

HEALTH AND SOCIAL CARE RECORDS POLICY AND PROCEDURES

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1. DEFINITION OF A RECORD

- 1.1 All NHS records are classified as public records. Ownership and copyright of records is with the Trust and not with the individual employee.
- 1.2 The Data Protection Act 1998 applies to data about identifiable living individuals. The Act gives conditions under which data may be processed (i.e. obtained, recorded or held):
- the individual has consented to the processing;
 - the processing is necessary for the performance of a contract with the individual;
 - the processing is required under a legal obligation;
 - the processing is necessary to carry out public functions;
 - the processing is necessary in order to pursue the legitimate interest of the data holder or third parties (unless it could prejudice the interests of the individual).
- 1.3 The Data Protection Act also makes specific provision for sensitive personal data, which includes data about:
- a person's physical or mental health;
 - racial or ethnic origin;
 - religious or other beliefs;
 - a person's sexual life;
 - the commission or alleged commission of any offence;
 - any proceedings for any offence committed or alleged to have been committed.
- 1.4 Sensitive personal data may be processed if it is necessary for medical purposes and is undertaken by:
- a health professional; or
 - a person who in the circumstances owes a duty of confidentiality which is equivalent to that which would arise if that person were a health professional.
- 1.5 'Medical purposes' includes the purposes of:
- preventative medicine,
 - medical diagnosis,
 - medical research,
 - the provision of care and treatment and
 - the management of healthcare services.
- 1.6 The Data Protection Act refers to 'accessible records', to which access was previously available under other legislation. These include health and social services records, both on paper and held on computer.
- 1.7 The term 'health record' is defined by the Data Protection Act as 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 that individual.

1.8 The term 'health professional' is defined by the Data Protection Act as any of the following:

- 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),
- a registered dentist as defined by section 53(1) of the Dentists Act 1984,
- a registered optician as defined by section 36(1) of the Opticians Act 1989,
- 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,
- a registered nurse, midwife or health visitor,
- a registered osteopath as defined by section 41 of the Osteopaths Act 1993,
- a registered chiropractor as defined by section 43 of the Chiropractors Act 1994,
- a clinical psychologist, child psychotherapist or speech therapist,
- a music therapist employed by a health service body,
- a scientist employed by such a body as head of department, and
- any person who is registered as a member of a profession to which the Professions Supplementary to Medicine Act 1960 extends. These professions are now regulated by the Health Professions Council and comprise:
 - art therapists,
 - chiropodists / podiatrists,
 - clinical scientists,
 - dietitians,
 - drama therapists,
 - medical laboratory technicians,
 - music therapists
 - occupational therapists,
 - orthoptists,

- prosthetists & orthotists,
- paramedics,
- physiotherapists,
- radiographers, and
- speech and language therapists.

1.9 Other professionals and practitioners meeting the criteria of 1.4, 1.5, 1.6 & 1.7 (such as social workers) will also make entries in Health and Social Care Records. Administrative staff (e.g. secretaries, Mental Health Act administrators and health records staff) are also permitted to document relevant patient contact in the Health and Social Care Record.

1.10 Record keeping may be delegated to unqualified staff. However the NMB recommends that all tasks delegated by a qualified nurse should be countersigned and the Royal College of Occupational Therapists requires student or support staff records to be countersigned (see 2.3.6 below).

1.11 A Health and Social Care Record can be recorded in manual form or in a computerised form or in a mixture of both. It may include such things as handwritten clinical notes, letters to and from other health professionals, laboratory reports, x-rays, printouts from monitoring equipment, photographs, videos and tape recordings.

1.12 The Purpose of Records

The purpose of Health and Social Care Records is to:

- 1.12.1 provide accurate, current, comprehensive and concise information concerning the condition and care of the patient or client and associated observations;
- 1.12.2 provide a record of any problems that arise and the action taken in response to them;
- 1.12.3 provide evidence of care required, intervention by professional practitioners and patient or client responses;
- 1.12.4 include a record of any factors (physical, psychological or social) that appear to affect the patient or client;
- 1.12.5 record the chronology of events and the reasons for any decisions made;
- 1.12.6 support standard setting, quality assessment and audit;
- 1.12.7 provide a baseline record against which improvement or deterioration may be judged.

