Checklist</td>
<td>29</td>
</tr>
<tr>
<td>2</td>
<td>Access to Personal Health Records Procedure Flowchart</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Exemptions</td>
<td>30</td>
</tr>
<tr>
<td>4</td>
<td>Application Form for Access to Personal Health Records</td>
<td>34</td>
</tr>
<tr>
<td>5</td>
<td>Access to Personal Health Records ‘Guidance for Applicants’</td>
<td>37</td>
</tr>
<tr>
<td>6</td>
<td>Application for Release of Deceased Patients Records</td>
<td>42</td>
</tr>
<tr>
<td>CONTENTS</td>
<td>Page</td>
<td></td>
</tr>
<tr>
<td>----------------------------------------------</td>
<td>------</td>
<td></td>
</tr>
<tr>
<td>Appendix</td>
<td>7</td>
<td></td>
</tr>
<tr>
<td>Requesting Access to Deceased Patient Records</td>
<td>45</td>
<td></td>
</tr>
<tr>
<td>‘Applicant Guidance’</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Version Control and Summary of Changes

<table>
<thead>
<tr>
<th>Version number</th>
<th>Date</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.0 Draft version 1</td>
<td>February 2012</td>
<td>Harmonisation of policies as a result of the TCS process</td>
</tr>
<tr>
<td>3.0 Final</td>
<td>May 2012</td>
<td>Final amendments to revised harmonised policy. Approved by Senior Clinical Quality Group</td>
</tr>
</tbody>
</table>

All LPT Policies can be provided in large print or Braille formats, if requested, and an interpreting service is available to individuals of different nationalities who require them.

Did you print this document yourself?
Please be advised that the Trust discourages the retention of hard copies of policies and can only guarantee that the policy on the Trust website is the most up-to-date version.

For further information contact:
Records Transformation and Information Governance Manager
Tel: 0116 2950997
Definitions that apply to this Policy

<table>
<thead>
<tr>
<th>Access</th>
<th>The availability of or permission to consult records</th>
</tr>
</thead>
<tbody>
<tr>
<td>Caldicott Guardian</td>
<td>The person within an NHS organisation who is responsible for the systems that protect patient data</td>
</tr>
<tr>
<td>Data Controller</td>
<td>Under the Data Protection Act 1998, LPT is a data controller i.e. the organisation (or person) that determines the purposes for which and the manner in which any personal data about individuals are processed.</td>
</tr>
<tr>
<td>Data Subject</td>
<td>According to the Data Protection Act 1998, the data subject is a living individual (not an organisation) who is the subject of the personal data.</td>
</tr>
<tr>
<td>Due Regard</td>
<td>Having due regard for advancing equality involves: • Removing or minimising disadvantages suffered by people due to their protected characteristics. • Taking steps to meet the needs of people from protected groups where these are different from the needs of other people. • Encouraging people from protected groups to participate in public life or in other activities where their participation is disproportionately low.</td>
</tr>
</tbody>
</table>
| Health Professional | a) A registered medical practitioner – also includes any person who is provisionally registered under Sections 15 or 21 of the Medical Act 1983 and is engaged in such employment as is mentioned in subsection (3) of the section.  
    b) A registered dentist as defined by Section 53(1) of the Dentists Act 1984  
    c) A registered optician as defined by Section 36(1) of the Opticians Act 1989  
    d) A registered pharmaceutical chemist as defined by Section 24(1) of the Pharmacy Act 1954 or a registered person as defined by Article 2(2) of the Pharmacy Act (Northern Ireland) Order 1976  
    e) A registered nurse, midwife or health visitor  
    f) A registered osteopath as defined by Section 41 of the Osteopaths Act 1994  
    g) A registered Chiropractors Act 1994  
    h) Any person who is registered as a member of a profession to which the Professions Supplementary to Medicine Act 1960 for the time being extends  
    i) A clinical psychologist, child psychotherapist or speech therapist  
    j) A music therapist employed by a health service body, and |
| **Health Record** | A ‘record consisting of information about the physical or mental health, or condition, of an individual, made by, or on behalf of, a health professional, in connection with the care of that individual. A health record can be computerised and/or manual form. It may include such documentation as handwritten clinical notes, letters to and from health professionals, laboratory reports, radiographs and other imaging records, printouts, photographs, video and tape recordings. |
| **Personal Identifiable Data or Information (PID)** | Personal-identifiable data or information is anything that contains the means to identify a person (e.g. name, address, postcode, date of birth, NHS number, National Insurance Number, photograph, etc) Reference 13 of the Caldicott Committee ‘Report on the Review of Patient-Identifiable Information’ (published December 1997) states: ‘All items of information which relate to an attribute of an individual should be treated as potentially capable of identifying patients and hence should be appropriately protected to safeguard confidentiality’. |
| **Record** | A record comprises of recorded information in any format (e.g. digital or physical) of any type, in any location (e.g. central database server, standalone PC, filing cabinet, archive store) which is created, received or maintained by the organisation in the transaction of its activities or the conduct of its affairs, and kept as unique evidence of such an activity. |
| **Redact** | To remove information that is subject to an exemption under legislation such as the Data Protection Act 1998 or the Freedom of Information Act 2000. |
| **Third Party Request** | An access to health records request from anyone other than the data subject (but with the data subject’s consent), e.g. solicitor, patient’s representative |
| **Third Party Information** | Information relating to another individual within the health record. Examples include:  
- A parent may apply for access to their 14 year old child’s health records. The child may have made some reference to his/her parents (the third party) contained within the health record, of which the child does not want disclosing. The clinician may therefore decide to withhold this information from the child’s parent.  
- A son (the third party) visits the doctor because |
he is concerned about his elderly mother, who is having problems with memory loss and self care. The doctor makes a note in his mother’s health record of the visit. If subsequently, for whatever reason, the mother decides to apply for access to her health records. The doctor may withhold any information within her records leading to the identity of her son’s visit, unless the son gave his consent to do so.
Equality Statement

Leicestershire Partnership NHS Trust (LPT) aims to design and implement policy documents that meet the diverse needs of our service, population and workforce, ensuring that none are placed at a disadvantage over others. It takes into account the provisions of the Equality Act 2010 and advances equal opportunities for all. This document has been assessed to ensure that no one receives less favourable treatment on the protected characteristics of their age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex (gender) or sexual orientation.

In carrying out its functions, LPT must have due regard to the different needs of different protected equality groups in their area. This applies to all the activities for which LPT is responsible, including policy development, review and implementation.

1.0 Summary

This policy provides guidance on the processes that are to be followed when dealing with requests for access to health records, under section 7 of the Data Protection Act 1998. It is consistent with the Data Protection Act 1998, the guidance provided by the Department of Health to NHS organisations in February 2010, and the Access to Health Records Act 1990, in so far as it relates to the disclosure of health records of deceased patients.

It is important that staff understand the requirements of these Acts, and the part that they have to play in ensuring that the Trust complies with these legal obligations.

2.0 Introduction

The Data Protection Act 1998 became effective from 1st March 2000 and superseded the Data Protection Act 1984 and the Access to Health Records Act 1990. The exception to this is the records of deceased persons, which are still governed by the Access to Health Records Act 1990.

The Data Protection Act 1998 covers all personal information whether held on paper or on computer. All organisations holding personal information are required to comply with this legislation. It therefore, does not only cover your health records held by the NHS but also covers health records held by private healthcare providers and your employer.

