Pennine Care NHS
NHS Foundation Trust

Policy Document Control Page

Title

Title: Access to Health Records Policy

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Supersedes
Supersedes: V5
Description of Amendment(s):

- **Minor amendments following review**

Important Notice
From May 2018 the UK will be adopting the European General Data Protection Regulations. These regulations will be replacing the Data Protection Act 1998. In the UK we are still awaiting some health sector specific guidance and instruction regarding GDPR, and as such have deemed that, unless there is a legal requirement or a fundamental change that is required in a policy, all policies, regardless of review date, shall remain current, valid and must be followed for the foreseeable future, to be reviewed prior to the implementation of GDPR from May 2018. Any queries in relation to this statement should be directed to the Trust Information Governance Manager.

Originator

Originated By: Jenny Spiers
Designation: Information Governance Manager

Equality Impact Assessment (EIA) Process

Equality Relevance Assessment Undertaken by: Information Governance Manager
ERA undertaken on: 31.10. 2011
ERA approved by EIA Work group on: 08.11.2011

Reviewed as appropriate: Kevin Tarleton, Information Risk Manager; 11 March 2015

Where policy deemed relevant to equality-

EIA undertaken by Information Governance Manager
EIA undertaken on 31.10.2011
EIA approved by EIA work group on 08.11.2011

Approval and Ratification

Referred for approval by: Information Governance Manager

Date of Referral: 1st March 2017

Approved by: Information Governance Assurance Group

Approval Date: 1st March 2017

Date Ratified by Executive Directors: 20th March 2017

Executive Director Lead: Medical Director

Circulation

Issue Date: 22nd March 2017

Circulated by: Information Department

Issued to: An e-copy of this policy is sent to all wards and departments

Policy to be uploaded to the Trust's External Website? YES

Review

Review Date: 1st March 2018 (to be updated prior to new GDPR regulations coming into force May 2018)

Responsibility of: Jenny Spiers

Designation: Information Governance Manager

This policy is to be disseminated to all relevant staff.

This policy must be posted on the Intranet.

Date Posted: 22nd March 2017

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ACCESS TO HEALTH RECORDS POLICY

1. INTRODUCTION

1.1 Individuals have a right to apply for access to health information held about them and, in some cases, information held about other people. The Trust needs to ensure it has adequate procedures in place to enable patients to exercise this right.

1.2 The main legislative measures that give rights of access to health records[1] include:

- **The Data Protection Act 1998** – rights for living individuals to access their own records. The right can also be exercised by an authorised representative on the individual's behalf.
- **The Access to Health Records Act 1990** – rights of access to deceased patient health records by specified persons.
- **The Medical Reports Act 1988** – right for individuals to have access to reports, relating to themselves, provided by medical practitioners for employment or insurance purposes.

1.3 It is important that all 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.

1.4 This policy provides procedures to be followed by Trust staff when dealing with requests for access to health records.

1.5 Compliance with Trust policies is a condition of employment and breach of a policy may result in disciplinary action.

2. SCOPE

2.1 This policy applies to all health records, both manual and computerised including joint health and social care records.

2.2 This policy applies to all staff who come into contact with patients, or are in some way responsible for keeping or handling health records.

2.3 Wherever, throughout the policy, the term 'record' is used this means both the manual file and/or the electronic patient record.

2.4 This policy does not apply to requests for records from:

- other NHS bodies or Health Professionals for treatment and care. (These types of requests are covered by the Information Sharing policy.)

[1] A health record is defined in the Data Protection Act 1998 as being any record which consists of information relating to the physical or mental health or condition of an individual and has been made by or on behalf of a health professional in connection with the care of the individual.

- Requests from the Coroners Office or for cases of litigation against the Trust – these are dealt with via the legal department (See Appendix A for a list of contacts).

2.5 This policy does not apply to case conference reports, court reports or chronologies requested under safeguarding children or vulnerable adults.

3. RECEIVING AN ACCESS REQUEST UNDER THE DATA PROTECTION ACT (DPA)

3.1 A request for access to health records in accordance with the DPA, (the DPA refers to these as a subject access request), should be made in writing, which includes by email, to the Trust.

3.2 Immediately upon receipt requests should be date stamped with the date the request came in to the department and directed to:

The Information Governance Department
225 Old Street
Ashton under Lyne
Lancashire
OL6 7SR
Tel: 0161 716 3149/3959/3991
pcn-tr.ig@nhs.net

A full list of contacts for the subject access teams are attached at Appendix A however the Information Governance department will direct the request to the correct co-ordinator.

3.3 If an individual is unable to make a written request it is the Department of Health view that in serving the interest of patients it can be made verbally, with the details recorded on the individual's file.

3.4 Requests must contain the following elements:

- Enough information to enable the identification and location of the information being requested. *A form is attached at Appendix B that may be used to ensure all the information required is included within the request.*
- Sufficient information to be satisfied as to the identity of the applicant. Forms of ID must include one copy of proof of identity and one copy of proof of address. Example forms of ID are:

Proof of Identity	Proof of Address
In order to be acceptable, this document must meet the following criteria 1. It is not expired and is issued by an acceptable source;	Generally, documents meeting this requirement will show the following characteristics: 1. The document is system generated, although tenancy agreements and/or

2. It contains a photograph affixed by the issuing agency; and 3. It contains the same signature as that on the request. There are many ways to meet this requirement, including Passport, Driving licence, EU Identity card, Student Identity card, work pass with photograph etc.	correspondence from a solicitor can also be accepted; also correspondence from an agency in the UK government, such as HMRC can be accepted; 2. The document has a date and is current, usually issued in the last 6 months, but longer periods may apply in some cases, a TV license for example; 3. The document shows the same name and address as given on the request; 4. The document is from an acceptable source and clearly shows that the person has an account or customer identification registered in their name; 5. The document is <u>not</u> a bill for a mobile telephone; and *It is not the same document presented as proof of identity.* Examples include – utility bill, DWP letter

3.5 If this information is not contained in the original request the Trust will seek proof as required. Where requests are made on behalf of the individual patient the Trust should be satisfied that the individual has given consent to the release of their information (see section 9)

3.6 If a member of staff cannot be sure that someone requesting access to information is who they say they are, or, there is no ID available e.g. the applicant is under the age of 16, the member of staff may require him/her to provide other proof by, for example:

- Asking the individual to give information which has been recorded as personal data by the Trust and which the individual might be expected to know;
- Asking the individual to have their signature witnessed by another person who is over 18 and not a relative;

3.7 Patients do not need to give a reason for applying to access their records, but they do need to give sufficient information to enable the records to be located.

3.8 As good practice the Trust may check with the applicant whether all or just some of the information contained in the health record is required before processing the request. This may decrease the cost for the applicant and eliminate unnecessary work by staff. However, there is no requirement under the Act for the applicant to inform the Trust of which parts of the health record they require.

3.9 <u>Repeat of an earlier request</u>

Where an access request has previously been met the Act permits that a subsequent identical or similar request does not have to be fulfilled unless a reasonable time interval has elapsed between.

In determining whether a reasonable interval has elapsed, the Trust will consider:

- The nature of the information
- How often it is altered
- The reason for the repeated request(s).

4. WHO CAN MAKE A REQUEST FOR HEALTH RECORDS

4.1 Formal access to a record can be made by any of the following: -

a) the patient

b) where the patient is a child (under 16), a person having parental responsibility for the patient **or** it may be possible to accept such a request from the child him or herself, see section 10.

c) where the patient is incapable of managing his/her own affairs, a person appointed by the court to manage those affairs **or** a person upon whom the patient, when capable, has endowed an Enduring Power of Attorney or a Lasting Power of Attorney (LPA) (see also section 9).

d) An agent/representative e.g. solicitor, carer, acting on behalf of an intellectually capable patient with written authority from the patient to make the request on their behalf or, a capable person might appoint someone to be his/her agent for the purpose of exercising data access rights by granting him/her a power of attorney.

e) where the patient has died, the patient's personal representative and any person who may have a claim arising out of the patient's death (see section 11).