1.13 Key features of Health and Social Care Records

In addition to fulfilling the purposes set out in the previous paragraph, properly made and maintained records will:

- 1.13.1 be made in a timely manner;
- 1.13.2 identify factors which jeopardise standards or place the patient or client at risk;
- 1.13.3 provide evidence of the need, in specific cases, for practitioners with special knowledge and skills;
- 1.13.4 aid patient or client involvement in their own care;
- 1.13.5 provide evidence to answer possible complaints which may be made;
- 1.13.6 be written, wherever possible, in terms which the patient or client will be able to understand.

2. STANDARDS FOR RECORDS AND RECORD KEEPING

2.1 Ethical aspects of Health and Social Care Records

- 2.1.1 A correctly made record honours the ethical concepts on which good practice is based and demonstrates the basis of the professional and clinical decisions made.
- 2.1.2 A basic creed of records and record keeping is that those who make, access and use the records understand the ethical concepts of professional practice which relate to them. These will include, in particular, the need to protect confidentiality, to ensure true consent and to assist patients and clients to make informed decisions.
- 2.1.3 The originator will ensure that the entry in a record that she or he makes is totally accurate and based on respect for truth and integrity.

2.2 The Health and Social Care Records will contain information to identify the patient. Each Record must contain the following identification data:

- 2.2.1 patient NHS number;
- 2.2.2 patient name **in full**, title and preferred name;
- 2.2.3 date of birth;
- 2.2.4 full address and postcode;
- 2.2.5 ethnic Group **as identified by the patient**.

2.3 The existence of the following must be identified in the Health and Social Care Record in the form of an alert sticker:

- 2.3.1 **allergy** - including hyper-sensitivity reactions (details to be recorded inside front cover);
- 2.3.2 **diabetes** (details to be recorded inside front cover);
- 2.3.3 **identification** of patient having a **similar name** to another (sticker to be put on front cover);

2.4 Each Record should contain the following identification data or be recorded as NOT KNOWN or NOT APPLICABLE:

- 2.4.7 contact home, work and mobile telephone number, if agreed by patient);
- 2.4.8 gender;
- 2.2.9 next of kin;

2.4.10 name and address of a person(s) to contact in an emergency by a member of the Service;

2.4.11 GP's name and address or telephone number.

The following will be included if appropriate to the needs of the service/client:

2.4.12 religion and

2.4.13 the person's care coordinator or named professional.

2.5 Entries in all Health and Social Care Records will be meticulous, in chronological order and relate to an identified episode of care or intervention.

2.5.1 Writing must be legible.

2.5.2 All entries will be made contemporaneously (i.e. during, or at the end, of clinical contact) or within 24 hours after the events to which they relate.

2.5.3 Abbreviations from a core list understood by professional colleagues and approved by the heads of professional/care services may be used. Otherwise the full text must always be written/typed when first used during an entry. The abbreviation may be put in brackets next to the initial full entry and used through the remainder of that entry.

2.5.4 All entries will be written/typed in black ink.

2.5.5 A full identifiable signature, not initials, is required, except where errors are scored out (2.5.14 below), which is identifiable against the database identified in 2.5.7 below.

2.5.6 If registered nurses delegate a task to another individual, irrespective of their training, the NMC expects them to review and countersign document entries at regular intervals to ensure compliance with required standards. The Royal College of Occupational Therapists requires records made by student or support staff to be countersigned to ensure and demonstrate accuracy.

2.5.7 An index of signatures and professional status will be held at agreed central locations within Gloucestershire Partnership NHS Trust.

2.5.8 All medication/prescription charts and records must comply with the most recent Gloucestershire Partnership NHS Trust Policy for Ordering, Prescribing and Administering medicines (POPAM).