Within the Data Protection Act 1998, a health record is defined as ‘a record consisting of information about the physical or mental health or condition of an identifiable individual made by or on behalf of a health professional in connection with the care of that individual.’

A health record can be computerised (electronic) and/or manual (casenotes). They may include such documentation as hand-written clinical notes, letters to and from other health professionals, laboratory reports, x-rays (these are now mostly stored electronically using PACS (Picture Archiving and Communication System) and other imaging records, printouts, photographs, DVD and sound recordings.
3.0 Purpose

This policy has been written as guidance for Leicestershire Partnership NHS Trust (LPT) in dealing with formal and informal applications to access personal health records under the provision of the Data Protection Act 1998. Staff working for LPT must make every effort to comply with this policy.

The Applications for Access to Patient Health Records Policy and associated procedures will apply to all Leicestershire Partnership NHS Trust (LPT) employees (permanent, temporary and contract staff) and to Non-Executive Directors

3.1 Principles

It is the preferred option that applications to access health records are, wherever possible, dealt with on an informal basis. Further guidance on informal access can be found in section 7 of this policy.

This document has been written with reference to the Department of Health’s ‘Guidance for Access to Health Records Request’ February 2010.

4.0 Duties within the Organisation

4.1 Responsibilities of the Board

The LPT Trust Board has a duty to ensure that the requirements of the Data Protection Act 1998 are upheld and the Chief Executive has overall responsibility for implementation of this policy.

4.2 Responsibility of the Caldicott Guardian

The Caldicott Guardian is responsible for the strategic management of confidentiality within the organisation and for providing advice on confidentiality issues. The Caldicott Guardian, as guardian of patient data, must approve each new or changed agreement to share personal data with bodies such as acute hospitals, social services, police, prisons and private health care. The Caldicott Guardian is responsible for determining a relevant clinician when needed, as well as providing trained resource for screening records when required.

4.3 Responsibility of Finance, Performance and Information Directorate

The Records Transformation and Information Governance team within the Finance, Performance and Information Directorate are responsible for supporting the administration of requests for access to patient health records. This includes:

- Provision of advice and guidance on the appropriateness of the request, and that the consent and identity of the requester are verified
- Keep a log of requests received and ensure they are processed in a legally and compliant manner
• Ensuring potential problems are reported in line with the LPT incident reporting procedures
• Ensuring that consent forms and all associated documentation is held securely and confidentially in line with the Records Management Policy and Data Protection Policies.

4.4 Responsibility of Managers

Managers are responsible for ensuring that information that is disclosable under the requirements of the Data Protection Act 1998 and ensuring that records are screened appropriately and provided in a timely fashion. It is their responsibility to ensure that the contents of this policy are discussed, e.g. at staff meetings, and that possible implications for service delivery are identified and acted upon.

4.5 Responsibility of all Employees

All employees whether permanent, temporary or contract should be aware of this policy and adhere to the principles set out. They should all be aware about how to access them.

All clinicians are responsible for ensuring that:

• Health records are maintained to the highest standards ensuring that content is legible, accurate, comprehensive and understandable
• Maintaining an awareness of confidentiality and record keeping standards including patients’ rights of access to their health records, and implications that this has on current record keeping practices.

4.6 ‘Relevant Clinician’

The ‘relevant clinician’ is normally the individual who is responsible or was responsible for the clinical care of the patient during the period to which the application refers.

In the case of deceased patient’s records, when there is no current clinician involved then this should ideally be the practitioner that was last involved in the care of the patient or the last consultant. Where this is not possible other arrangements must be made to ensure that an appropriate clinician is able to undertake this role. This process must be agreed with the Caldicott Guardian.

They have the following responsibilities:

For third party access requests

• Assess the capacity of the patient to consent to disclosure of their health records to that third party;
• Check whether the patient has at any time indicated a wish not to give access to all or part of their record

For all requests
• Check if any part of the health record, if disclosed, is likely to cause serious harm to the physical or mental health of the data subject or any other person;
• Check if any part of the record discloses information relating to another individual, or information provided by a third party, who can be identified from the entry (unless that person has consented to disclosure, or is a health professional involved in the care of the patient)
• To sign off the record as being fit to provide to the requester

Trust staff should refer to the Operational Guidance for further detail.

4.7 Responsibility of Records and Information Governance Sub-group

The Records and Information Governance Sub-group has the responsibility to approve this policy and forward to the relevant committees/board for information, as well as monitoring compliance with this policy.

5.0 Rights of Access

The Data Protection Act 1998 gives individuals the right to know whether the Trust is holding or processing information about them. Patients who wish to see what is written about them in their health records have a legal right to do so, subject to given exemptions and unless there are compelling reasons to the contrary.

An individual does not have the right to access information about someone else, unless they are an authorised representative, have parental responsibility, or are acting on behalf of the deceased.

LPT are not required to respond to requests for accessing health records, unless it is provided with sufficient details to enable the location of information, and to satisfy itself as to the identity of the individual making the request.

Applicants also have the following rights:

• The right to an explanation of any terms in the records that they do not understand, e.g. technical language or terminology
• The right to ask for correction to be made to inaccurate personal information in the record, and to request a copy of the corrections.

Individuals are entitled to apply for access to their total health record as it stands at the request was received. However, the information provided may take account of any amendment or deletion that was made to the record in the period between the request having been received and dealt with, which would have been regardless of the request.

If a patient feels information on their health record is incorrect then they may firstly make an informal approach to the health professional responsible for their records to have the records amended. If this is unsuccessful, then they make a formal complaint, following the normal complaints process.
5.1 Types of Requester

5.1.1 The patient

Patients or ex-patients do not need to give a reason for applying to request their health records, but they do need to give sufficient information to enable the records to be located.

5.1.2 A person acting on the Patient’s Behalf

A person acting on the patient’s behalf (e.g. a relative, a carer, a solicitor) may apply for a copy of the patient’s records – however they must have obtained informed, explicit and written consent from the patient, have lasting Power of Attorney, or be an Independent Mental Capacity Advocate (IMCA). Such a request should be dealt with in exactly the same way as a request from a patient. The applicant should be given access only to the information and explanation that would otherwise have been made available to the patient, subject to the exemptions.

If there is any doubt as to whether the patient has mental capacity to give consent, the record holder must refer to the Mental Capacity Act 2005. The mental capacity assessment and outcome must be recorded. If the patient is assessed as lacking mental capacity to give consent, the record holder and the Caldicott Guardian must then jointly consider that:

- Releasing the information would be lawful – if I doubt, legal advice should be sought
- The applicant is acting in the best interests of the patient

If a decision is taken to release the information, then:

- The reasons leading to the decision must be recorded
- Only enough information should be released for the purpose

5.1.3 A person with Parental Responsibility for a Child

A person with parental responsibility has the right to request a copy of a child’s health records, although it must be remembered that disclosure may be refused if the child is deemed competent as per the “Fraser Guidelines” and thus refuses to give consent.

Parental responsibility for a child is defined in the Children Act 1989, and amended in the Adoption and Children Act 2002, as “all the rights, duties, powers, responsibilities, and authority which by law a parent of a child has in relation to the child and his property”.

Married parents have parental responsibility, unless a Court Order has removed that status from any party.