However, access may also be requested from the following:

- Criminal Injuries Compensation Authority (CICA) or Department for Work and Pensions (DWP).
- Independent Mental Health Advocate (IMHA) (see section 16)
- The Police, who may wish to have access under the Crime and Disorder Act 1998 (see section 12)
- The Crown Prosecution Service
- The Court via an Order (see section 17)

5. SITUATIONS WHERE ACCESS TO HEALTH INFORMATION MAY BE LIMITED OR DENIED

5.1 The Data Protection (Subject Access Modification) (Health) Order 2000 (S.I. No. 413)) enables the data controller to limit or deny access to an individual's health record where:

- The information released may cause serious harm to the physical or mental health or condition of the patient, or any other person.

Before deciding whether this exemption applies, a data controller who is not a health professional (as defined in the Act – see Appendix C) is obliged to consult the health professional responsible for the clinical care of the data subject, or if there is more than one, the most suitable one.

5.2 The 'appropriate health professional' is defined as,

> *"(a) the 'appropriate health professional' who is currently or was most recently responsible for the clinical care of the data subject in connection with the matter to which the information which is the subject of the request relates."*

Where there may be more than one such person, the 'appropriate health professional'' will be:

> *"(b) the 'appropriate health professional' who is the most suitable to advise on the matter to which the information which is the subject of the request relates"*

In the absence of anyone else who might qualify for the role, the 'appropriate health professional'' will be:

> *"(c) an 'appropriate health professional' who has the necessary experience and qualifications to advise on the matters to which the information which is the subject of the request relates"*

5.3 The appropriate health professional will be asked to sign a release form (Appendix D) stating they have been consulted and whether the records should be released either fully, partially or whether the request is refused.

The purpose of the release form is to prove that the administrative staff have consulted the appropriate health professional.

5.4 **Information provided by a third party**

Access may also be limited or denied where it 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 compiled 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 that information.
- It is reasonable to disclose without that third party's consent.

5.5 **Joint health/social care records**

Access to parts of the record containing information relating to the social care of the patient cannot be denied on the grounds that the identity of a third party would be disclosed where the third party is a social worker or other social work professional unless to disclose it would cause the social worker or other social care professional serious harm. Where the record contains information written by social services staff permission to disclose must be obtained from the social services staff responsible for that part of the record. In some cases, this may involve liaising with the legal team of the social services department concerned.

5.6 The Subject Access Team will review the records for information relating to third parties and either seek consent from the third party or redact the information.

6. FEES TO ACCESS HEALTH RECORDS UNDER DPA

6.1 The DPA states that fees for a subject access should be paid in advance, but in the interest of providing a helpful service to patients the Trust will request the fee at the release stage of the access request.

6.2 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 to be 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: up to a maximum £10 charge.

Health records held in part electronically and in part on other media (paper, x-ray film) up to a maximum £50 charge.

Health records held entirely on other media: up to a maximum £50 charge.

All these maximum charges include postage and packaging costs. Any charges for access requests should not be made in order to make a financial gain.

To allow patients to *view* their health records (where no copy is required) the *maximum* costs are:

Health records held electronically: a maximum of £10 (The Trust is not currently able to allow a patient to directly view the electronic record. The record will be printed onto paper and provided to the client to view. Should the client wish to retain the copy they can do, otherwise it will be confidentially destroyed once viewed).

Health records held in part electronically and in part on other media (paper, x-ray film) a maximum of £10 charge.

Health records held entirely on other media: up to a maximum £10 charge **unless the records have been added to in the last 40 days in which case there should be no charge.**

Note: if a person wishes to view their health records and then wants to be provided with copies this would still come under the one access request. The £10 maximum fee for viewing would be included within the £50 maximum fee for copies of health records, held in part on computer and in part manually.

6.3 Where the client is deceased, the applicant can be charged an initial fee of £10 plus photocopying and postage. There is no limit on this charge, but it should not result in profit. This fee is over and above the £10 for initial access.

7. REQUEST TO VIEW THE RECORD

7.1 Wherever possible in response to a verbal request by the patient/client, informal access should be allowed by the 'appropriate health professional' to the parts of the record for which they have responsibility.

7.2 The 'appropriate health professional' must review the record first to decide if access can be permitted to all or parts of the record (see Section 5). The notes must also be reviewed by the Subject Access team or Information Governance Manager to ensure that any third party information is removed. (see section 5)

7.3 The 'appropriate health professional' must then decide whether the access should be supervised by themselves or whether an appointment should be made for supervision by a lay administrator e.g. ward clerk, secretary. In these circumstances the lay administrator must not comment or advise on the

content of the record and if the applicant raises enquiries, an appointment with the 'appropriate health professional' should be offered.

7.4 If full or partial access is granted, the patient should make an appointment in which they can view the record. It should be agreed, if there is more than one volume, which volume is to be viewed first. Appointments should then be arranged in consultation with the health professional/layperson and each appointment should not exceed one hour unless the health professional/layperson agrees otherwise.

7.5 For informal access the record must **not** be removed from Trust premises.

7.6 When informal access is granted a full explanation of any abbreviations or medical terminology should be offered by the 'appropriate health professional' and thus any subsequent discussions must be documented clearly in the record.

7.7 Access should not normally be granted to someone other than the subject of the records, at least where s/he is capable of requesting it him/herself.

8. DOCUMENTING THE REQUEST

8.1 All requests for access to health records under this policy must be logged by the Subject Access Team onto the Safeguard Risk Management System.

8.2 A copy of the request and release form should be filed onto the patient record.

9. CONSENT REQUIREMENTS

9.1 A patient's written consent should be less than 6 months old. In relation to Criminal Injury Compensation Authority/Veterans Agency requests the time period may be extended. The Information Governance Manager can be consulted where there is any doubt.

9.2 **Where the patient has capacity**

A patient may request access to information about him/her through an agent. This must be done in writing and the consent form of the patient obtained. (A standard consent form is attached at Appendix E.)

9.3 It is best practice to ensure that the patient understands what information is contained within their health record and is being disclosed so that consent can be fully informed.

9.4 **Where the patient is incapacitated**

As the law stands, nobody is empowered to give consent on behalf of an adult. However, where a person is incapable of giving or withholding his/her

consent, it will be the person in charge of the patient's treatment who will decide whether information about him/her may be disclosed to someone else. A patient may be incapable because s/he is unconscious or mentally ill, or for some other reason. In many cases, the person in charge of his/her treatment may be the one identified as the 'appropriate health professional', but this will not necessarily be the case. Disclosure of information may only take place if it is in the patient's 'best interests'. In order to decide whether this requirement is met, the person making the decision must consider everything that is known about the patient (including any wishes s/he might have expressed while capable), together with the views of his/her relatives or carers.

Where an adult is, or becomes, incapable of making decisions on his own behalf, the law provides that another may be appointed to act on his behalf as his agent.

9.4.1 An Enduring Power of Attorney (EPA)

Individuals who made provision for a specified party to be appointed to act as their attorney should they become mentally incapacitated did this by way of an Enduring Power of Attorney (EPA) prior to the Mental Capacity Act 2005 coming into force. The scope of the general powers is limited to "the management of property and affairs" of the donor. Persons with EPA have no data protection or common law consent functions. Nevertheless, sometimes it may be appropriate to involve them as the persons who have the authority to make commercial arrangements for patients, including arrangements to provide both accommodation and nursing care. They, on the patient's behalf, may have an interest in securing the best value in a nursing and care package. Where that is the case, it may be necessary to consider whether the vital interests/medical care needs of the patient in question also require the disclosure of all or some of the sensitive personal information in question to the person who holds the EPA. The EPA must be registered with the Public Guardian when the patient can no longer manage their affairs and a copy provided to the Subject Access Team prior to a decision being made regarding disclosure of any information.

The Mental Capacity Act 2005 came into force in October 2007 and replaced the EPA with the Lasting Power of Attorney (LPA). From October 2007 only LPA's can be made but existing EPA's will continue to be valid.

9.4.2 A Lasting Power of Attorney (LPA)

The Mental Capacity Act 2005 increased the range of different types of decisions that people can authorise others to make on their behalf. As well as property and affairs (including financial matters), LPAs can also cover personal welfare (including healthcare and consent to medical treatment) for people who lack capacity to make such decisions for themselves. The patient can choose one person or several to make

different kinds of decisions. An LPA must be registered with the Office of the Public Guardian (OPG) and a copy provided to the Subject Access Team prior to a decision being made regarding disclosure of any information.