2.5.9 The date and time of each entry will be recorded.

2.5.10 Any additions to existing information will be individually dated, timed and signed.

- 2.5.11 All new documentation held in Records will have patient/client identification details as in paragraphs 2.2 – 2.4.
- 2.5.12 Continuation sheets in a Record will contain a patient name in full and either a unique identifiable patient number or date of birth.
- 2.5.13 Continuation sheets will be numbered on the first side.
- 2.5.14 Any small errors, in a pocket of larger text, can be scored out with a single line, dated and initialled. **No correction fluid will be used.**
- 2.5.15 Blank spaces on continuation sheets will be scored through.
- 2.5.16 Statements within Records must only be written from a clinical or professional perspective. When writing statements of a personal nature, the clinician should always bear in mind that they would be held to account to justify these judgements.

2.6 Assessment, planning, implementation review and evaluation of care will be distinctly recorded in the Health and Social Care Records

- 2.6.1 A clear and logical format will be used
- 2.6.2 Details of referral will be recorded specifying date received
- 2.6.3 Subjective information defining problems or needs from patient/client will be documented
- 2.6.4 Base line assessment of needs will be recorded
- 2.6.5 Long and/or short term goals will be specified in measurable terms
- 2.6.6 A treatment plan as agreed between the professional and the patient will be recorded and reviewed at agreed intervals. Due consideration will be given to the sharing of information in accordance with Professional and Local Guidelines of Confidentiality and Consent
- 2.6.7 All significant details, in connection with the patient/client care will be recorded to provide a comprehensive picture of care delivered. These include associated outcomes, reviews, important decisions, significant discussions with the patient, family members or other professionals and other relevant information including details of non attendance.
- 2.6.8 It should be possible to trace the decision-making process through the records. However, it is not always possible to record every verbal exchange, and discretion should be used in identifying those decisions which are of sufficient significance to require recording.
- 2.6.9 A copy of any discharge summary will be retained in the Record
- 2.6.10 In patient discharge will comply with the Gloucestershire Partnership NHS Trust Discharge Policy

- 2.6.11 Any information which the professional does not wish to be discussed with the patient/client or relative because the disclosure is likely to cause serious harm to the physical or mental health of the patient (Data Protection Act 1998), will be placed in a separate part of the Health Record designated for confidential documentation.
- 2.6.12 Documentation relating to a patient's complaint will be held separately from their Health Record, in accordance with the most recent Gloucestershire Partnership NHS Trust Complaints Policy subject to the need to record any information, which is strictly relevant to their health in the patient's Health and Social Care Records. Any correspondence between clinicians and the Trust's legal advisors or a defence organisation about a claim will also be held separately
- 2.6.13 Any information, which the patient/client does not wish to be discussed with a relative, will be placed in a separate part of the Record designated for confidential documentation.
- 2.7 Information provided to other agencies must be clear. If information received from other agencies or professionals is not clear, it must be queried.
- 2.8 If information is to be shared outside the Trust, careful consideration should be given to the distribution. Information should be sent either to all relevant members of the health care team or to one person with the specific request that they share it with others. (For example, different professionals in primary care may still maintain separate records, and it cannot be assumed that a letter sent to a GP will necessarily be seen by other members of the primary health care team.)

3. FOLDERS

- 3.1 The Trust maintains its own record system specifically for mental health and learning disability services.
- 3.2 With the exception of items which are too bulky, all records for each patient should be contained in one case note folder.
- 3.3 In exceptional circumstances where it is impractical for two groups of staff to use the same case note folder at the same time a subsidiary folder may be used by one group. The tracer system should show the location of both folders. The existence of the subsidiary folder must be indicated in the main folder and the two folders be merged as soon as the course of treatment is over.
- 3.4 Social care records are normally combined with health records for patients receiving a service from the Working Age Adults and Substance Misuse Care Groups. In other care groups health and social care records are maintained separately.
- 3.5 When it is necessary to make up a new set of case notes, the new countywide case note folder must be used.
- 3.6 Instructions for the use of the new folder are printed in the inside cover and must be followed.
- 3.7 When a folder becomes too bulky, it may be split into two or more volumes. Each cover should clearly state the period covered in that volume. It may also indicate the number of that volume and the total number of volumes (e.g. volume 1 out of 3.) The tracer system should indicate whether all volumes are together and, if not, the location of each one.
- 3.8 When there is more than one case note folder for a patient, the current case notes must contain the current core assessment, care plan, risk assessments, section documentation and any other statutory documents.
- 3.9 It is the responsibility of the ward/department holding a case note folder to file any loose papers.