A separated or divorced parent who no longer lives with the child has parental responsibility unless a Court has removed that status from either party.
An unmarried father does not have parental responsibility, unless he acquires it by:

- Registering the birth, along with the mother, as the child’s father (for children born after 1 December 2003)
- Formal agreement with the mother (Section 4 of the Children Act 1989) – agreement can then only be brought to an end by a Court
- Marrying the mother
- Obtaining a court order
- Obtaining a residence order

5.1.4 **Individuals Other than Parents with Parental Responsibility**

Individuals other than parents can acquire parental responsibility by:

- Adoption Order – this confers full parental responsibility upon adoptive parents and that formerly held by their birth parents is extinguished
- Appointment of a Guardian (after a parent’s death) – this gives guardians all the parental responsibility that the parent would have had
- Residence Order – parental responsibility is shared with the parent, and is subject to the limitation that the person with the order cannot withhold consent to adoption or appoint a guardian (limitation may not be relevant for the policy)
- Parental Order – full and permanent responsibility is conveyed to a married couple of a child born in surrogacy, where at least one member of the couple is the genetic parent

Parental Responsibility is also acquired by local Authorities – and is shared with the parents, using the following orders:

- Emergency Protection Order
- Interim Care Order
- Full Care Order

5.1.5 **Rights of Children**

“Fraser Guidelines” is a term used in medical law to describe when a minor, despite a young age, has reached the necessary maturity and intelligence to understand and consent to his or her own medical treatment. This was originally developed to make professional judgements about providing contraceptive advice and/or treatment, are used by professionals to help them frame a judgement about whether a child is competent.

If a doctor (or health professional) has judged a child to be competent according to the Fraser guidelines, then the health records of that child must not be disclosed to the child’s parents, unless the child has clearly given consent.

Where, in the view of the doctor (or appropriate health professionals), the child is not deemed to comply with the Fraser guidelines, the record holder is still entitled to deny the parents access to the child’s health records if it is judged not to be in the child’s best interest.
Any reason for denying parental access to part or all of a child’s health records must be recorded. The professional involved in making this judgement should seek legal advice if necessary.

5.1.6 Rights of Adolescents

The law regard young people aged 16-18 to be adults for the purposes of consent to treatment and right to confidentiality. If they are judged competent to make a decision about their own medical treatment, then they have the right to deny parental access to their health records.

However, good practice dictates that, as with children, they should be encouraged, but not required, to involve parents or other legal guardians in any treatment or consent. Any reasons for denying parental access to part or all of a young person’s health records must be recorded.

5.1.7 A patient living abroad

When a patient moves abroad, their health records will be retained by the Trust for the recommended period specified in Records Management: NHS Code of Practice, before the record holder will decide whether to retain them any longer or destroy them.

Patients who move outside the UK are not permitted to take their health records with them – however, they are entitled to request a copy of their records, and then take a copy abroad with them. The record holder should provide the patient with a summary of the patient’s treatment to take to their new healthcare professional.

5.1.8 In-patients

If a patient who is currently staying at one of the community hospitals requests access to records of previous episodes of care, providing the last treating Clinician has determined that the information can be accessed, the patient can view the records providing a member of the medical or nursing team, or Senior Manager is present.

5.2 Access requests by other organisations (Solicitor, Police, Court Order, Pensions and Benefits Office, Research organisations)

Various organisations and agencies are likely to demand access to patient’s health records at different times. In almost all cases, staff must not share any information that is not directly related to the healthcare of the patient, unless they have consent from the patient. Examples of requests from other agencies are listed below:

5.2.1 Solicitor

Solicitors may apply to see their client’s health record, but informed, explicit and signed consent must have been obtained from the patient, along with proof of the client’s identity, before a copy of the records is released. The solicitor should be
given access only to the information and explanation that would otherwise have been made available to the patient, subject to the restrictions stated in the appendix.

5.2.2 Court Order

A Court may order disclosure of a patient’s health record (e.g. under the Civil Procedure Rules, the Data Protection Act 1998). Unlike a request from a solicitor, a Court Order should be obeyed unless there is a robust justification to challenge it, in which case the Trust, may challenge the order through the Court. The Court’s decision is law, unless the Trust decides to appeal the order and take the case to a higher Court in an attempt to override the Court’s decision.

Courts and Coroner’s are entitled to request original records. If they do, copies of the records must be retained by the Trust. Coroners normally give sufficient notice for copies to be made, but have the power to seize records at short notice, which may leave little or no time to take copies.

5.2.3 Pensions and Benefits Office

Section 29 of the Data Protection Act 1998 allows (but does not require) personal data to be disclosed to assist in the assessment or collection of any tax or duty. Any request by the Department of Works and Pensions for access to a patient’s health records must be accompanied by the relevant form. These access requests are generally sent directly to the Consultant involved in order to send copies of reports or for a synopsis regarding the patients’ care/illness/or treatment.

5.2.4 Police

Section 29 of the Data Protection Act 1998 allows (but does not require) personal data to be disclosed to assist in the prevention or detection of crime and the apprehension of prosecution of offenders.

The patient should be asked (if possible) for their informed, explicit and signed consent to disclose the information, unless this would prejudice the enquiry or court case. Any request by the Police for access to a patient’s health record must be accompanied by the relevant consent form (Section 29 Form) from the requesting police officer and signed by a Senior Officer within the requesting police force.

The Crime and Disorder Act 1998 also allows (but does not require) the Trust to disclose information to the police, local authority, probation service, or health authority for the purposes of preventing crime and disorder. For the Trust to consider releasing any information without consent, the access request must relate to a serious crime in line with the Crime and Disorder Act 1998 (e.g. murder, rape, etc), otherwise the Police should be asked to obtain a Court Order or written approved signed consent (see above regarding Court Orders).

All such requests from the Police should be in writing and forwarded immediately to a Senior Manager.
5.2.5 Research Organisations

Although research is considered an important factor in the improving of healthcare, the Information Commissioner does not consider it an essential element in the provision of healthcare.

If personal identifiable or pseudonymised information is required, informed, explicit and signed consent must be obtained. Patients and service users are generally aware and supportive of research, but it is not reasonable to assume that they are aware of, or likely to consent to, each and every research subject or proposal.

If it is sufficient for the purposes of the research to anonymised data, consent is not required, but patients should be informed by posters and/or leaflets how their information may be shared.

All research projects require the approval of the local ethics committee.

5.2.6 Telephone requests

If a telephone request is received for access, an explanation of the process should be given, and details taken to forward the relevant application form and guidance sheet.

6.0 Applications to Access Personal Health Records – Formal Applications

6.1 General principles

In general the Data Protection Act allows any person to apply to access information held about them. The person is entitled to know what information is being held, how it is being held and for what purpose it is being held. This applies to all information held, irrespective of when it was created.

A request for access under the Act must be made in writing – the applicant is under no obligation to provide a reason for submitting the application. The appropriate fees – see section 6.3, should accompany the application and also appropriate proof of identification (see Appendix 5 Guidance for Applicants).

The applicant may be either the subject of the information held, or someone acting on their behalf. Where another person is making the application, the consent of the subject is necessary if the information is required. Where there is any doubt about whether consent can be provided, i.e. where the subject is unable to provide consent, for example if the person is a child or lacks capacity to consent, every consideration should be given to any disclosure being in the person’s best interest.