9.4.2.1 Personal Welfare LPA's

LPA's can be used to appoint attorneys to make decisions about personal welfare, which can include healthcare and medical treatment decisions. Personal welfare LPA's might include decisions about:

- Where the donor should live and who they should live with
- The donor's day-to-day care, including diet and dress
- Who the donor may have contact with
- Consenting to or refusing medical examination and treatment on the donor's behalf
- Arrangements needed for the donor to be given medical, dental or optical treatment
- Assessments for and provision of community care services
- Whether the donor should take part in social activities, leisure activities, education or training
- The donor's personal correspondence and papers
- Rights of access to personal information about the patient, or
- Complaints about the patient's care or treatment

The patient, when making an LPA can add restrictions or conditions to areas where they would not wish the attorney to have the power to act. It is therefore essential that the LPA is registered by the Office of the Public Guardian (OPG) and is carefully reviewed before any information is disclosed.

9.4.2.2 Property and affairs LPA's

A patient can make an LPA giving an attorney the right to make decisions about property and affairs (including financial matters). A patient can state in the LPA document that the LPA should only apply when they lack capacity to make a relevant decision. It is essential that the LPA is registered by the OPG and is carefully reviewed before any information is disclosed.

9.4.3 The Court of Protection

Prior to the introduction of Mental Capacity Act 2005 where a person lost mental capacity or never had mental capacity, the management of a patient's property and affairs fell to the Court of Protection. The new Act increased the remit of the Court of Protection to include dealing with serious decisions affecting healthcare and personal welfare matters. These were previously dealt with by the High Court under its inherent jurisdiction.

An attorney or agent appointed by the Court of Protection would have, under his general powers, appropriate authority to make a subject access request on the patient's behalf.

10. CHILDREN & YOUNG PEOPLE

10.1 A person, with parental responsibility – see 10.5, can make subject access requests on behalf of their children who are too young to make their own request. A young person aged 12 or above can be considered mature enough to understand what a subject access request is. If they are judged to be mature enough to understand they can make their own request and would need to provide their consent to allow their parents to make the request for them. The health professional must use their own judgement to decide whether a young person aged 12 or above is mature enough to make their own request as they do not always have the maturity to do so.

10.2 Where more than one person has parental responsibility, each may independently exercise rights of access. In the case where a child lives with his or her mother and whose father applies for access to the child's records, there is no obligation to inform the child's mother that access has been sought. However, the father may only be given access to information where he has parental responsibility for the child (see 10.5). Access should only be given with the child's consent if the child is capable of giving consent.

10.3 Children of all ages vary in their level of maturity and understanding, and therefore, each case should be dealt with on an individual basis.

10.4 Where the child is 12 or above it will be necessary to enquire of the clinician/practitioner who has most recently treated the child as to whether in his/her opinion the child has reached an age where he/she has sufficient understanding and intelligence to understand the nature of the application for access to his/her records. Each application must be assessed on an individual basis.

10.5 Not all parents have parental responsibility. Both parents have parental responsibility if they were married at the time of the child's conception, or birth, or at some time after the child's birth. Neither parent loses parental responsibility if they divorce. If the parents were not married, the mother will automatically have parental responsibility at birth, the father will only have it automatically if the child's birth was registered on or after 1st December 2003 and his details were included on the birth registration. However, there are circumstances in which a father who is not married to the child's mother and not registered on the birth certificate may acquire parental responsibility. Furthermore, parental responsibility for a child may be enjoyed by, for example grandparents, or by a local authority".

10.6 Where a child is "looked after" by the Local Authority permission needs to be given by both the Local Authority and the parents as they share parental responsibility.

10.7 Competent young people may also seek access to their own health records.

10.8 The Data Protection Act does not allow disclosure of information whose disclosure is already prohibited in legislation concerning adoption records and reports, statements of a child's special educational needs and parental order records and reports. Health professionals who believe their records may contain such information should seek advice from the Information Governance Manager.

10.9 Child Protection Cases

Section 47 of the Children Act 1989 places certain duties on local authorities where they have reasonable cause to suspect that a child, who lives in their area, is suffering or is likely to suffer significant harm. Local authorities are required to make such enquiries, as they consider necessary to enable them to decide whether any action should be taken to promote a child's welfare.

10.10 A corresponding duty is placed upon the Trust to assist with those enquiries by providing relevant information and advice about a child if called upon to do so.

10.11 If a request for information about a child is received in the context of proceedings to protect the vital interests of the child, where the consent of the child cannot be obtained, the records may be released where necessary.

10.12 It is important that appropriate advice is sought via the Child safeguarding leads or the Information Governance Manager before the records are released if the request is not accompanied by a Court Order requiring disclosure of the medical records.

10.13 If the record contains child psychiatry information the 'appropriate health professional' within child psychiatry should be contacted before access to that part of the record is permitted.

10.14 **Children and Proceedings**

Where health records of children held by the Trust are requested for the purposes of assisting in criminal or civil proceedings relating to that child, the Trust shall not disclose such records if it is satisfied that access to them is likely to cause serious harm to the physical or mental health or condition of the child in accordance with article 5(1) of the Health Order, even where, parental consent has been gained by the Crown Prosecution Service or Police.

10.15 The Trust shall only disclose health records where the purpose of disclosure is in accordance with that stated in clause 10.14 above when it has been served with a Court Order.

10.16 Each request shall be considered on a case by case basis in consultation with the lead clinician involved with the child. Final approval will be sought from the Caldicott Guardian where there is a disagreement between the

Information Governance Manager or Legal Department and the Clinician involved.

11. WHERE THE PATIENT IS DECEASED

11.1 Health records of deceased patients are still covered by the Access to Health Records Act 1990, which entitles the applicant to access records made on or after 1st November 1991. Access must also be given to information recorded before this date if this is necessary to make any later part of the records intelligible.

11.2 "Where the patient has died, the patient's personal representative is entitled to apply for access to information about the deceased. A patient's personal representative is:-

(a) An executor appointed under the deceased's will,
(b) Where there is no will, a person appointed as administrator"

11.3 If the applicant is not a Personal Representative the dependants of a deceased patient may have a claim arising out of the death under the Fatal Accidents Act 1976. Dependants are defined under that Act as including:

the wife or husband or former wife or husband of the deceased

any person who:

(i) was living with the deceased in the same household immediately before the date of death and
(ii) had been living with the deceased in the same household for at least two years before that date and
(iii) was living during the whole of that period as the husband or wife of the deceased

any parent or other ascendant of the deceased

any person who was treated by the deceased as his parent

any child or other descendant of the deceased (including an infant born after the death but who was en ventre sa mare (i.e. conceived but not yet born) at the time of the injury that caused the death)

any person (not being a child of the deceased) who, in the case of any marriage to which the deceased was at any time a party, was treated by the deceased as a child of the family in relation to that marriage

any person who is, or is the issue of, a brother, sister, uncle or aunt of the deceased.

11.4 Once proof of appointment as a Personal Representative or that the applicant is a dependant who may have a claim arising out of the death has been

obtained then it is necessary to consider which part of the records are relevant to the claim. Section 5 (4) of the Access to Health Records Act 1990 states that access shall not be given to any part of the records which, in the opinion of the holder of the records, would disclose information which is not relevant to any claim which may arise out of the patient's death. It is necessary to consider the type of claim envisaged by the applicant and decide which records are relevant to the claim.

In addition, a claim arising out of the Inheritance (provisions for Family and Dependants) Act 1975 would also be a valid claim.

11.5 "Dependants are defined under the 1975 Act as follows: -
(a) A spouse or former spouse of the deceased,
(b) A child of the deceased,
(c) A child of the family,
(d) A dependant of the deceased at the time of the deceased's death."

11.6 Before providing access to healthcare information to any personal representative of the deceased or anyone with a claim arising out of the death of the deceased, the deceased's records should be checked to ensure that the deceased made no request, when he/she was alive, that his/her records which are relevant to a legal claim arising out of the death of the deceased should not be disclosed to the applicant. In addition, the 'appropriate health professional' should agree that disclosure would not be likely to cause serious harm to somebody's physical or mental health and any third party information must be removed.

11.7 The request must be dealt with by the Subject Access Team.

11.8 **Fees to access records under the Access to Health Records Act**

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

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

Hard copies of information – The applicant will be charged an initial fee of £10 plus there will be additional charges for photocopying and postage. This payment should not result in any profit for the Trust.