4. STORAGE OF HEALTH AND SOCIAL CARE RECORDS

- 4.1 Case note folders of non-current and deceased patients should be sent to the appropriate Health Records Department at Charlton Lane or Wotton Lawn for storage.
- 4.2 Records of patients currently undergoing care will be kept in the appropriate ward or department or team base. They will be stored in locked and secure locations.
- 4.3 When not in use, portable filing systems (i.e. which can potentially be carried by an individual) must be locked and placed in a secure area.

5. THE DUTY OF CONFIDENCE

- 5.1 All NHS bodies and those carrying out functions on behalf of the NHS have a common law duty of confidentiality to patients and a duty to maintain professional ethical standards of confidentiality.
- 5.2 Data held on computer is subject to the same confidentiality rules as the written Health and Social Care Record. Any information pertaining to a patient's clinical condition is confidential regardless of where that information is held.
- 5.3 The following Guidelines apply to all patient identifiable information and must be read in conjunction with the Gloucestershire Partnership NHS Trust's Health and Social Care Records Standards, Guidelines on Disclosure of Information and Code of Confidentiality.
- 5.4 Data will be held in accordance with the Data Protection Act 1998, Health Records Act 1990 and the Gloucestershire Partnership NHS Trust IM&T Security Policy.
- 5.5 There are rights of subject access under the Data Protection Act 1998 which, with some exemptions, entitles individuals to a copy of information held about them. (See section 7.)
- 5.6 Subject to certain safeguards, a personal representative of a deceased patient has a statutory right, in accordance with the Access to Health Records Act 1990, to see the deceased patient's records made after 1st November 1991 and earlier ones if they are necessary to understand the later ones. (See section 7.)
- 5.7 There are occasions when disclosure of information is required by law, e.g. disclosure regarding infectious diseases is required by doctors under the Public Health Act 1936, disclosure of issues related to Child Protection may be required as directed in the current Gloucestershire Area Child Protection Procedures Manual.
- 5.8 Clinical information should not be given to anyone without the permission of the Health Professional responsible for the patient's care and treatment, or on the advice of a nominated senior professional within that body. For further guidance see Appendix A of this policy and Confidentiality and Practice Guidelines in the Trust's Care Practice Procedures.
- 5.9 A patient's manual Health and Social Care Record should not be handed over to anyone unless the identity of that person has been ascertained and it has been established that they are authorised to have access to such information. If the person is the patient or their representative, the Gloucestershire Partnership NHS Trust's guidelines for Access to Health and Social Care Records must be observed.
- 5.10 If a stranger is seen looking at a patient's Health and Social Care Record, they are required to show evidence of their identity, which must be checked, and also that they have the authority to handle Health and Social Care Records.