Any information that is held by the Trust in relation to a patient’s care that has been created by the Trust is considered as first party information in relation to such requests. Any contributory information from another source, i.e. outside of the Trust, is considered ‘third party’ information. It remains the responsibility of the clinician in
charge of the patient’s care to decide if disclosure is appropriate in the first instance, and to contact, where feasible, the third party responsible, in the second.

Where the patient is no longer a patient of the Trust the responsibility remains with either the last clinician in charge of the patient’s care, or the most suitable health professional within the service that the patient last attended or Head of Service.

6.2 Exceptions to access rights

There are a number of exceptions to the provision of information, namely where:

- The fee has not been supplied;
- The information is held purely for research or historical reasons;
- Disclosing the information could reveal information that identifies a third person, unless that person has consented to the request and when that person is not a health professional;
- Permitting access would be likely to cause serious harm to the physical or mental health or condition of the patient or any other person (which may include a health professional)
- The request is made on behalf of a person other than the patient, such as a parent of a child, and the information held was provided in the expectation, or on indication, that it would not be disclosed to the applicant.

See Appendix 3 for further detail on Exemptions

6.3 Charging – The Fee

As of 1st August 2009, the following fees are chargeable:

The DPA states that fees should be paid in advance, but in the interests of providing a helpful service to patients, NHS organisations may request the fee at the release stage of the access request.

The Data Protection (Subject Access) (Fees and Miscellaneous Provisions) Regulations 2000 sets out the fees a patient may be charged to view their records or provided with a copy of them. These are summarised below:

To provide copies of patient health records the maximum costs are:

- Health records held electronically - £10 max
- Health records held in part on computer and part if another media (paper, x-ray film) - £50 max
- Health records held totally on other media - £50 max
- The Trust retains the right not to charge for copies should it choose not to do so.

All these maximum charges include postage and packaging costs. These are maximum costs and any charges for access requests should not be sought to make a financial gain.
6.4 Time Limits

For living individuals the Data Protection Act 1998 superseded the Access to Health Records Act 1990 which requires requests to be complied with within 40 days. Ministers gave a commitment to Parliament (Hansard Ref 25/10/2000 Col 464) that the 21 day response period contained within the Access to Health Records 1990 would be retained for the NHS and extended to all requests; not just those where the record had been recently amended and therefore best practice requires that Leicestershire Partnership NHS Trust will endeavour to comply with requests within this time limit.

Where information is required by the Trust to identify the record required or validate the request, this must be requested within 14 days of receipt of the application and the timescale responded will commence on receipt of the full information.

The applicant should be advised as soon as practicable if the time limits given cannot be complied with for any reason. This applies in exceptional circumstances only.

**Failure to comply gives the applicant the right of action in the County Court or High Court. It is therefore essential that all applications be processed as a matter of priority, thereby minimising risk to the organisation.**

6.5 Sending Copies of Records

Copies of records sent externally in the post should be:

- In a sealed ‘tamper proof envelope (e.g. self sealing jiffy bag)
- Addressed to a named person
- Marked ‘Private and Confidential’
- To be opened by Addressee only
- Sent by special delivery only

Copies are **not** be sent via fax, and not by e-mail unless the using a suitably secure means of electronic transfer is in place - i.e. NHS authorised encryption facility (This should not be done without authorisation of the Information Governance Manager)

Copies of records sent internally should be:

- In a sealed, tamper-proof envelope (e.g. self sealing jiffy bag)
- Addressed to a named person
- Marked ‘Private and Confidential’
- Sent via the Internal Secure Courier (e.g. van run)

6.6 Sending Original Records

Original health records must **not** be sent to any applicant (including solicitors) because of the potential detriment to patients and the Trust if the records are lost. The main exception to this is a Court Order, in which case the originals may be sent and copies must be retained by the Trust.
6.7 Disproportionate Effort

The obligation to provide a copy may be waived where the data subject agrees otherwise or it is not possible to supply a copy of the material sought, or to do so would involve disproportionate effort (for example because papers have been destroyed, or are spread around the country).

7.0 Applications to Access Personal Health Records – Informal Request

The preferred option is for applications, particularly from current patients, to be dealt with on an informal basis. The same conditions for responsibility, consent and proof of identity apply as in section 6.1 above, with the following exceptions:

- Where a patient requires viewing of their records it is the responsibility of the health professional in charge of the patient’s care to organise an appropriate viewing. The patient should not be allowed to view their health records on his or her own, or to take original records away from Trust property. The health professional should arrange suitable representation for the patient to help understand the contents of the records.

- There is no charge levied where a patient requests sight of their health records only, however where a patient requires copies of the information that has been viewed, refer to the charging section at 6.3 above.

8.0 Applications to Access Personal Health Records – Deceased Patients

The Data Protection Act relates solely to applications relating to ‘living’ individuals. The Act refers applications relating to information held about deceased patients back to the Access to Health Records Act 1990.

The Trust remains responsible for the confidentiality of patient information after that patient’s death. It should be remembered that the rules of consent remain in such cases with the Trust in the absence of the patient’s consent.

The Access to Health Records Act 1990 restricts access to records compiled on or after the 1st November 1991. There remains, therefore, no right of access to information compiled prior to this date.

The 1990 Act provides for an application to be submitted by the patient’s personal representative, and by any person who may have a claim arising out of the patient’s death.

Proof of authority in relation to the above plus a copy of the deceased death certificate will be required prior to processing such request, plus in the case of the patients personal representative, evidence of identity is required. Where an application is being made on the basis of a claim arising from the deceased’s death, applicants must provide evidence to support their claim. See Appendix 6 for Guide to Applicants for Deceased Patient Records.
The personal representative is the only person who has an unqualified right of access to a deceased person’s record and need give no reason for applying for access to a record.

There is less clarity regarding which individuals may have a claim arising out of the patient’s death. Whilst this is accepted to encompass those with a financial claim, determining who these individual’s are and whether there are any other types of claim is not straightforward. The decision as to whether a claim actually exists will be made in conjunction with the Caldicott Guardian. In cases where it is not clear, legal advice will be sought.

A health professional will need to inspect records taking into account the following:

- If it is known whether the deceased patient did not wish for their records to be disclosed or the records contain information that the deceased patient expected to remain confidential
- If the release of the information is likely to cause serious harm to the physical or mental health of any individual

Note that a request for access to the health records of a deceased person must also be considered (according to a judgement made in August 2007 by the Information Commissioner) under section 41 of the Freedom of Information Act, which relates to information provided in confidence.

8.1 Access to Patient Health Records Fees

- **Records held manually**- where an applicant is permitted to view a record which is held manually and had been added to in the 40 days preceding the application, access is **free of charge**. Where the record has not been added to in the preceding 40 days a charge of **£10** may be charged 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 a computer a fee of **£10** may be charged
- **Hard copies if 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 organisation. This fee is over and above the £10 for the initial access.

9.0 Access to CCTV records

See the CCTV Policy

10.0 Access to Audio or Digital Images

An individual may listen to an audio tape or view a digital recording if it contains personal information about them. There should be in place arrangements to provide transcripts or CDs of the recorded information. Normal exemptions rules would apply.
11.0 Mistake or Inaccuracies

If the applicant considers that there are mistakes or inaccuracies in the record they can ask the record holder for a note to be made in the records stating their opinion. If the practitioner agrees that the information is inaccurate, he/she should make the correction. Care must be taken not to simply obliterate information, which may have significance for future care and treatment of the patient, or for litigation purposes.

