Mid Essex Hospital Services NHS
NHS Trust

Access to Records Policy	**Policy** **Register Number: 04086** **Status: Public when ratified**

Developed in response to:		NHSLA requirement IG Toolkit requirement
Consulted With	**Post/Committee/Group**	**Date**
Helen Hughes	Director of business Development & Performance	20 March 2014
Helen Clarke	NHSLA Lead	20 March 2014
Sharon Salthouse	Head of Health Records	20 March 2014
Professionally Approved by		
James Day	Trust Secretary	20 March 2014

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Author/Contact for Information	Liz Stewart
Policy to be followed by (target staff)	All Trust Staff
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Related Trust Policies (to be read in conjunction with)	Confidentiality Policy Information Governance Policy Sending Trust Information out of the UK Data Protection Strategy Incident Policy

Document Review History

Review No	Reviewed by	Issue Date
1.0	Liz Stewart	January 2004
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5.1	Liz Stewart - Extension agreed to December 2018 due to review of GDPR	27th February 2018

It is the responsibility of staff accessing this document to ensure that it is the most up to date version. This will always be the version on the intranet.

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1. Purpose

1.1 The purpose of this policy is to define the Trust's response to requests for access to records from either a patient, their relatives or a third party legal professional for litigation purposes. It also includes access to records by other NHS or non-NHS clinical care providers and to records required for Research and Audit purposes.

1.2 It also defines the responsibilities of the Human Resources and Occupational Health Departments in relation to requests for access to personal records by staff.

1.3 This policy reflects various current legal and professional guidelines and places controls that meet the needs of:

- Data Protection Act 1998
- Access to Health Records 1991
- Subject Access Code of Practice – Information Commissioners Office 2013

2. Scope

2.1 A health record for the purposes of the Act is a recording, which relates to the physical or mental health of an individual, which has been made in connection with the care of that individual.

2.2 A health record is defined as being any data or image held in any media that provides information about a patient. It therefore includes:

- Paper records, both current, archived or overflow volumes
- Data on microfilm
- Digitally held archive
- Any imaging media, radiographic, photographic or televisual
- Emergency Attendance records
- Therapy Records
- EEG/ECG Traces
- Information held on any Trust clinical system
- Information held on any register that has not been transferred to the Essex Records Office.

2.3 Staff Records are provided under the Act and these can include:

- Personal file
- Occupational health records
- Emails and other correspondence relating to the requester that constitutes "personal data" under the Act, however not all correspondence that may relate to the requester is disclosable, for example, if it would identify a third party who had not given their consent to the disclosure.
- CCTV images are excluded from routine disclosure because they usually include images of other patients, staff and visitors. These would be subject to a decision on a case by case basis.

2.4 This policy excludes:

- duplicate records provided to other health care providers
- duplicate individual letters provided directly to patients by consultants/medical secretaries in line with the “Copying Letters to Patients” government objective
- medical reports that are completed by consultants for the benefit of the courts, insurance companies and the Police are outside the scope of this Policy as they do not constitute health records
- access to data that is anonymised. The Trust will manage requests for anonymised or pseudonymised information under the Freedom of Information Policy
- the provision of original records for court purposes, however the Trust will take a paper copy of these records prior to their release. The Access to Records Bureau only may undertake this task.
- Adopted children with new names are outside the scope of this policy. There is one national register of old and new names of adopted children held by the Department of Health to whom these adopters will need to apply

3. Policy Statement

3.1 It is not the intention to unreasonably withhold access to records. The policy enables access to those who require information whilst ensuring that essential safeguards are in place to protect patient information from inappropriate or illegal requests.

3.2 The Data Protection Act 1998 repealed the Access to Health Records Act 1990 in all respects other than access to records of deceased patients. However the Information Commissioners Office has defined, through case law, that the information relating to the deceased should be protected in the same way as that of the living.