- 5.11 The rights of the patient to privacy concerning their names, addresses, background, family relationships and nature of their problems are to be respected at all times.
- 5.12 Under no circumstances should there be discussion regarding a patient/client outside of the work environments of the Gloucestershire Partnership NHS Trust and any sensitive conversations should not be allowed to be overheard. Non-clinical staff should only have any such discussions with colleagues that contain the minimum information required to execute their duties effectively.
- 5.13 It may be necessary for non-clinical staff to read part of the contents of Health and Social Care Records, but this should only be as much as is absolutely necessary in the efficient performance of their duties.
- 5.14 Filing, storing, security, transporting, retention and destruction of Health and Social Care Records must comply with Gloucestershire Partnership NHS Trust standards.
- 5.15 All care should be taken to ensure that unintentional breaches of confidences do not occur. For example, by not leaving files, fax machines or computer terminals unattended, double-checking to avoid transmitting information to the wrong person (refer to Standards for Transmission of Patients' details by FAX below) and guarding against people seeking information by deception.
- 5.16 Clinical information should not be given to anyone by telephone or personally, including requests made by General Practitioners, except by authorised professionally qualified clinical staff. A senior clinician may make a judgement to share information with relatives and be able to justify their decision.
- 5.17 Basic dates, such as admission and discharge dates, may be given to certain authorised bodies, e.g. Departments of Health and Social Security, over the telephone. However, staff must telephone back with the information to be sure of the authenticity of the caller. If any doubt, the information must be withheld and the incident reported to a Manager to be dealt with.
- 5.18 Requests for information from patients, relatives or other sources about their records should not be dealt with by telephone. Wherever possible such requests should be in writing.
- 5.19 Enquiries with regard to Inpatients and the Ward on which they are accommodated should be checked on PAS, and the call referred to the appropriate Ward.
- 5.20 Press enquiries of any kind should be transferred immediately to the Corporate Administration Manager.

6. TRANSMISSION OF PATIENT IDENTIFIABLE INFORMATION BY FAX

- 6.1 Fax transmission of patient identifiable information should only be used in exceptional circumstances when it is necessary for the welfare of the patient and when no suitable alternative exists.
- 6.2 The recipient of the details must have been informed of the proposed transmission and they, or a person nominated by them, is awaiting the transmission by their fax machine.
- 6.3 It must be confirmed that the fax is going to be received into a Safe Haven location where it cannot be overlooked.
- 6.4 The fax number must be confirmed as being correct and up to date.
- 6.5 A cover sheet should accompany the details to be faxed and should contain:
 - 6.5.1 the words 'confidential patient information' prominently displayed;
 - 6.5.2 the name of the recipient clearly stated;
 - 6.5.3 the sender's name and telephone number;
 - 6.5.4 the number of sheets to be sent;
 - 6.5.5 the following notice "This communication and any documents following are confidential and may be privileged from disclosure. They must not be disclosed to anyone other than the addressee. If you receive this communication in error, please advise us by telephone at once".
- 6.6 Any fax machine used for sending confidential patient information should display the number and name of the sender on the documents sent.
- 6.7 The patient should be identified only by the NHS number, initials and date of birth. The patient's name should not be used other than in the most exceptional circumstances.
- 6.8 If a pre-programmable facility is available, this may be used, but extra care must be taken to ensure that the correct key is chosen. A test sheet may be sent through first if there is any uncertainty.
- 6.9 The sender and recipient should confirm receipt with each other.

7. TRANSMISSION OF PATIENT IDENTIFIABLE INFORMATION BY E-MAIL

- 7.1 Patient identifiable information must not be sent by e-mail. The Information Commissioner has advised that e-mail in general is not secure enough and should not be used to transmit confidential information. The Trust's e-mail system is not encrypted, but this may change when the Trust becomes part of the NHS system

8. PATIENTS' ACCESS TO HEALTH AND SOCIAL CARE RECORDS

8.1 Patients have the right of access to their Health and Social Care Records under the Data Protection Act 1998.

8.2 Where the patient has died, the patient's representative and any person who may have a claim arising out of the patient's death have access to Health Records under the Access to Health Records Act 1990.

8.3 Informal access

Health professionals can share their own professional information with the patient who is under their care on an informal basis.

8.4 Formal access

8.4.1 If the patient or representative is not satisfied with 8.2 or if informal access is considered inappropriate, they will be advised to make an application, preferably using the appropriate form available from the Health Records Departments, although a written request is acceptable.

8.4.2 All formal requests should be referred to the appropriate Health Records Department at Charlton Lane or Wotton Lawn.

8.4.3 If the application indicates the intention of taking legal action against the Trust, it should be referred immediately to the Litigation Manager.