If he/she does not agree, a note recording why the applicant considers the information to be inaccurate must be made in the relevant part of the record. Consideration should be given to whether it is appropriate to note any associated records, e.g. computer records.

It should be understood that in Law nothing may be erased from a paper health record but a correction may be added.

A copy of any correction or note should be supplied to the patient. No fee may be charged for this.

12.0 Complaints

If the applicant feels that they have not been fairly treated and that the holder of the record has not complied with the Act, then they should first complain through the Trust Data Protection Officer (Records Transformation & Information Governance Manager) who will convene an Internal Review process. The outcome of which will be communicated to the applicant. If they are still unhappy after this, the patient has the right to apply to Court or directly to the Information Commissioner if necessary. Both the Court and the Information Commissioner can order that the applicant be given access to the records if it is satisfied that the complaint is justified.

13.0 Training

Staff should be aware of their responsibilities in relation to individuals rights under the Data Protection Act, to have access to information that we hold about them. The LPT Induction provides training in relation to the Data Protection principles and this training is also included in the mandatory training programme.

The Records and Information Governance Sub-group will ensure that through the development of a comprehensive Information Governance Training Programme for staff, they are given clear guidance on how to manage individuals requests for access to their information and have a working knowledge of the process in place to manage these requests.

14.0 Dissemination

Copies of this Policy will be made available to all staff via the Policy Files found on the Information Governance Web-pages of the Intranet.
Further guidance and access to training materials in relation to Subject Access Requests will be made available through the Information Governance Training Portfolio.

All staff will be notified of a new or reviewed Policy via e-Source and the weekly Newsletter.

This document will be included in the LPT Publication Scheme in compliance with the Freedom of Information Act 2000

15.0 Monitoring Compliance and Effectiveness

The following process should be followed as a minimum, in terms of monitoring staff compliance with the policy and its effectiveness:

- Monitoring of the policy against staff compliance will be achieved through the process of reporting against the compliance with the statutory time frame.

- It is the responsibility of the Records Transformation & Information Governance department in conjunction with the Divisional Governance leads to ensure that this compliance is met.

- An audit in the form of a staff questionnaire will also be used to monitor staff understanding and implementation/compliance with the policy.

- The audit process should be undertaken on a rolling basis (not less than 3-monthly), and will be the responsibility of the Information Request Officer in liaison with the Divisional Governance Leads.

16.0 Due Regard

This policy has been screened in relation to paying due regard to the general duty of the Equality Act 2012 to eliminate unlawful discrimination, harassment, victimisation; advance equality of opportunity and foster good relations.

This is evidenced by undertaking consultation involving staff across all protected characteristics together with information generated from the Patient Satisfaction Questionnaires in relation to their awareness of their rights of access to their health records. This policy has also been developed from feedback received from patients/service users and carers who have requested access to their information.

Every effort has been made to ensure all equality groups (protected characteristics) are given equal access to service provision, especially in the context of disability. This is demonstrated through the provision of information leaflets which are in development to provide information in a readily understood format. These leaflet will be available in different languages, Easy Read and Braille formats.
There is no likely adverse impact on staff or service users from this policy as all requests for information are managed and handled within clear guidance. This policy sets out what the process is and what requirements for making requests are.

Benefits to the organisation in regard to the compliance with legal and statutory duties in relation to the handling and management of requests for information.

17.0 Review

This Policy will be reviewed every 2 years by the LPT Records and Information Governance Sub-group or as and when significant changes make earlier review necessary.

18.0 Standards/Key Performance Indicators

This policy supports the requirements of both CQC Outcome measures: Outcome 21 - Records, the Information Governance Toolkit requirement 205, NHS Confidentiality Code of Practice and the Records Management NHS Code of Practice.

Performance Indicators:
- There are documented procedures in place for handling subject access requests.
- All staff are aware of the need to support subject access requests and where they should be directed
- The procedures are implemented effectively to meet statutory deadlines

19.0 References

- Access to Health Records Act 1990
- Access to Medical Records Act 1998
- Adoption and Children Act 2002
- Children Act 1989
- Crime and Disorder Act 1998
- Data Protection Act 1998
- Freedom of Information Act 2000

- Mental Capacity Act 2005

**NHS and DH Guidelines**

- NHS Confidentiality Code of Conduct 2003

- Records Management: NHS Code of Practice

- Guidance for Access to Health Records Request

**20.0 Associated Documentation**

The following LPT policies and procedures should be referred to in conjunction with this Subject Access Request Policy and Procedure:

- Data Protection Policy
- Records Management Policy
- Applications for Access to Personal Health Records Procedure
- Freedom of Information Policy
APPENDIX 1

Checklist for the Review and Approval of Procedural Document

To be completed and attached to any document which guides practice when submitted to the appropriate committee for consideration and approval.

<table>
<thead>
<tr>
<th>Title of document being reviewed: Applications to Personal Health Records Policy</th>
<th>Yes/No/Not Applicable</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Will any sections of this Policy satisfy one or more criteria of the NHSLA Risk Management Standards?*</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>If Yes – Have you attached the relevant self-assessment(s) for those criteria as an appendix?*</td>
<td>Not applicable</td>
<td></td>
</tr>
<tr>
<td>* for further guidance consult the Trust Lead for Corporate Risk Assurance: <a href="mailto:Richard.Apps@leicspart.nhs.uk">Richard.Apps@leicspart.nhs.uk</a></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

1. **Title:**

   - Is the title clear and unambiguous? Yes
   - Is it clear whether the document is a guideline, policy, protocol or standard? Yes

2. **Key Points / Changes to the Policy**

   This policy provides guidance on the processes that are to be followed when dealing with requests for access to health records, under section 7 of the Data Protection Act 1998. It is consistent with the Data Protection Act 1998, the guidance provided by the Department of Health to NHS organisations in February 2010, and the Access to Health Records Act 1990, in so far as it relates to the disclosure of health records of deceased patients.

3. **Rationale**

   - Are reasons for development of the document stated? Yes Section 5

4. **Development Process**

   - Does the front page include a sentence which summarises the contents of the policy? Yes Front sheet
   - Is the method described in brief? Yes
   - Are people invited in the development identified? Yes Contribution list
   - Do you feel a reasonable attempt has been made to ensure relevant expertise has been used? Yes Contribution list
   - Is there evidence of consultation with stakeholders and users? (with representatives from all relevant protected characteristics) Yes Section 16

5. **Content**

   - Is the objective of the document clear? Yes Section 2
   - Is the target population clear and unambiguous? Yes Front cover
   - Are the relevant CQC outcomes identified? Yes Front cover
   - Are the intended outcomes described? Yes
<table>
<thead>
<tr>
<th>Title of document being reviewed: Applications to Personal Health Records Policy</th>
<th>Yes/No/Not Applicable</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Are the statements clear and unambiguous?</td>
<td>Yes</td>
<td></td>
</tr>
</tbody>
</table>

6. Evidence Base

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes/No/Not Applicable</th>
<th>Section</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is the type of evidence to support the document identified explicitly?</td>
<td>Yes</td>
<td>2</td>
</tr>
<tr>
<td>Are key references cited?</td>
<td>Yes</td>
<td>19</td>
</tr>
<tr>
<td>Are the references cited in full?</td>
<td>Yes</td>
<td>19</td>
</tr>
<tr>
<td>Is there evidence to show that there has been due regard for equality legislation? (include equality statement setting out summary of evidence to support public sector equality duty ‘due regard’ has taken place)</td>
<td>Yes</td>
<td>16</td>
</tr>
<tr>
<td>Are supporting documents referenced?</td>
<td>Yes</td>
<td>20</td>
</tr>
</tbody>
</table>