4. Rights of Access

4.1 Subject Access is most often used by individuals who want to see a copy of the information an organisation holds about them. However subject access goes further than this and an individual is entitled to be:

- Told whether any personal data is being processed
- Given a description of the personal data, the reasons it is being processed and whether it will be given to any other organisations or people
- Given a copy of the personal data
- Given details of the source of the data

4.2 Subject Access provides a right for the requester to see their own personal data, rather than a right to see copies of documents that contain their personal data. There is therefore no obligation to supply copies of original documents.

4.3 Most personal data, however stored, falls within the scope of the Data Protection Act to which the Data Subject (patient or staff member) or legal representative, has access and that access applies to all Trust held records that constitute “personal data” and are within their retention period. But there are some exceptions. Records will not be supplied if:

- It is not possible to identify the data requested from the information provided
- If the information given about the proof of the identity of the enquirer is insufficient

- Where disclosing the personal data would reveal information that had been provided by a third party with the clear expectation that it would never be passed on to the data subject
- Where having all or some of the information is not in the best psychiatric interests of the patient or member of staff. This decision will always be taken in conjunction with the treating clinicians, but the expectation will be that the information will be supplied unless there is an overwhelming reason not to so. But this is not a "forever" decision as it might be decided just to postpone the disclosure pending an improvement in the a patient's mental wellbeing and in these the cases the treating clinicians will officially write to patients explaining the decision and there should be a copy of the this letter placed in the patient's medical record.

4.4 In disputed cases, the disclosure decision will be taken by the Trust's Data Protection Officer who if necessary will consults the relevant health and legal professionals and with the Information Commisioners Office.

4.5 There are also a range of public bodies that have lawful authority to require the disclosure of health information. These include the Courts, legally constituted Public Enquiries and various regulators and commissioners eg the Care Quality Commission. In these cases the common law obligation to confidentiality is overridden.

5. Access to Deceased Records by a Third Party

5.1 The Access to Health Records Act (AHRA) 1990 provides certain individuals with a right of access to the health records of a deceased individual. These individuals are defined under Section 3(1)(F) of that Act as, 'the patients' personal representative and any person who may have a claim arising out of the patient's death'. A personal representative is the Executor or administrator of the deceased person's estate. Apart from statutory bodies, only the deceased patient's legitimate and legal representative has a statutory right to have a copy of the medical records. They do not need to state why they are making the request but they do need to provide evidence that they are the legal representative.

5.2 Disclosures in the absence of a statutory basis should be in the public interest, be proportionate, and judged on a case-by-case basis. The public good that would be served by disclosure must outweigh both the obligation of confidentiality owed to the deceased individual and any other individuals referenced in a record.

5.3 Key issues for consideration include any preference expressed by the deceased prior to death, the distress or detriment that any living individual might suffer following the disclosure, and any loss or privacy that might result and the impact upon the reputation of the deceased. The views of surviving family and the length of time after death are also important considerations. The obligation of confidentiality to the deceased is likely to be less than that owed to living patients and will diminish over time.

5.4 Another important consideration is the extent of the disclosure. Disclosing a complete health record is likely to require a stronger justification than a partial disclosure of information abstracted from the records. If the point of interest is the latest clinical episode or cause of death, then disclosure, where this is judged appropriate, should be limited to the pertinent details.

5.5 Individuals requesting access to a deceased patients health information should be able to demonstrate a legitimate purpose, generally a strong public interest justification and

in many cases, a legitimate relationship with the deceased patient. On making a request for information, the requester should be asked to provide authenticating details to prove their identity and their relationship with the deceased individual. They must also provide a reason for the request including explaining to the satisfaction of the Trust that they have a claim arising out of patients's death if they are not the Personal Representative. Where possible they should specify the parts of the deceased health record they require for the reasons outlined in 5.4. If a requester is turned down because the Trust believes that the request is not valid, the requester has a right of complaint to the Information Commissioners Office.