12. REQUESTS FOR INFORMATION BY THE POLICE

12.1 The Trust wishes to foster good relations with the police, and to play its part in keeping the public safe and protecting it from crime. However, the Trust also has a duty to protect the confidentiality of its patients, whether they are in

hospital or in the community, and whether they are alive or dead. The duty is breached where information about a patient – including the mere fact that s/he is a patient – is disclosed to someone else including the police.

12.2 The Trust has a duty to comply with the provisions of the Data Protection Act 1998. It follows that information may only be disclosed with the consent of the patient, save in exceptional circumstances.

12.3 Disclosure may be necessary in the public interest where a failure to disclose information may expose the patient, or others, to the risk of death or serious harm. In such circumstances the information should be disclosed promptly to an appropriate person or authority. Such circumstances may arise where the disclosure is necessary for the prevention of serious crime. The circumstances where this can arise are diverse and will need to be considered on an individual basis. They can include circumstances where a patient or former patient is the victim of an offence or is suspected of having committed an offence.

12.4 **Consent**

If capable, an adult patient should be asked to give explicit consent to information about him/her being disclosed **unless** the police give good reasons why this would be detrimental to the investigation or prevention of a serious arrestable offence. A child of any age may also give such consent, provided s/he is sufficiently mature to understand the nature of disclosure. If the child is not sufficiently mature, consent to disclose may be given by anyone with parental responsibility of him/her (see section 10). **The consent must be less than 6 months old, and must detail to whom the information is being disclosed, what parts of the record are being disclosed and why the information is requested.**

12.5 Even if consent has been given, the procedures around permitting access by the 'appropriate health professional' and subject access team still apply.

12.6 If the consent of the patient cannot be obtained the following principles apply:

a) The police do not have a general right of access to records or information about patients. Unless there is a court order, the final decision about what may be disclosed will rest with the Trust. However, any request for information by the police should be considered by the health professional who is in charge or was in charge of the patient's treatment in the first instance.

b) Disclosure of confidential information may be necessary for the prevention or detection of serious crime. If, therefore, a police officer is investigating a "serious offence" the health professional in charge of the patient's care should bear this in mind when deciding whether or not to disclose confidential information. A serious offence would include any offence that may have caused or could cause serious harm to any person.

c) A police officer requesting disclosure of confidential information relating to a patient should be asked to provide:

- Confirmation that the offence being investigated is a serious arrestable offence;
- Why it is believed the subject matter of the request has committed or is about to commit such an offence;
- The reason it is believed the provision of the information requested will assist the investigation
- If the request is urgent, the reason for this.

d) If time allows the police request for information form 819T as shown at Appendix F should be completed by an officer and retained by the Subject Access Team.

e) Only information that is relevant to the police enquiry should be given.

f) If the health professional in charge of the patient's treatment decides against releasing information and the Police dispute this then the matter should be referred to the Caldicott Guardian for further consideration. The Caldicott Guardian shall consult with the health professional in charge of the patient's treatment before a decision is made whether or not to release the information.

g) <u>Ensuring the request is genuine</u>

Anyone who claims to be a police officer and to be acting as such should be asked to produce his/her warrant card. The card is credit card sized and pale blue in colour. It should include:

- The Greater Manchester Police logo
- The officer's photo
- Their warrant number
- A signature from the chief constable

In addition, the officer should be asked for their collar number, which should match the number on the warrant card.

If there is any doubt that the request is genuine verification can be sought by contacting the police on 0161 872 5050.

Requests received over the phone can also be verified on the above number. A flowchart is attached at Appendix G, which explains the process when receiving a request from the police.

13. TIME LIMITS

13.1 Legally, a formal request for Access to Health Records must be actioned and <u>completed</u> within 40 days or, if later, 40 days from the day on which the Trust

has the necessary information to confirm the identity of the applicant and locate the record.

13.2 However, the Department of Health has issued guidance that states that Trust's should be aiming to complete within 21 days.

13.3 In all cases it is therefore essential that any formal request is date stamped with date of receipt and sent to the subject access team immediately.

14. REQUESTS FROM SOLICITORS

14.1 These should be made in writing and clarification of whether or not action is intended against the Trust must be obtained.

14.2 **If action against the Trust is intended the request must be forwarded immediately to the Legal Department who will action the request.**

14.3 In all other cases the request must be dealt with by the Subject Access Team

14.4 Solicitors have no greater right of access to information than is enjoyed by their client.

15. REQUESTS IN RELATION TO TRIBUNAL SERVICE MENTAL HEALTH

These are dealt with by the Mental Health Law Administrators - see Appendix H.

16. REQUESTS FROM INDEPENDENT MENTAL HEALTH ADVOCATES (IMHA)

16.1 Under section 130B of the Mental Health Act 1983 ("the Act"), for the purpose of providing help to a qualifying patient, IMHAs may require the production of and inspect any records relating to a patient's detention or treatment in any hospital or registered establishment or to any after-care services provided for the patient under section 117 of the Act. IMHAs may also require the production of and inspect any records of or held by, a local social services authority, which relate to the patient.

16.2 Under section 130B, IMHAs may only access records for the purpose of providing help to a qualifying patient in their role as IMHA, and where the following conditions are met:

- Where the patient has the capacity (or in the case of a child, the competence) to decide whether to consent to the IMHA seeing the records, the IMHA can only access the records if the patient has consented.
- Where the patient does not have the capacity or competence to consent to this disclosure:
    - Records must not be disclosed if that would conflict with a decision made in accordance with the Mental Capacity Act 2005

on the patient's behalf by a done of lasting power of attorney or a deputy, or by the Court of Protection;

- Otherwise, the record holder must allow the IMHA access if they think that it is appropriate and that the records in question are relevant to the help to be provided by the IMHA.

In this latter case, the Code of Practice to the Act advises that the record holder should ask the IMHA to explain what information they think is relevant to the help they are providing to the patient and why they think it is appropriate for them to be able to see that information.

16.3 Anyone who refuses, without reasonable cause, to produce records that an IMHA has a right to inspect may be guilty of the offence of obstruction under section 129 of the Act.

16.4 All requests from IMHA's are dealt with by the Subject Access Team

17. COURT ORDER/AFFIDAVIT

17.1 Often disclosure of medical records of the alleged victim of, or witness to, a crime is requested by the alleged perpetrator's defence lawyers, and occasionally by the Crown Prosecution Service or prosecution team. Initial refusal by the 'appropriate health professional' to release such records will usually be met by a witness summons being issued by the court (under the Criminal procedure (Attendance of Witnesses) Act 1965 in the Crown Court. The defence legal team are only entitled to have access to confidential material that is relevant to the matters in issue in the criminal trial. They are not entitled to trawl through a patient/victim's entire psychiatric history seeking material for cross-examination.

17.2 Prior to the applicant (defence/prosecution) requesting a court order to be served on the Trust they should issue the Trust with an affidavit and copy of the application notice to answer within 7 days (crown court rules 1982). This gives the Trust a period of time to decide whether the records should be disclosed or whether it would not be in the best interests of the patient, or the third parties mentioned within the notes, to disclose the whole record(s) to the court. If the patient does not consent to disclosure, the 'appropriate health professional' remains obliged to refuse disclosure on the grounds of confidentiality. The Trust can then either write to court setting out the reasons why it is felt a summons should not be issued or the Trust can attend the hearing for the summons (legal representation would be required if this is the case).

17.3 If the Trust is not issued with the affidavit it may be served with a summons to produce the records to the court on a specific date. Failure to comply with the order may be contempt of court, and therefore a very serious matter. A Court Order will usually require a consultant/lead clinician or member of the Subject Access Team to produce healthcare records <u>to the court</u>, and in these circumstances they should <u>not</u> be handed over to the police, defence or prosecution.

17.4 It is essential that all original records the Trust holds relating to the patient are taken to the court with a copy of the records. The Subject Access Team will establish what records are held and inform the Information Governance Manager of the order. The Information Governance Manager will liaise with the Subject Access Team and/or lead clinician regarding attendance at court (if required) and production of the records

17.5 If an affidavit or court order is issued to the Trust it must immediately be telephoned through to the Subject Access Team on 0161 716 3149 and a copy of the affidavit/order faxed 0161 716 3389 or scanned and emailed via secure mail. The Information Governance Manager can advise on the action to be taken if the Subject Access Team is not available.