7. Approval

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes/No/Not Applicable</th>
<th>Section</th>
</tr>
</thead>
<tbody>
<tr>
<td>Does the document identify with committee/group will approve it?</td>
<td>Yes</td>
<td>Front cover</td>
</tr>
<tr>
<td>If appropriate have the joint Human Resources/staff side committee (or equivalent) approved the document?</td>
<td>NA</td>
<td></td>
</tr>
</tbody>
</table>

8. Dissemination and Implementation

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes/No/Not Applicable</th>
<th>Section</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is there an outline/plan to identify how this will be done?</td>
<td>Yes</td>
<td>14</td>
</tr>
<tr>
<td>Does the plan include the necessary training/support to ensure compliance?</td>
<td>Yes</td>
<td>14</td>
</tr>
</tbody>
</table>

9. Document Control

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes/No/Not Applicable</th>
<th>Section</th>
</tr>
</thead>
<tbody>
<tr>
<td>Does the document identify where it will be held?</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Have archiving arrangements for superseded documents been addressed?</td>
<td>Yes</td>
<td></td>
</tr>
</tbody>
</table>

10. Process to Monitor Compliance and Effectiveness

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes/No/Not Applicable</th>
<th>Section</th>
</tr>
</thead>
<tbody>
<tr>
<td>Are there measurable standards or KPIs to support the monitoring of compliance with and effectiveness of the document?</td>
<td>Yes</td>
<td>18</td>
</tr>
<tr>
<td>Is there a plan to review or audit compliance with the document?</td>
<td>Yes</td>
<td>15</td>
</tr>
</tbody>
</table>

11. Review Date

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes/No/Not Applicable</th>
<th>Section</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is the review date identified?</td>
<td>Yes</td>
<td>17</td>
</tr>
<tr>
<td>Is the frequency of review identified? If so it is acceptable?</td>
<td>Yes</td>
<td>17</td>
</tr>
</tbody>
</table>

12. Overall Responsibility for the Document

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes/No/Not Applicable</th>
<th>Section</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is it clear who will be responsible for co-ordinating the dissemination, implementation and review of the document?</td>
<td>Yes</td>
<td></td>
</tr>
</tbody>
</table>

**Individual Approval**

If you are happy to approve this document, please sign and date it and forward to the chair of the committee/group where it will receive final approval.

<table>
<thead>
<tr>
<th>Name</th>
<th>Signature</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sam Kirkland</td>
<td></td>
</tr>
</tbody>
</table>

**Committee Approval**

If the committee is happy to approve this document, please sign and date it and forward copies to the person with responsibility for disseminating and implementing the document and the person who is responsible for maintaining the organisation’s database of approved documents.
<table>
<thead>
<tr>
<th>Name</th>
<th>Dr Bhaumik</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Signature</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
APPENDIX 2

ACCESS TO PERSONAL HEALTH RECORDS PROCEDURE
FLOWCHART

Subject Access Request Received by Letter/ Email

Request is checked/validated.
Patient application form/ letter of request including proof of ID completed as required

NO
Send out SAR letter 1 with application form and Guidance for Applicants/ asking for ID

Completed application and ID received

YES
Log request on Subject Access Database. Send SAR Letter 2 acknowledging receipt and/or requesting further information

Notes/records collated
Arrange appointment for applicant to meet clinician to view notes/records

Ask ‘relevant clinician’ to check through information, and confirm what can or cannot be disclosed using SAR Form 2

Send Letter to applicant for Fee

Fee not received within 14 days of sending SAR Letter 3, send SAR Letter 3(a) advising fee still not received and information awaiting despatch

If fee still not received after further 14 days file as closed

Fee received

Forward payment to Management Accountant
Proof of request and documentation filed and request closed on SAR Database
APPENDIX 3 EXEMPTIONS

Disclosure Might Cause Harm

Under the Data Protection (Subject Access Modification) Health Order 2000, the Trust has the right to deny patients access to all or part of their health records if one of the following condition applies:

- If, in the opinion of the healthcare professional in charge of the patient’s care, access would disclose information likely to cause serious harm to the physical or mental health or condition of the patient or any other person (for example, a child in a child protection case)
- If giving access would disclose information relating to or provided by a third person who has not consented to that disclosure unless:
  - The third party is a health professional who has complied or contributed to the health records or who has been involved in the care of the patient
  - The third party, who is not a health professional, gives their consent to the disclosure of the information
  - It is reasonable to disclose without the third party’s consent.

Those who make the disclosure decision (e.g. healthcare professionals) must consider carefully, and be prepared to justify any decisions to disclose or withhold information. The Caldicott Guardian must be advised if there appear to be any grounds for withholding information.

If information is withheld, the Trust are free to advise applicants of the grounds on which information has been withheld – but they are not obliged to do so. For example, the Trust may not wish to volunteer the fact that information has been withheld if they believe that such disclosure would cause undue distress, or if it might jeopardise a child.

Child Protection Concerns

There may be situations in which access to all or part of a child’s health records can be refused – for example, where there are ongoing child protection issues, or where releasing information may put a child or young person at risk of harm. In these cases, advice must be sought from the appropriate managers and child protection professionals within LPT, as well as the Caldicott Guardian, before releasing any information.

Wishes of Deceased Patients

Health records relating to deceased people do not carry a common law duty of confidentiality. However, it is the policy of the Department of Health and the General Medical Council (GMC) that records relating to the deceased people should be treated with the same level of confidentiality as those relating to living people. For example, if the record contains a note made at the patient’s
request that they did not want a particular individual to know the details of their illness or their care, then no access should be granted to that individual.

In addition, the record holder has the right to deny or restrict access if it felt that disclosure would cause serious harm to the physical or mental health of any other person, or would identify a third person.

Repeat of Earlier Request

Access to health records can be refused where an access request has previously been granted. The Data Protection Act 1998 permits record holders not to respond to a subsequent identical or similar request unless a reasonable interval has elapsed, record holders should consider:

- The nature of the information
- How often it is altered
- The reason for its processing
- Whether the reason for the request(s) is also relevant

Note: Any requests that may involve a claim being made against the Trust should be notified to the claims department.

Minor requests for personal information such as a confirmation of dates of attendance or inpatient stays for claims purposes can normally be handled by the department itself without having to log it with the Information Governance Manager as an access to patient health records request. The same rules, however, for these kinds of requests, will continue to apply e.g. consent of the individual to release the information.

<table>
<thead>
<tr>
<th>Category</th>
<th>Exemption</th>
</tr>
</thead>
<tbody>
<tr>
<td>Crime and Taxation</td>
<td>Where part of the personal information contained within the records, or individual records, relates to the prevention and detection of crime or the apprehension or prosecution of offenders</td>
</tr>
<tr>
<td>Health, Education and Social Work</td>
<td>Health exemptions are covered in section 6.1.2</td>
</tr>
<tr>
<td></td>
<td>Social work records exemptions come under the Data Protection (Subject Access Modification)(Social Work) Order 2000 which relates to personal information used for social work purposes: “Where the release of the information may prejudice the carrying out of social work by causing serious harm</td>
</tr>
</tbody>
</table>
to the physical or mental condition of the data subject or others”

Certain third party’s information can be released if they are a ‘relevant person’ (a list is contained in the order) as long as release of the information does not cause serious harm to the relevant person’s physical or mental condition.