8.4.4 If the application does not give the Trust sufficient information to identify the patient or show that the applicant, if not the patient, is entitled to make the application, the Trust should within 14 days of the application request further information and, if necessary, evidence of the applicant's identity. The time limits for access will run from the date of receipt of this information.

8.4.5 The Trust must reply within 21 days of receiving the written application stating that they have complied or intend to reply within 40 days or give reasons for and the extent of any delay.

8.4.6 The appropriate Health Records Manager will receive the completed form and liaise with the appropriate clinician(s) to ascertain whether disclosure of records is appropriate. This will normally be the consultant(s) nominally in charge of the patient's care. If the relevant consultant is not available (e.g. because they have left the Trust's employment) the advice of the Caldicott Guardian should be sought.

8.4.7 Access to records or any part shall not be given for any of the following reasons.

- It is likely to cause serious harm to the physical or mental health or condition of the patient or any individual (including a health professional).
- It relates to a third party who has not given consent for the disclosure (excluding a health professional).

- The request for access is made on behalf of the patient (such as the parent of a child) and the patient has:
 - provided the information in the expectation it would not be disclosed to the applicant: or
 - has indicated it should not be so disclosed: or
 - consented to an examination or investigation on the basis that information arising from it would not be so disclosed.
- 8.4.8 There is no obligation to inform an applicant if any information is being withheld for any of the reasons above.
- 8.4.9 In the cases of deceased patients, there is no obligation to disclose records made before 1st November 1991, unless access to those earlier records is necessary to make sense of any records made after that date.
- 8.4.10 Data that is not intelligible should be explained to the applicant.
- 8.4.11 The Trust should consider whether access should be supervised by a health professional or by a lay administrator. A lay administrator must not comment or advise on the content of the record and, if the applicant raises enquiries, an appointment with the health professional should be offered. A copy of the record should also be provided to the applicant, if requested.
- 8.4.12 If access does not need to be supervised, a copy of the record should be sent to the applicant.
- 8.4.13 Under no circumstances should the original records be taken away by or sent to the applicant. If access to the originals is needed, they can be viewed on Trust premises.
- 8.4.14 Under the Data Protection Act 1998 the following maximum fees can be charged. This includes photocopying and postage charges. The maximum fee must not be charged in all cases, but on a cost recovery basis only.

Access to the record but no copy is made	No fee
Supplying copies of computerised records	£10
Supplying copies of manual records or a combination of computerised and manual records.	£50

- 8.4.15 Under the Access to Health Records Act 1990 a fee of £10 may be charged for access to the record, whether or not a copy is provided, unless the record has been added to within 40 days of the application. If copies are provided, a fee not exceeding the copying and postage costs may be charged.
- 8.4.16 A request may be refused if the fee is not paid, although each case should be judged according to the circumstances of how much information is being supplied and the reason for refusal of payment.

- 8.4.17 Once access has taken place, a note should be included in the record to the effect that access, whether informal or formal, has taken place and when and whether copies have been supplied.
- 8.4.18 If an applicant feels that information recorded in their Health and Social Care Record is incorrect, the health professional should firstly be approached to discuss having the records amended. If the health professional is unable to resolve the situation, the applicant should be advised of the right to make a complaint under the NHS Complaints Procedure and/or to the Information Commissioner, who may rule that any erroneous information is rectified, blocked, erased or destroyed.