17.6 Where information is disclosed under court order, those who disclose it will usually have a complete defence to any allegation that they have breached confidentiality, but the order must be interpreted correctly and information only be disclosed in accordance with the terms of the order. However, even though the court has ordered production of the notes the 'appropriate health professional' and the Subject Access Team should still review the notes for anything that may harm the patient or any other person. It may then be necessary for the Trust to seek legal representation if it is felt it would not be in the best interests of the patient, or the third parties mentioned within the notes, to disclose the whole record(s) to the court. In these circumstances the Information Governance Manager should be contacted so that, if the Trust agrees, legal representation can be appointed.

18. DISCLOSURES TO MEMBERS OF PARLIAMENT CARRYING OUT CONSTITUENCY WORK

18.1 An Order[2] has been introduced because of concerns that organisations sometimes took the view that they could not respond fully to a Member of Parliament's request for information regarding a constituent without the constituent's consent. In general, Members can safely assume that constituents who have raised matters with them expect that the Member will retain any personal information provided, will disclose it as appropriate and that organisations asked to explain their actions will disclose personal information to Members where this is necessary to provide an appropriate response. In such circumstances the constituents concerned can reasonably be considered to have implicitly consented to processing that is reasonably necessary to pursue their concerns.

18.2 The Order does not place an obligation on organisations to disclose personal data to Members. It merely gives those who want to disclose relevant sensitive personal information, when this is necessary to respond to matters raised on behalf of constituents, a basis to do so.

18.3 However, there may be exceptional circumstances when an organisation responding to a Member is justified in contacting the constituent to inform

[2] Data Protection (Processing of Sensitive Personal Data)(Elected Representatives) Order 2002. S.I. 2001 No. 2905

them of intended disclosures despite the effect of this Order. An example would be where an organisation considered that to provide a proper response it was necessary to disclose sensitive personal information outside the likely expectation of the individual concerned where it was possible that such disclosure could cause genuine distress. In such circumstances the duty of confidentiality could dictate that the individual should be alerted to the intended disclosure.

19. DEPARTMENT OF SOCIAL SECURITY (DSS) (INCLUDING BENEFITS AGENCY AND WAR PENSIONS AGENCY)

19.1 **Requests for information used for Benefit Assessment Purposes**

In order to assess the benefit claims of their client it is often necessary for the DSS to request sight of copies of the hospital case notes or to have a factual report prepared. This is in order that the claim can be objectively considered.

19.2 The request should not be passed on to the patient's General Practitioner. If approached by the DSS for information the responsibility to provide it lies with the Trust and not a third party. The request will therefore be dealt with by the Subject Access Team who will remove any third party information accordingly.

19.3 **Consent to release of information**
It is not necessary for patients or their representatives to exercise their rights under the Data Protection Act 1998 to obtain information to support a claim for benefit. The patient will be aware that the DSS may be required to make such requests and the consent from the patient is an integral part of the benefit claim form.

19.4 **Response Time**
Requests should be met within 10 working days of receipt. Prompt and accurate responses are essential if the DSS is to meet its own obligations to its clients.

19.5 Failure to comply with the 10 day "turn round" may result in delay of benefit payment to the client.

19.6 **Charges for release of records**
The information required should be supplied without charge.

19.7 The NHS has never levied charges on the DSS for the supply of this information and as a result has never been funded to pay for copies etc. There is, consequently, no justification for the introduction of charges.

19.8 **Confidentiality**

The DSS is required to handle all information in a manner that is in accordance with NHS Policy on the secure handling of confidential patient information.

20. SENDING THE RECORD TO THE APPLICANT

20.1 Only copies of records should be sent to any applicant. Under no circumstances must original records be removed from Trust premises.

20.2 All access responses should be enclosed in a sealed tamper proof envelope clearly marked **'TO BE OPENED BY ADDRESSEE ONLY'**. Where the address of the patient applicant is different to that shown on their health record, proof of identity and address (e.g. household bill or driving licence) may be required before the records can be sent through the post. The department name and address should be on the reverse of the envelope marked **"return address in case of non-delivery** tamper proof envelopes should be used which are of sufficient thickness to obscure the information contained inside. Best practice is to send the records special delivery.

20.3 It would be prudent to clarify with the data subject whether they would prefer the records to be sent via post (special delivery) or collected in person.

21. RESPONSES COLLECTED IN PERSON

21.1 Where an access response is to be collected personally by the applicant, then positive proof of identity (see section 3.4) must be provided before such information is released if the applicant is unfamiliar (Evidence of identity may have already been provided when the applicant made the request, and would not need to be provided again).

22. DEALING WITH COMPLAINTS

22.1 If a patient is unhappy with the outcome of their access request, for example, information withheld from them or they feel their information has been recorded incorrectly within their health record and a request to amend their record has been refused, the patient should be encouraged to go through the following channels:

(a) The health professional may wish to have an informal meeting with the individual in the hope to resolve the complaint locally.

(b) If the health professional feels that they cannot do anything for the patient locally, the patient should be advised to make a complaint through the Trust's complaints procedure (see the Trust's Complaint Policy for further information).

(c) Ultimately, the patient may not wish to make a complaint through the Trust's complaints procedure and take their complaint direct to the Information Commissioner. The Information Commissioner has such powers to rule that any erroneous information is rectified, blocked, erased or destroyed and can also request an assessment around the

non-disclosure of information to the applicant. Any requests for assessment from the Information Commissioner will be investigated by the Information Governance Manager.

(d) Alternatively, if the patient wishes to do so, they may wish to seek legal independent advice to pursue their complaint.

Useful contact addresses for complaints:

Pennine Care Complaints Department

The Complaints Manager
Pennine Care NHS Foundation Trust
225 Old Street, Ashton-under-Lyne
Lancashire, OL6 7SR
Telephone: 0161 716 3000

Information Commissioner's Office

Wycliffe House
Water Lane, Wilmslow,
Cheshire, SK9 5AF
Switchboard: 01625 545700
Fax: 01625 524510

23. WHAT IF CORRECTIONS ARE REQUESTED?

23.1 Where a person considers that any information contained in a health record or part of a health record to which he/she has been given access, is inaccurate, he/she may apply to the holder of the health record for the necessary correction to be made (an application form is enclosed at Appendix I).

23.2 An extra sheet may be added to the health care record for such corrections.

23.3 When such an application occurs, the holder of the health record should either:

a) if he/she is satisfied that the information is inaccurate, make the necessary correction or
b) if he/she is not satisfied, insert a copy of the completed Appendix I in the relevant part of the health records, the matters which the applicant alleges to be inaccurate should be discussed and any discussion documented.

23.4 The correction should be signed and dated by the holder of the health record and applicant.

23.5 The applicant must be provided, without charge, a copy of the correction or the note of the request and any discussion.

23.6 When corrections are made, care must be taken not to obliterate information. It is recommended that a single line is drawn through the error and the correction should be dated and signed. The use of obliterating material, e.g. tippex, must **never** be used.

23.7 Should the patient not be satisfied as to the outcome of their application for the record to be amended they can make a complaint using the NHS complaints procedure (see Section 22).

24. 'SIGNIFICANT DAMAGE OR DISTRESS' - SECTION 10 OF THE DATA PROTECTION ACT 1998

24.1 If the patient feels that keeping some inaccurate information in their health record is causing them a significant amount of substantial and unwarranted damage or distress, section 10 of the Data Protection Act allows the patient to write to the Trust asking that it stops keeping or using the information. The patient will need to quote section 10 and give the specific reasons for why keeping or using the information is causing, or is likely to cause, them significant, unnecessary damage or distress. This is known as a Section 10 Notice.

24.2 The Information Commissioner takes the view that a Section 10 Notice is only likely to be appropriate where the particular processing e.g. holding/using the information has caused, or is likely to cause, someone to suffer loss or harm, or upset and anguish of a real nature, over and above annoyance level, and without justification.

24.3 Any Section 10 Notice received must be forwarded to the Information Governance Manager who will advise on the appropriate action to be taken.

24.4 In all cases the patient should expect a response within 21 days of the Section 10 Notice being received and this will be completed by the Information Governance department.

24.5 The patient must have tried all other ways of getting the record amended and also have considered what effect removing the information could have on their care and treatment, including on decisions that might need to be made in the future.