<table>
<thead>
<tr>
<th>Research, history and statistics</th>
<th>Where the personal data is used solely for research purposes and as long as resulting statistics are not made available which identify the person</th>
</tr>
</thead>
<tbody>
<tr>
<td>Human fertilisation and embryology</td>
<td>Personal information can be withheld in certain circumstances where it relates to human fertilization and embryology.</td>
</tr>
</tbody>
</table>

**The full list of subject areas where exemptions may apply:**

- National Security
- Crime and Taxation
- Health, education and social work
- Research activity
- Journalism, literature and statistics
- Research, history and statistics
- Information made available to the public or under enactment
- Domestic purpose
- Confidential references
- Armed forces
- Judicial appointments
- Crown employment
- Management forecasts
- Negotiations
- Examination marks
- Examination scripts
- Legal professional privilege
- Self incrimination
- Crown appointments
- Human fertilisation and embryology, and adoption records and reports.
Application form for Access to Patient Health Records

Part A: Patient Details (Please provide the name of the person about whom the information is being requested: (i.e. the Data Subject))

Surname: ........................................................................................................................................

(Previous names where appropriate): .............................................................................................

Forename(s): ....................................................................................................................................

Current Address: .............................................................................................................................

..........................................................................................................................................................

Previous Address: ............................................................................................................................

..........................................................................................................................................................

Date of Birth: .....................................................................................................................................

..........................................................................................................................................................

NHS Number if known (from Medical Card): ......................................................................................

..........................................................................................................................................................

Part B: Content required (please select one of the options below)

1. I wish to receive photocopies of some of my health records □

Please provide as much detail as possible relating to the episodes of treatment that you require the health records to cover (the more information you can provide the easier it will be for us to locate your records).

<table>
<thead>
<tr>
<th>Details of episodes of treatment</th>
<th>Location of treatment</th>
<th>Date range</th>
</tr>
</thead>
<tbody>
<tr>
<td>e.g. Physiotherapy, District Nurse, Outpatients</td>
<td>Loughborough Hospital, Glenfield DN Team, Bradgate Unit</td>
<td>e.g. April 2009 – June 2009</td>
</tr>
</tbody>
</table>
2. I would like photocopies of all of my health records held by Leicestershire Partnership NHS Trust □

3. I wish to view my health records □

Part C: Consent

I declare that the information given on this form is correct to the best of my knowledge and that:

(a) I am the patient/data subject named previously and give consent and authorisation for my health records as detailed in Section B to be disclosed to (please specify below)

................................................................................................................................................
................................................................................................................................................
................................................................................................................................................

I am fully aware of the risks that may be involved in disclosing confidential and sensitive information to the individual named as above □

(b) I am acting on behalf of the person named overleaf in the capacity of (please state relationship to data subject)

................................................................................................................................................

Please attach a consent form to this effect. Please note that the consent form must be dated in the last 6 months

Please give address if different from the Data Subject

................................................................................................................................................
................................................................................................................................................
................................................................................................................................................

Signed: ................................................. Date: .................................................

Address: .................................................................................................................................
................................................................................................................................................
................................................................................................................................................

Please return this form and copies of required evidence to:

Information Requests Officer
Central Medical Records Department
CBridge Park Plaza
Bridge Park Road
Thurmation
Leicester LE4 8BL

NB It is recommended that you keep a copy of this form. Please mark the envelope ‘Private and Confidential’

WARNING: You are advised that the making of false or misleading statements in order to obtain access to personal information to which you are not entitled is a criminal offence
Access to Patient Health Records – A Guide for Applicants

Who can see a health/medical record?

- The patient
- Another person (with the patient’s written permission)
- A parent or guardian of a person under 16 (Where a child is considered capable of making decisions about his/her medical treatment, the consent of the child must be sought before a person with parental responsibility can be given access)
- A court appointed representative of someone who is not able to manage their own affairs
- Where the patient has died, the executor or administrator or anyone having a claim resulting from the death (this could be a relative or another person), may apply to see the records, or part of them

When can the record holder refuse to provide information?

Under the Data Protection Act 1998 you have the right to see information held about you subject to certain safeguards:

- When the record holder thinks access is likely to cause you or anyone else serious physical and/or mental harm
- When the record contains details that the patient has asked not to be revealed to a third party
- When disclosing the records would reveal information that relates to or identifies another person unless their consent has been given (except where it is reasonable to disclose the records without the person’s consent)
- When the records have been destroyed under the NHS Records Management Code of Practice

What are the fees for access?

<table>
<thead>
<tr>
<th>Service</th>
<th>Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>Viewing (records not added to within the last 40 days)</td>
<td>£10</td>
</tr>
<tr>
<td>Viewing (records added to within the last 40 days)</td>
<td>£0</td>
</tr>
<tr>
<td>Computer records</td>
<td>£10</td>
</tr>
<tr>
<td>Paper records</td>
<td>£50</td>
</tr>
<tr>
<td>Paper records including x-rays</td>
<td>£50</td>
</tr>
<tr>
<td>Computer records including x-rays</td>
<td>£20</td>
</tr>
<tr>
<td>X-rays alone</td>
<td>£10</td>
</tr>
</tbody>
</table>
The only exemption to the above in reference to copies of records, is where entries have been made to the record within the last 40 days. In this case, no charge is made.

Where a combination of the above are required the higher charge will be levied only.

Please note that if you require copies from more than one hospital within the Trust you will not be charged more than £50.

Acceptable forms of payment are personal cheque or postal order. We cannot accept cash. Please make cheques payable to Leicestershire Partnership NHS Trust. You will be notified of the exact cost once we have retrieved the information requested.

**Proof of Identity**

The Trust will not process your request unless we are certain that you are the person that you say you are. In most cases we will require a copy of one of the following:

<table>
<thead>
<tr>
<th>Type of applicant</th>
<th>Types of documentation required</th>
</tr>
</thead>
<tbody>
<tr>
<td>An individual applying for his/her own records</td>
<td>One copy of identity required, e.g. copy of birth certificate, passport, driving licence, utility bill, etc</td>
</tr>
<tr>
<td>Someone applying on behalf of an individual</td>
<td>One item of proof of the person’s identity (see examples above)</td>
</tr>
<tr>
<td>Person with parental responsibility applying on behalf of a child</td>
<td>Copy of birth certificate (identifying the parent (s) and copy of correspondence addressed to person with parental responsibility relating to the patient</td>
</tr>
<tr>
<td>Power of attorney/ agent applying on behalf of an individual</td>
<td>Copy of court order authorising power of attorney/ agent plus proof of patients’ identity (see examples above)</td>
</tr>
</tbody>
</table>

(Please note the copies of any identity paperwork will be destroyed as soon as your identity has been checked)

*Please do not send original documents*

**Special Circumstances**

Where none of the above are available, the following are acceptable:
• Pension Book
• Income Support Letter

If you are applying for records on behalf of the patient you will need to provide proof of your identity (as above) and you must also include the patient’s written authorisation for you to have access to their records as well as proof of their identity.