5.6 Relatives, friends and carers may not qualify to have copies of medical records but still have a range of important and valid reasons for requesting information about deceased patients. For example, talking to relatives to help them understand the cause of death and actions taken to ease suffering of the patient, may help aid the bereavement process and these conversations should still take place irrespective of their legal rights to copy documentation.

6. Fees Payable

6.1 The Data Protection Act defines a fee of £10 however in order to reflect the costs of providing duplicate manual health records, the NHS can charge up to a maximum of £50.

6.2 Fees must be received by the Trust prior to work commencing on collation of the records.

6.3 For copies of staff personal files and/or Occupation Health records, the maximum fee is £10.

6.4 If a request can be met totally by providing electronic information onto CD Roms, the charge is £10. However if a request is for a combination of electronic and paper, the higher charge of £50 applies.

6.5 If a request can be met totally with an emailed file, these will be provided free of charge. The Trust will not undertake scanning of documents for the purpose of providing free copies. The documents must have been previously scanned to qualify for the free service. If a request is for a combination of emailed and paper files, the higher charge of £50 applies.

6.6 If records are copied and are subsequently updated within 21 days of being supplied, the requester is entitled to receive copies of the updated material free of charge.

6.7 Where solicitors require more copies of photographs that the one copy that is legally required to be provided, the solicitors will deal with the Medical Photography Department direct for the additional copies, however the additional fees will be paid in to the one centrally held budget for all duplicate records NABD 1W02. The fees for additional copies are outside the scope of the Data Protection Act, so the Trust may charge whatever it considers reasonable for this service.

6.8 Charges may be waived if:

- the requester is pursuing a complaint against the Trust and it is considered that in the circumstances, the complaint process would not be assisted by levying a fee

and the decision to waive will be taken by the Complaints Manager

- the requester can demonstrate genuine hardship in affording the charge, however the decision to waive on these grounds may only be taken by the Access to Records Bureau staff, the Information Governance Manager and Data Protection Officer, the SIRO (Senior Information Risk Owner), Complaints Manager, or members of the Executive Team

7. Overview of Procedure

7.1 The Access to Records Bureau logs requests and releases all copy records except those released by the Complaints Department, Claims Manager and Trust Secretary. Other Trust staff are not permitted to provide duplicate records under the Act.

7.2 All records will be released by the Access to Records without reference to any clinical view other than the situation already explained in 4.3 last bullet point. This is on the basis that within acute healthcare records there should not be anything recorded that is not releasable.

7.3 Solicitors may apply by letter but must supply an applicant signature on appropriate documentation although this now may be either an original or an electronic signature. Electronic signatures will not be accepted by any other requesters other than solicitors.

7.4 A request for copy records must be responded to within 40 days but the clock does not start ticking until either the fee is received or, a decision made for the fee to be waived.

7.5 If the requester is outside of EEA (European Economic Association) it is necessary to inform the requester that the Trust cannot guarantee the security of manual or electronic data transfer and they will have to confirm in writing that they consent to accept the risk. Refer to the Trusts's Sending Information out of the UK Policy for more information.

7.6 All radiographic data that is downloaded from PACS and issued as a duplicate record under the Act will be encrypted in line with Department requirements. However it is understood that in some circumstances, usually relating to organisations with complex IT networks in terms of security, that the encrypted discs will not open. In these circumstances it is necessary to provide discs unencrypted, however encryption is the default position.

8. Childrens Records

8.1 For the purposes of disclosure a child is a person who has not attained their 16th birthday. If the applicant is 16 or over they should be treated in the same way as an adult. The parents or guardians of the applicant over 16 years are not entitled to see the records without the consent of the young person. The only exception to this is when the child lacks capacity and the parents or guardian hold a Lasting Power of Attorney.

8.2 If the application is by a data subject who is under 16, the Trust will need to obtain parental authority on the basis that an applicant under 16 is not authorised to make a request under the Data Protection Act 1998. However the Trust will look sympathetically at a request from a child aged between 12-16 who is judged to be "Gillick Competent" but any release will be authorised by the child's treating consultant based on the perceived maturity of the individual and the situation that pertains at the time. Decisions will be made only on a case by case basis.