8.5 Parental responsibility

- 8.5.1 As a general rule a person with parental responsibility will have the right to apply for access to a child's Health and Social Care Record.
- 8.5.2 A person with parental responsibility for a child is:
- the natural mother;
 - the father, if married to the mother or if he registered the birth with the mother after 1 December 2003;
 - the unmarried father by agreement or court order;
 - the local authority under a care order;
 - the court.
- 8.5.3 As a child grows older and gains sufficient understanding, he/she will be able to make decisions about his/her own life. Where a child is considered capable of making decisions about his/her medical treatment, the consent of the child must be sought before a person with parental responsibility can be given access. Where, in the view of the appropriate health professional, the child patient is not capable of understanding the nature of the application, the Trust is entitled to deny access if it were not felt to be in the patient's best interests.
- 8.5.4 The law regards young people aged 16 or 17 as adults for the purposes of consent to treatment and right to confidentiality. Therefore if a 16 year old wishes a health professional to keep the treatment confidential, that wish should be respected.
- 8.5.5 Children under the age of 16 who have the capacity and understanding to take decisions about their own treatment are also entitled to decide whether personal information may be passed on and generally to have their confidence respected. Case law has established that such a child is known as 'Gillick Competent', i.e. where a child is under 16 but has sufficient understanding in relation to the proposed treatment to give, or withhold consent, consent or refusal should be respected. However, good practice dictates that the child should be encouraged to involve parents or other legal guardians in any treatment.

8.6 Where the patient is unable to give consent

- 8.6.1 If a patient is unable to give consent or to communicate a decision, the health professionals concerned must take decisions about the use of information. This needs to take into account the patient's best interests and any previously expressed wishes and be informed by the views of relatives or carers as to the likely wishes of the patient. If a patient has made his or her preferences about information disclosures known in advance, this should be respected.
- 8.6.2 Health professionals should always consult people close to the patient to agree the best course of action or treatment, unless the patient has made it clear in the past that they do not want a particular individual involved. This may involve sharing part of the Health and Social Care Record, if the health professional considers this in the patient's best interest. However, it does not necessarily mean the full disclosure of the case notes.
- 8.6.3 There may be occasions covered by the Data Protection Act whereby an individual could request access to the data subject's records without the data subject's consent if it is necessary in order to pursue the legitimate interests of a third party, except where the release of such records could prejudice the rights and freedoms or legitimate interests of the data subject. An individual could also state that disclosure is in the vital interests of the data subject, or another person, where consent cannot be given on behalf of the data subject.
- 8.6.4 A Power of Attorney is a legal mechanism where one person (called the donor) can give another (the attorney) the power to act on his/her behalf in specified matters. The attorney can enter in legally binding commitments on behalf of the donor. This ordinary Power of Attorney comes to an end if the donor becomes mentally incapacitated. However an Enduring Power of Attorney (EPA), obtained through the Court of Protection, can still be valid, even if the donor becomes mentally incapacitated. Although an EPA can apply to the donor's property and affairs, it does not entitle the attorney to make decisions about personal or health care. It is therefore not possible for a person to apply for access to another person's Health and Social Care Records on the basis of holding an EPA.
- 8.6.5 The exceptions to the above are when
- the donor has specifically stated in the EPA that the attorney should have access to his/her records; or
 - the attorney is acting under an Order of the Court of Protection. (It is always open to the attorney to make an application to the Court of Protection for clarification of his or her powers if it is not clear whether the Power allows them access to the records.)

In both of these cases the donor must show the Trust the terms of their Power or the Order.

- 8.6.6 Advice on individual access requests should be sought from the Caldicott Guardian.

8.6.7 The decision to disclose and the justification for doing so should be noted in the record.

9. PROCEDURE FOR NEW REFERRALS

- 9.1 Staff registering new referrals must check on both PAS systems to ascertain whether the patient is already known to the service and if records already exist.
- 9.2 When a patient is identified on PAS in the west to mental health or learning disability services, a Patient Alert is flagged on the Patient Main Detail screen of PAS. In the east a PSY number is shown under EGT.
- 9.3 If the patient is not known, they are registered with either a PSY (EGT) number (in the east) or a GO number (in the west). A new countywide case note folder is made up.
- 9.4 If the patient is known and case notes exist, they are obtained and transported to the appropriate clinician/ward/department. A subsidiary file may be used until the existing case notes are available, but this must be merged with the case notes as soon as possible by the ward/department caring for the patient.
- 9.5 If a patient has both PSY (EGT) and GO case notes, both must be obtained and merged into one set of case notes showing both PSY and GO numbers.
- 9.6 If the existing folder is full, a new countywide folder is made up (see 3.7 above).