25. RESPONSIBILITIES

25.1 Any enquiries with regard to this policy should be directed to the Information Governance Manager.

25.2 The Caldicott Guardian has Executive responsibility for the management of Health Records.

25.3 The Information Governance Manager will oversee the day-to-day management of the policy.

25.4 It is the responsibility of the 'appropriate health professional' and the Subject Access Team to review the record prior to its release and to decide what information, if any, should be released and what should be withheld (see section 5) In the case of Mental Health Review Tribunals it will be the

responsibility of the Mental Health Act Administrator to remove third party information.

26. TRAINING

26.1 A training hand-out is given at induction to all new starters to the Trust.

26.2 Specific training on removing third party information is provided to the Subject Access Team by the Information Governance Manager.

26.3 In addition to the mandatory on-line Information Governance training ad hoc training, provided by the Information Governance Manager, is available on request.

26.4 An 'Awareness campaign' has been disseminated to all staff throughout the organisation during 2016.

27. AUDITING AND MONITORING

27.1 A quarterly report will be provided to each borough/division via the Information Governance Assurance Group (IGAG) meeting (except Trafford who handle requests locally) on the following:

- No. of requests dealt with within 40 day legal timeframe
- No. of requests dealt with within 21 day good practice timeframe set by the Department of Health
- Reasons for any delay in responding within the appropriate timeframe

28. REFERENCES

Guidance for Access to health records requests – Department of Health Feb 2010
Information Commissioner – Data Protection Act 1998 – Legal guidance
Independent Mental Health Advocates – Supplementary guidance on access to patient records under section 130B of the Mental Health Act 1983
HSC 1999/001 The Provision of Patient Information by NHS Trusts to the Department of Social Security
Mental Capacity Act 2005 Code of Practice

Appendix A

LIST OF CONTACTS

All services		
Information Governance Team Pennine Care Trust HQ 225 Old Street Ashton under Lyne Lancashire OL6 7SR 0161 716 3145/3899 **pcn-tr.ig@nhs.net**	Subject Access Team Pennine Care Trust HQ 225 Old Street Ashton under Lyne Lancashire OL6 7SR 0161 716 3149/3959 **pcn-tr.sar@nhs.net**	Tom Walker Records & Information Manager Pennine Care NHS Foundation Trust Trafford Division Meadway Health Centre Meadway Sale Greater Manchester M33 4PS Tel No: 0161 975 4754 **tomwalker@nhs.net**

Information Governance Manager
Pennine Care NHS Foundation Trust HQ
0161 716 3145/6/9

Caldicott Guardian (Medical Director)
Pennine Care NHS Foundation Trust HQ
0161 716 3005

Legal Department
Pennine Care NHS Foundation Trust HQ
0161 716 3142/3197/3074

Appendix B

Form AHR2

APPLICATION FOR ACCESS TO HEALTH RECORDS

Pennine Care NHS
NHS Foundation Trust

#

Form AHR2

APPLICATION FOR ACCESS TO HEALTH RECORDS
(DATA PROTECTION ACT 1998)

#

The **Data Protection Act 1998 (DPA)** gives individuals certain rights regarding information held about them. It places obligations on those who process information (data controllers) while giving rights to those who are the subject of that data (data subjects). Personal information covers both facts and opinions about the individual.

Anyone processing personal information must comply with the eight data protection principles. Data must be:

1. Fairly and lawfully processed
2. Processed for limited purposes
3. Adequate, relevant and not excessive
4. Accurate and up to date
5. Not kept longer than necessary
6. Processed in accordance with the individual's rights
7. Secure
8. Not transferred to countries outside the European Economic area unless country has adequate protection for the individual.

The disclosure of records of deceased persons is dealt with under the Access to Health Records Act 1990. Under that legislation, when a data subject has died their personal representative or executor or administrator or anyone having a claim resulting from the death (this could be a relative or another person), has the right to apply for access to the deceased's health records. Health records relating to deceased people do not carry a common law duty of confidentiality but it is Department of Health and General Medical Council policy that records relating to deceased people should be treated with the same level of confidentiality as those relating to living people. If the deceased person had indicated that they did not wish information to be disclosed, or the record contains information that the deceased person expected to remain confidential then it must remain so.

ABOUT THIS FORM

This form should be used if you want to make a request for information you believe Pennine Care NHS Foundation Trust holds about you (or someone else if it falls into the criteria outlines above). This is called a 'Subject Access Request' under the DPA or Health Records Act and if you are seeking information about you, then you are the 'data subject'.

Under **Section 7(3)** of the DPA, a data controller (in this case, the Trust) is not obliged to comply with a request unless we are supplied with such information as we may reasonably require in order to satisfy ourselves as to the identity of the person and to locate the information which that person seeks. So while you may have already made a request to us by other means, we may still require you to fill in this form.

STATUTORY DEADLINE

There is a 40 calendar day statutory deadline for Subject Access Requests. We will respond to your request within 40 days of receipt of a valid request and the appropriate fee.

TERMS & CONDITIONS

You are entitled to receive a copy of your records but should note that a charge will usually be made. You should also be aware that in certain circumstances your right to see some details in your records may be limited in your own interest or for other reasons.

Any information you have supplied in making this request will be treated in confidence. It will only be used for the purpose of carrying out the search for your information in accordance with Section 7 of the Data Protection Act 1998. This Trust is only responsible for providing information which is held by us. If your request indicates the release of information to a Third Party (e.g. a solicitor, insurance company or relative) please indicate in Section D, Part 2.

FEES PAYABLE – THIS IS FOR INFORMATION ONLY AT THIS STAGE, YOU WILL BE ADVISED OF THE PRECISE FEE IF YOUR APPLICATION IS ACCEPTED

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

- Health records held electronically: up to a maximum £10 charge
- Health records held in part electronically and in part on other media (paper, x-ray film) up to a maximum £50 charge
- Health records held entirely on other media: up to a maximum £50 charge.

Where the client is deceased

The applicant will be charged an initial fee of £10 plus there will be additional charges for photocopying and postage. You will be advised of the total cost. This payment will not result in any profit for the Trust.

To view the health records (where no copy is required) the maximum costs are:

- Health records held electronically: a maximum of £10 (The Trust is not currently able to allow anyone to directly view the electronic record. The record will be printed on to paper and provided for viewing on Trust property.)
- Health records held in part electronically and in part on other media (paper, x-ray film) a maximum of £10 charge.
- Health records held entirely on other media: up to a maximum £10 charge unless the records have been added to in the last 40 days in which case there should be no charge.

Note: if the requester wishes to view the health record and then wants to be provided with copies this would still come under the one access request. The £10 maximum fee for viewing would be included within the £50 maximum fee for copies of health records, held in part on computer and in part manually.

HOW TO COMPLETE THE FORM

Section A

This section must be completed for all applicants. Please complete all details relating to the data subject (person about whom the information is requested).

Section B

This section should only be completed when the applicant is not the data subject but has been authorised by the data subject to make the application or is requesting access to a deceased persons health records.

Section C

This section must be completed for all applicants. Please specify the records/information you wish to access providing as many details as possible. It is not sufficient merely to state "all records". If you have insufficient space, please attach a continuation sheet containing full details.

Section D

This section must be completed for all applicants and is split into 3 parts.

- Part 1 should be completed by the data subject or legal parent/guardian.
- Part 2 should be completed when the applicant is not the data subject but has been authorised by the data subject to make the application.
- Part 3 should be completed when the applicant is not the data subject but is requesting information of a deceased data subjects records under the Access to Health Records 1990.

Section E

Supporting identification must be in order for us to process your request.

APPLICATION FOR ACCESS TO HEALTH RECORDS
(DATA PROTECTION ACT 1998)

Please complete this form in capital letters using black ink. Please give as much information as you can to help us deal with your request

SECTION A : Details of the Data Subject (person to whom the information relates)				
Title				
Surname				
Forenames				
Date of Birth		Sex Please circle	M	F
NHS Number				
Address (for correspondence)	…… ……Postcode: ……			
Telephone Number		E-mail address (optional)		
If the person's name and/or address was different from the above during the period/s for which you are applying, please give details: Previous name/s 1 …… 2 …….. Previous address/s With dates 1 …… 2 …….. …… ……..				