9. Adult requesters without Capacity

9.1 The Data Protection Act makes no special provisions about requests for access on behalf of an adult who lacks mental capacity and is incapable of managing their own affairs.

9.2 Mental disorder does not equate with mental incapacity and many persons suffering from the mental disorder have sufficient capacity to enable them to deal with their own affairs. The patient's clinician(s) will make a decision, if necessary in conjunction with their colleagues within mental healthcare, about the appropriateness of releasing records.

9.3 Patients with learning difficulties, depending on their individual circumstances may have enough capacity to understand the process, albeit with support. The Hospital Liaison Specialist Nurse, Learning Disability Lead, will advise in these situations.

9.4 Patients with learning disabilities are unlikely to have the capacity and should have an MCA2 form in their medical records. Any requests from such a patient should be referred initially to the Trusts Adult Safeguarding Lead.

10. Requests by the Police

10.1 It is important that all staff are aware that only the Access to Records Bureau discloses health records to the police unless the Police provide a Data Protection Act Section 28 or Section 29 Exemption form, usually referred to as their A101 form.

10.2 In the event that the Police request staff records, including Occupational Health Records, these will only be provided to the Police by a senior member of the HR Team, again on the production of an A101 form.

10.3 The A101 form must be fully completed in order to be valid. It must contain an explanation of why the information is required and be signed by a more senior officer than the officer requesting.

10.4 All email communications with the Police must be sent on nhs.net accounts to a secure email address that includes pnn.police in the title.

10.5 In the event of telephone calls from the Police, their identities must be verified before any information is provided. Staff should ask for the name of their force eg Essex Police/Metropolitan Police and their extension number that can be reached via phoning 101. Staff must not accept a number from a mobile or ring back a mobile until after communications have been set up via a 101 number and officers become individually recognisable.

10.6 Police will attend the hospital soon after an admission of an injured victim (or assailant) and will need certain information to provide to magistrates courts that may well be taking place the following day. In these instances, they will require Medical Statements which must be given by a member of the clinical staff, but these do not constitute "health records". The need for police to have copies of the medical records is usually much later on and that is the process managed by the Access to Records Bureau. But as set out in 10.3, if the police are in attendance in clinical areas and asking for copies of any part of the medical record, then they must provide an A101 form.

10.7 In the event that any member of the Police demands copies of medical records without an A101, particularly out of hours, the Trust understands that staff can feel very intimidated and might be inclined to hand over the documentation just to have the Police leave the clinical area particularly late in the evening or at night. In this circumstance, staff should call the Bed Office for assistance. But, staff won't be blamed if they were genuinely in a difficult situation and help was not available..

10.8 All attempts by police to obtain information inappropriately, must be datixed. These will all be reported to the Chief Superintendants of the relevant police force.

11. Records Required as Evidence for Investigatory or Disciplinary Processes

11.1 Staff who are under investigation or are subject to disciplinary proceedings may require access to information that is held in patient health records because either:

- they recorded it and need to provide it as evidence or
- there are entries made by other staff that support their case

11.2 In these cases, staff will only have access to the elements of the records that they need and any access will be supervised either by the Access to Records Bureau or by HR Department staff.

11.3 Staff will only be able to have photocopies of the material specified in 11.1 and patient names will be redacted and replaced by hospital numbers before they are provided to the staff member. Staff are not permitted to retain any photocopied medical records beyond the end of the investigation/disciplinary/appeal event to which they pertain. The copied records must be confidentially disposed of at the earliest possible opportunity.

12. Viewing Medical Records

12.1 If It is agreed that the patient or their representative may directly inspect their health records, the viewing must supervised by a lay administrator who can ensure the safety of the documents. The lay administrator must not comment on any aspect of the content but may explain the construction of records so that the viewer may more easily navigate around them.