**Types of records required**

It is important that you provide us with as much information as possible regarding the records you wish to have access to. If you do not know the date you attended or was treated please give approximate date instead. Computer records are printouts of the records that are held.

**What will happen after I apply?**

When the department has received the completed application form the validity of the request is checked to ensure that the person applying has the right to apply – particularly if applying for another person’s records.

The relevant records are then obtained and photocopied (if copies are required).

If access is granted the records are posted by special delivery to the applicant or if the applicant does not require copies they will be contacted to arrange an appointment to view the records.

**How long will it take to get access?**

We aim to make your records available to you within 21 days of receiving your fully completed request, proof of your identity and the fee (if applicable).

If the application form and proof of identity has not been received by us within 15 working days of the organisations letter of request for said information, we will advise you or your personal representative of this situation and the access request will be suspended.

**Requests for GP Records**

If you require access to your GP Practice records you should write directly to your Practice

**Where do I send my request to?**

Requests should be put in writing to:

Information Requests Officer
Central Medical Records Department
Bridge Park Plaza
Bridge Park Road
Thurmaston
Leicester
LE4 8BL

OR

the Head of a Specific Service i.e Head of Therapy Services, Hinckley and Bosworth Community Hospital

If you are not satisfied with your response

In the first instance you should write to either Leicestershire Partnership NHS Trust, explaining why you are dissatisfied with the response. The address is:

Records Transformation & Information Governance Manager
Leicestershire Partnership NHS Trust
Lakeside House
4 Smith Way
Enderby
Leicester
LE19 1SS

If you are not then satisfied with the Trusts response you can contact the Office of the Information Commissioner – the body with responsibility for enforcing Data Protection Act. The address is:

Information Commissioner’s Office
Wycliffe House
Wycliffe Lane
Wilmslow
Cheshire
SK9 5AF

Where you have used an application form, all sections should be completed and appropriate documentation must be enclosed together with the correct fee (where this has been advised). Incomplete forms will be returned to the applicant which may in turn delay the processing of your request.
APPLICATION FOR RELEASE OF DECEASED PATIENTS RECORDS

SECTION 1 – PATIENT DETAILS

Surname: ..............................................................................................................

Former Surname (if applicable) .............................................................................

First Name(s): ....................................................................................................

Known as Forename: ..............................................................................................

Date of Birth: .......................................................................................................

Date of Death: .....................................................................................................

NHS Number (If known): ......................................................................................

Former Address: ...................................................................................................

..............................................................................................................................

SECTION 2: PERSONS WHO CAN MAKE A REQUEST UNDER THE ACT

1. The patient’s personal representative (this will be the executor of the will, or the administrator of the estate)
2. Any person who may have a claim arising out of the patient’s death

SECTION 3 – APPLICANT DETAILS

Surname: ..............................................................................................................

First Name(s) ........................................................................................................

Address: ................................................................................................................

..............................................................................................................................
Telephone number: .................................................................

Relationship (to patient) ............................................................................................................

If you are requiring access because you have a claim arising out of the patient’s death, please state the reason for this claim:

..................................................................................................................................................
..................................................................................................................................................
..................................................................................................................................................

SECTION 4 – FURTHER INFORMATION

IMPORTANT: It would be helpful if you could provide details in the section below informing us which of the records you require access to (e.g. Loughborough Hospital record; Hinckley Physiotherapy records), which periods and parts of those records, together with details which you may feel have relevance, e.g. consultant name and location, etc. If you have a claim arising out of the patient’s death you should request only the relevant information that is required to process your claim.

..................................................................................................................................................
..................................................................................................................................................
..................................................................................................................................................
..................................................................................................................................................

SECTION 5 – PROVISION OF INFORMATION

Please note that our usual method of providing access to records is to post copies to your stated address. If you wish to access records by any other means please tick the relevant box below. We will then contact you in order to facilitate this.

Viewing records at a Trust Location  □

Collecting records from a Trust Location □

Other (please specify): □

..................................................................................................................................................
SECTION 6 – CONSENT

Please tick one of the following boxes and sign below:

- I confirm that I am the patient’s personal representative and have enclosed evidence of my status as executor of the will/administrator of the estate together with one item of evidence of my identity
- I can confirm that I have a claim arising out of the patient’s death and have enclosed proof of my identity and documented evidence of my claim

Print Name:

............................................................................................................................................................

Signature:

............................................................................................................................................................

Date:

............................................................................................................................................................

Please return this form and copies of required evidence to:

Information Requests Officer
Central Medical Records Department
Bridge Park Plaza
Bridge Park Road
Thurmaston
Leicester LE4 8BL

NB It is recommended that you keep a copy of this form. Please mark the envelope ‘Private and Confidential’
REQUESTING ACCESS TO DECEASED PATIENT RECORDS – APPLICANT GUIDANCE

The Access to Health Records Act 1990

This Act allows certain individuals to request access to deceased patient’s health records.

Who can make a request for a deceased patient’s records under the Act?

- The Patient’s personal representative (this will be the Executor of the Will or Administrator of the Estate); or
- Any person who may have a claim arising out of the patient’s death. The applicant or their representative must specify what claim is being made, and only information that is relevant to the claim should be considered for release.

How you can request access to records

You must put your request in writing to the:

Information Requests Officer
Central Medical Records Department
Bridge Park Plaza
Bridge Park Road
Thurmaston
Leicester LE4 8BL

You may be required to complete an Access to Deceased Patient Health Records application form so that we have the relevant information to process your request.

Information Requirements

- The name, address and date of birth of the patient
- Name and address of the person/agency making the request
- The records that are required (information such as relevant dates, name of clinic or hospital, etc would be useful in locating records);
- Other information that may be relevant – e.g. NHS number
Evidence of identity and authority

Leicestershire Partnership NHS Trust will not process your request unless we are certain that you are the person that you say you are. In most cases we will require copies of two items of evidence of identity – for example:

<table>
<thead>
<tr>
<th>Type of applicant</th>
<th>Types of documentation required</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient’s personal representative</td>
<td>Evidence of being granted power of the Executor of the Will or the Administrator of the Estate, and proof of identity</td>
</tr>
<tr>
<td>Person making a claim arising out of the patient’s death</td>
<td>Proof of identity and documented evidence of the claim</td>
</tr>
</tbody>
</table>

Exemptions to the release of personal information

There may be circumstances where certain information could be restricted. These include:

- If it is considered that certain information in the records, if released, may cause serious harm to an individual;
- Where there is personal information about another person in the records

How will the information be provided?

In most cases, copies of the records will be made and sent to you (or you can collect the copy if you prefer). You may, however, prefer to view the records – in which case the Trust will arrange with you a suitable time and location for you to come in and view the records. A qualified member of staff will be in attendance to advise on any aspect of the records.

Will I be charged for access to the records?

A fee of £10 may be charged for providing access to information where all of the records were made more than 40 days before the date of application. No fee may be charged for providing access to information if the records have been amended or added to in the last 40 days.

Where a copy is supplied, a fee not exceeding the cost of making the copy may be charged. The cost of posting and packaging may also be charged.

The Trust will inform you where a charge is to be made and the amount of that charge.

If you are not satisfied with your response
In the first instance you should write to the Trust explaining why you are dissatisfied with the response to the request to access the records of a deceased patient. The address is:

Records Transformation & Information Governance Manager
Leicestershire Partnership NHS Trust
Lakeside House
4 Smith Way
Grove Park
Enderby LE19 1SS