SECTION B : Details of person acting on behalf of the Data Subject		
Title		
Surname		
Forenames		
Address	…… ……Postcode: ……	
Telephone Number		E-mail address (optional)
Relationship to data subject		
ICO Data Controller Registration Number (If applicable)		

SECTION C: Details of Treatment / Description of information requested (this section must be completed)			
Please describe the information that you believe we hold, and that you would like access to. If you can be specific about the information that you would like, it will assist us to locate it (if we hold it). If we require further details about the information that you are requesting, we will contact you.			
Location e.g. name of hospital / clinic	**Department** e.g. Psychiatry, district Nursing	**Condition or illness**	**Date from and to** (approx.)

Are you applying for photocopies of health records/part of the health records?			
Are you applying to view the health records (at Trust location)? i.e. read only			
Tick only one of the above options			

#
#

SECTION D: Declaration	
Please complete either Part 1, 2 or 3. **Part 1** I, the undersigned declare that the information given by me is correct to the best of my knowledge and that I am entitled to apply under the Data Protection Act 1998 for access to personal data that the Trust holds about me under the terms of that Act.	
I am the data subject	
I am the legal parent/guardian of the data subject who is • under the age of 12: □ • over the age of 12 and under the age of 16 years and either: consented to my making this application (attached): □ Is incapable of understanding the request: □	
Signed _____ Date _____ Print Full Name _____	
Part 2 I have been asked to act by the data subject and below is the data subject's written authorisation: I hereby give my consent for _____ (full name of person) to make a Subject Access Request on my behalf under the Data Protection Act 1998 to Pennine Care NHS Foundation Trust. Signed _____ Date _____ Print Full Name _____	

Part 3

I declare that the information given by me is correct to the best of my knowledge and I am entitled to apply under Access to Health Records Act 1990 because:

I am the deceased data subject's next of kin/personal representative (please provide one of the following documentary evidence) i.e. - Grant of probate – If deceased made a will - Letter of administration – If deceased died intestate and Proof of identity (see below)	
I have a claim arising from the data subject's death and wish to access information relevant to my claim and attach details of the grounds of my claim (please provide documentary information) i.e. - Written confirmation/evidence of intended claim and broad nature of claim and Proof of identity (see below)	

If none of the above apply, please provide a brief explanation as to why you require the records

Signed _____ Date _____

Print Full Name _____

SECTION E : Supporting Identification

Identity documentation may be required in order to for us to process your request. Please provide us with a copy of either your passport or drivers' license, and a copy of one utility bill with your current residential address. Complete the checklist below to indicate what you have enclosed with this form.

Please note:

*1. This supporting identification will be **securely destroyed** once we have verified your identity.*
2. It is an offence under Section 55 of the Data Protection Act to impersonate a Data Subject

ADMINISTRATIVE USE ONLY	**TICK**
Copy of passport / driver's license supplied (containing the same signature as that on the request)	
Copy of utility bill supplied (as proof of current residential address **NB:** mobile phone bills are not accepted)	
Copy of Enduring/Lasting Power of Attorney/Grant of Probate or letter of administration	
Other (please specify)	

Please send your form (fully completed), and copies of the identification documents to:

Subject Access Team
Pennine Care NHS Foundation Trust, 225 Old Street, Ashton-Under-Lyne, OL6 7SR

Appendix C

Definition of Health Professional

Under the Data Protection Act 1998 “Health Professional” means any of the following;

a) A registered medical practitioner (a "registered medical practitioner” includes any person who is provisionally registered under section 15 or 21 of the Medical Act 1983 and is engaged in such employment as is mentioned in subsection (3) of that 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 (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 1993

g) A registered chiropractor as defined by section 43 of the Chiropractors Act 1994,

h) Any person who is registered as a member of the 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

k) A scientist employed by such a body as a head of department.

Appendix D

Pennine Care NHS
NHS Foundation Trust

RELEASE FORM

Date:	
To:	(appropriate health professional)
From:	(Subject Access Team)
Re: Access to Health Records	
Record details:	
Applicant details:	

The above has made an application to view the records detailed. I would be grateful if you could review the record and ascertain whether there is any information contained within the record that should not be disclosed to the applicant on the grounds that it may cause serious harm to the physical or mental health or condition of the patient or of any other person. *The Subject Access co-ordinator will review the notes for any third party information.*

Please note, the Trust must respond to the applicant within a maximum of 21 days (DOH good practice guidance but 40 days legally under the Data Protection Act 1998) including the notes being reviewed and photocopied. Please complete the following no later than _____. If it is impossible to comply with this timescale please contact the Subject Access Co-ordinator who may agree to extend the deadline with the applicant if there is a valid reason.

Following review, please complete the following:

Full access granted	☐	Partial access granted (please give details)	☐
		Access denied* (please give details)	☐

Reason access denied:

Signed: _____ Print Name_____

Date: _____

Ensure the decision is recorded in the health record or a copy of this release form filed within the health record.

As documented in Section 5 of the Access to Health Records Policy, under the Data Protection (Subject Access Modification) (Health) Order 2000 (S.I. No. 413)) the information should not be provided unless the appropriate health professional has been consulted.

The purpose behind this release form is for the Trust to have evidence that the 'appropriate health professional' has been consulted.

*please note: if access is denied rationale must be given. This will not be conveyed to the applicant but may be required if the applicant complains against non-disclosure of the information requested either via the Trust's complaints procedure or via the Information Commissioner.

Please return completed forms to:

Subject Access Team
Information Governance Department
Pennine Care NHS Foundation Trust HQ
pcn-tr.sar@nhs.net

Appendix E

Pennine Care NHS
NHS Foundation Trust

Consent Form
Access to Health Records under the
Data Protection Act 1998 (Subject Access Request)

Patient's authority for release of records

To:

*(**full** name and address of Consultant and/or Keyworker)*

1. **Full name of patient**

   (Mr/Mrs/Miss/Ms) _____

   Surname _____

   Forename _____

   Any former names _____

2. **Date of Birth** _____

3. **NHS Number *** _____

4. **Current Address** _____

   _____

   _____

   Postcode _____

5. **Previous Address ***
   (if in current property less than 3 years) _____

   _____

   _____

   Postcode _____

* This information is voluntary

Consent

1. I consent to copies of my records* being disclosed to:

   _____

2. I consent to the release of copies of **either**: (please tick)

   ☐ records dated from/to:

   _____

   ☐ records relating to the following admission or condition:

   _____

   _____

   ☐ All information contained within my records from birth

**** PLEASE TICK ONE OF THE ABOVE BOXES AND READ POINTS 3–4 BELOW CAREFULLY.***

3. I understand that if my records are being disclosed to the Police, my Solicitor or the Court they may be made available to my opponent and/or my opponent's solicitor or experts. I understand that this may include details from birth if I decide to consent to the release of all my record.

4. I understand a fee will be charged for the work performed in releasing notes as governed by the Data Protection Act 1998.