12.2 If the viewer raises clinical queries, then the lay administrator must inform the viewer hat they should seek an appointment with a clinical member of staff from the appropriate pecialty and that meeting will be outside the Access to Records process.

13. Requests to amend medical records after the Data Subject has received copies

13.1 Credible records are an important aid in providing safe healthcare to patients. Records should reflect the observations, judgements and factual information collected by the contributing health professional.

13.2 The DPA 4th Principle requires that information should be factual and kept up to date. This provides the legal basis for enforcing correction of factual inaccuracies. An opinion or judgement recorded by a health professional, whether accurate or not, must be deleted. Retaining relevant information is essential for understanding the clinical decisions that were made and to audit the quality of care.

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

13.4 Where the health professional and patient disagree about the accuracy of the entry, the Trust will allow the patient to include a statement within their records to the effect that they disagree with the content. This should be placed in a selaed envelope and filed in the correspondence section of their record. It should be marked on the front what the envelope contains and what date during their care it refers to. The section of the records to which the patient objects should be asterisked and a signed and dated statement placed adjacent to it, marked:- "the patient disagrees with this section and their comments are in a dated envelope and filed in the correspondence section.

13.5 There is only one scenario when an entry in a medical record can be obliterated and that is when it has been entered into the wrong patients record. If this occurs, the entry must first be replicated in the correct folder ie it must be entered as it was written and then checked that the wording is correct. After that the recording in the wrong record may be redacted. However a statement must be input next to the redaction, explaining that the entry did not refer to the patient named on the record. In this scenario it is acceptable for someone other than the staff who made the initial incorrect entry, to copy across that entry to the correct folder, but again, that entry must be fully explained, dated and signed.

14. Patients living abroad requiring access to their medical records

14.1 Former patients living outside the UK who had treatment in the UK and are now domiciled outside of the EEA, have the same rights under the DPA to apply for access to their UK medical records. Similarly, ex staff who may move or retire abroad retain the right under the DPA to access their employment records.

14.2 Original records must not be given to patients to keep or take to a new GP abroad. In instances when a patient moves abroad a CP may be prepared to provide the patient with a summary of the patients's treatment. Alternatively, the patient is entitled to make a request for access under the DPA to obtain a copy and the appropriate fee will apply.

14.3 Patients moving abroad must consider how they will pay for the Access process as the Access to Records Bureau only accepts cheques and, if necessary cash, (Sterling only), having no mechanism for accepting credit cards.

14.4 If the former patient resides in a country outside of the EEA, the Trust must comply with Data Protection Principle 8 that requires that person identifiable information should not be transferred out the EAA. In these situations, the patient must not only make the request but issue explicit informed consent that they understand that there is a security risk in transferring the data, both manual and especially electronically.

15 Non-Compliance with this Policy

15.1 Any non complaince with this policy must be recorded on a risk event form (Datix) and fully investigated and reported in accordance with the Incident Reporting Policy.

16. Audit & Monitoring

16.1 Breaches of this policy that are categorised as breaches of confidentiality will be reported to the Information Governance Group, the minutes of which go to the Patient Safety & Quality Group. Appropriate action plans will be put in place.

17. Communication & Implementation

17.1 This policy will be uploaded to the intranet and Trust website and will be communicated to staff via Focus.

17.2 Individual copies will be emailed to each member of the Access to Records Team, the Trust Secretary and Head of Complaints.

18. References

Subject Access Code of Practice, Information Commissioners Office, August 2013
Access to Records, Department of Health, updated February 2010

Mid Essex Hospital Services NHS
NHS Trust

ACCESS TO HEALTH RECORDS APPLICATION FORM

I am applying for a copy of part or whole of a patient's medical record in accordance with the Data Protection Act 1998 or the Access to Health Records Act 1992, for which a pre-pay fee is required. Details of the fees payable are in the Supporting Information section.

Complete the following details relating to the person whose records you are seeking – you must provide enough information for us to identify the data subject (patient). Sections marked with an asterisk * must be completed.