Signature of Patient: _____

Date: _____

Office use only

Date application received _____

Received by _____

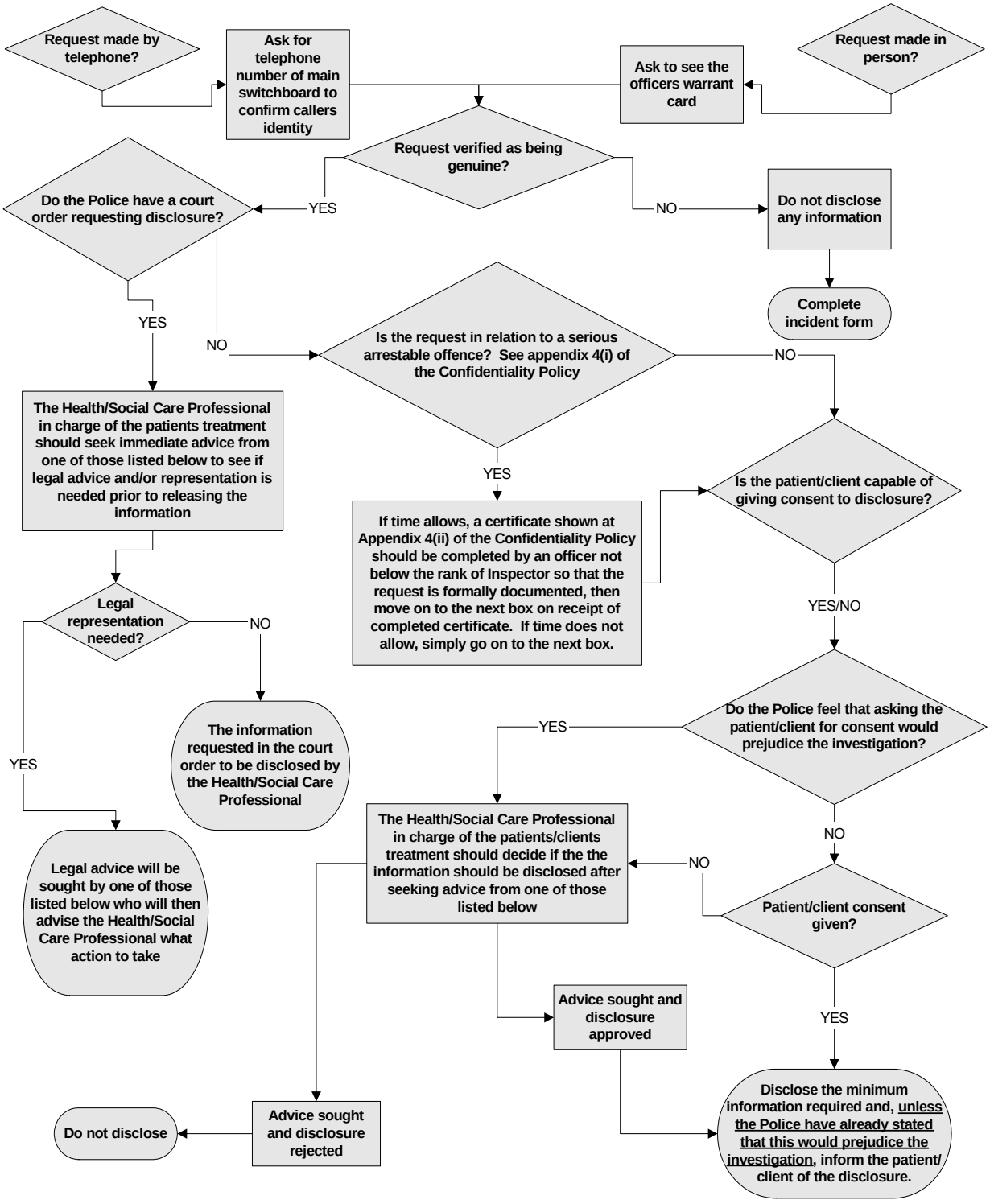
Appendix F

In order to print the form double click on the icon below in the electronic version of this policy available on the Trust intranet and internet

mso2E.dot

Procedure for dealing with requests for information by the Police

Verify that the request is genuine

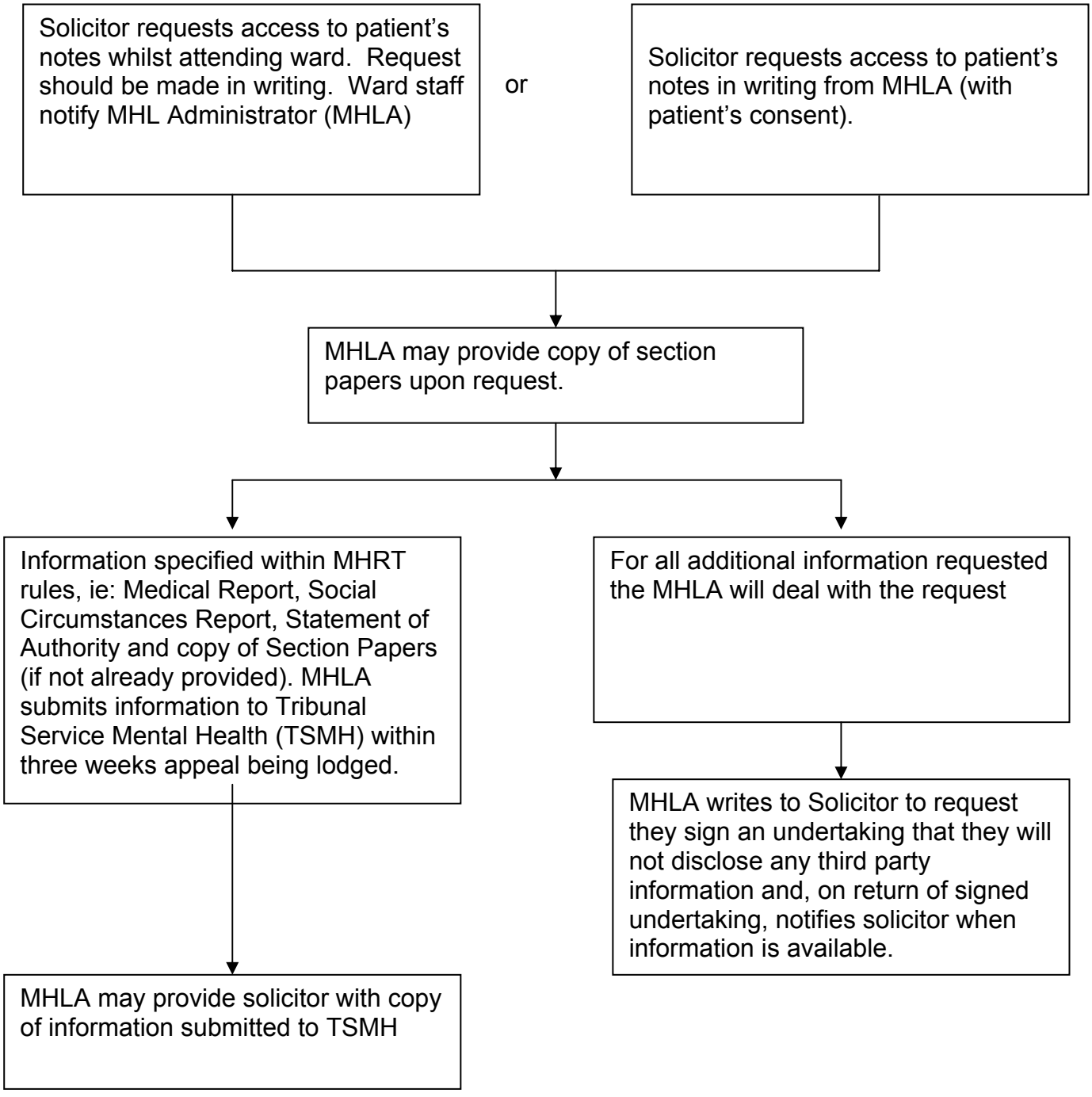


All steps and decisions taken must be recorded in the patients/clients record

Advice: Information Governance Manager – 0161 716 3145/6/9 Trust Solicitor – 0161 716 3031
Medical Director – 0161 716 3005
Social Services staff may contact the Information Governance Manager who may advise they contact their own legal department

Procedure to be followed when request for access to patient records received from a solicitor (Tribunal Service Mental Health)

UNDER NO CIRCUMSTANCES SHOULD NOTES BE HANDED OVER FOR VIEWING ON THE WARD - ALL REQUESTS SHOULD BE SENT TO THE MENTAL HEALTH LAW ADMINISTRATOR (MHLA)



Appendix I

APPLICATION TO AMEND OR REMOVE INFORMATION

Please complete **ALL** sections of this form and return to:

_____

_____

_____

_____

Section 1: Application Details

Name: _____

Address: _____

_____

_____

Postcode: _____

Telephone Number: _____

_____

If application is being made on behalf of the patient, state relationship to patient.

Relationship to patient: _____

Patient Name (if different from above): _____

Address: _____

_____

_____

Postcode: _____

Telephone Number: _____

_____

Section 2: Purpose of Request (please tick)

☐ Amendment ☐ Removal

Reason for Removal: _____

_____

_____

Section 3: Amendments

Please state the amendments that need to be made to the record(s).

Section 4: Certification

A. Patient

I certify that the information listed in Section 2/3 is accurate and request that the amendments be made to my record.

Signed: _____

Date: _____

B: 'appropriate health professional'

I do/do not certify that I agree to the amendments/ removals requested by the patient/patient's representative.

Signed: _____

Name: _____

Position: _____

Date: _____

Reason for non-certification: _____

Amended: Yes/No Date: _____

Removed: Yes/No Date: _____

Patient/Representative notified: Yes/No Date: _____