* SURNAME (family name)	
* FIRST Name(s)	
* DATE OF BIRTH	
Hospital Number	
NHS Number	
Previous Names or other names known by	

Ideally, you should requests the parts of the records that you seek, for example, if you only really want the medical records relating to the last admission, then ask for that, because although you can request the whole record, in some cases this could mean a very substantial amount of paper that can prove difficult to navigate.

Please use this space to indicate the records required:

Manual Medical Records – you can indicate here a time period required, all records relating to a specialty or all records held. If you request these you will automatically also receive printouts of any relevant information held on electronic systems	
Radiology – CT Scans, plain film xrays or MRIs , either over a specific time frame or ALL	
Photographs – specify a time frame or ALL	
Therapy records – specify, Physiotherapy, Occupational Therapy, Dietetics, Speech & Language Therapy, relating to a specific time frame or ALL	
A&E Records – specify an attendance (s)	
Archived Records and Microfilmed Records – will not automatically be provided unless the items you have already requested are in the archived or microfilmed records – indicate in this box if you require these	
Provision of ALL records held – Put YES in this box to receive a complete records	

Please Tick the appropriate box	
I am applying for a copy of my own records	
I am applying for the records of a child under 16 for whom I am the parent/guardian	
I am the deceased person's legal representative and I attach evidence of that status	
I am applying for the medical records of a deceased person and I am not their legal representative. Please provide evidence of your identity and relationship to the deceased person. Please also provide the reason for your request which needs to be a valid claim arising out of the patient's death. Please note that unless the request is valid, your request may be rejected and your cheque returned.	
I am acting on behalf of a consenting adult with capacity and attach their authorisation to release their records to me	
I am applying for the medical records of a deceased person for the purposes of identifying familial genetic information. I attach an original letter from my GP confirming this.	
Any other request not covered by the above, please provide supporting information	
Cheque Enclosed, value of	

Name of Applicant PRINT……

Signature of Applicant……

Address of Applicant……

……

Send the completed form with any evidence requires and a cheque to:

Access to Records Bureau
Old Outpatients
Broomfield Hospital
Court Road
Chelmsford
CM1 7ET

Email: accesstorecordsbureau@meht.nhs.uk
Tel: 01245 514288
Fax 01245 516844

The 1998 Data Protection Act allows an individual the right to access their health records.
The access may be limited in some cases, specifically:

- if a clinician believes that the patient would be harmed by the access, the request may be refused in part or whole but this may not be a permanent decision and the requester may be able to re-apply at a later date
- where a third party has divuled information given in confidence to a clinician concerning the patient and given on the basis that it would not be shared with the patient – these parts of the record will never be released. However this rarely applies to acute hospital records

The Trust has 40 days to respond to requests but the clock does not start ticking until all the correct evidence and funds have been received .

Once records have been copied and sent, applicants are entitled to receive any updates that are made to the records in the following 21 days, free of charge.

Radiology will only be provided on encrypted CDRoms

Charges for the Service

To view records in the Access to Records Bureau by appointment only, at a time convenient to the patient/representative and to hospital staff	**FREE**
To have emailed copies of records that have been previously scanned (records that have not been previously scanned will not be scanned for the purpose of providing free copies)	**FREE**
Radiographic images provided on CDRom – this only applies if the request in total can be met by the provision of a CD Rom. (If it is part of a more comprehensive request that includes copies of paper documents the £10 fee does not apply) **Note: Microfilmed Records:** These do not count as radiographic images as they cannot be downloaded onto CDRom – prints from these count as copies of medical records	**£10**
Copies of Paper documents that do not exceed 20 pages approximately (this will include an A&E attendance or a day surgery episode -	**£20**
Radiographic images as above plus an A&E attendance	**£30**
All other requests: copies of medical records current or archived or both with or without any of the above	**£50**

Note: The most you can pay is £50 and that sum includes postage and packing costs

Cheques should be made payable to: Mid Essex Hospital Services NHS Trust