9.7 Out of hours procedure

- 9.7.1 In certain circumstances out of hours, a patient may be admitted to any inpatient unit, be taken to an Accident and Emergency Department or be in contact with the police in an emergency.
- 9.7.2 The admitting ward will enquire from PAS / STAR whether the patient is already known to the service and, if so, where the records are located. (At present records are traced on PAS in the east only.) If the records are easily accessed, they should be obtained.
- 9.7.3 If the case note folder is not immediately available, information (such as a previous discharge summary) may be available on a ward.
- 9.7.4 Appropriate clinical information may also be available from one of the patient information systems:-
 - PAS (Patient Administration System used across the county. There are separate systems in the east and west. PAS is used for all Learning Disabilities Services) on the west and CAMHS on the east.
 - GEORGE (Used for community services in east for CAMHS, Working Age Adults and Older People's Services and for Mental Health Act Administration in the east).
 - SUNRISE (Used for community services in west for Working Age Adults and Older People's Services).

- CHILD HEALTH SYSTEM (Used in west for CAMHS and linked to PAS)
 - PROTOCOL (Used in west solely for Mental Health Act Administration)
 - STAR (SSD system)
- 9.7.5 If the on-call doctor considers it necessary to obtain the case note folder before the start of office hours, ward staff will notify the on-call manager, who will attempt to obtain the record.
- 9.7.6 For records held in the Wotton Lawn Health Records Department, the Manager must be contacted in order to gain access.
- 9.7.7 For records held in the Charlton Lane Health Records Department, all wards carry a key to the department and a system is in place for staff to access the files.
- 9.7.8 For records held at any of the resource centres, if the on-call manager is the service manager, they should attempt to locate the file. If they are not the service manager, they should contact the respective manager using the telephone list enclosed in the on-call booklet and request assistance to access the resource centre and locate the file.
- 9.7.9 Whenever records are located and retrieved, the on-call manager is responsible for making sure that they are delivered to the admitting ward as soon as possible following admission of the patient.
- 9.7.10 If a patient is not known to the service, a new record will be made up on the admitting ward. This will be registered on the PAS system the next working day.

10. GENDER CHANGE

10.1 Background

- 10.1.1 According to current English law the gender recorded on a person's birth certificate is unalterable, unless an error occurred when the birth was registered. A person can use the facilities for the assumed sex once gender reassignment surgery has taken place.
- 10.1.2 English law allows a person to adopt such first and surnames as he/she wishes. In order to change official records, such as passports and driving licences, the name(s) must be changed by deed poll. However, for social security and national insurance purposes a person continues to be stated as the sex recorded at birth.

10.2 Policy

- 10.2.1 A person may apply to have their title and name changed on the patient information systems and in their health and social care records. They may be asked to produce evidence of the change by deed poll. Normally the person will retain the same registration number and set of case notes, and the patient information system will show the previous name(s) as an alias.
- 10.2.2 If a person who has undergone gender reassignment surgery wishes a new identity, a new NHS number can be obtained. The person can apply to have their title, name and sex changed on the patient information systems and for a new registration number and set of case notes. An application form available from the Health Records Departments will set out the potential problems with having two sets of records and will seek agreement to retain one set. It will also request permission for the Trust to seek confirmation of surgery from the patient's GP.
- 10.2.3 The clinician in charge of the gender change, when counselling the patient, will request consent to include relevant previous clinical information in the new health and social care records.
- 10.2.4 The Trust has an obligation to keep a person's details confidential but also to provide safe care and to maintain the safety of other people. A person will always be urged to agree for information from and about their previous identity to be available to clinicians, otherwise there is a danger that clinicians will not have access to essential clinical information. Should a person not agree, details of the previous identity will be put inside a sealed envelope which will be placed in the health and social care record. The member of staff doing this will sign and print their name over the seal. The envelope will display the following wording.

The Trust holds clinical information about this patient under a different name, but the patient has not agreed for it to be shared. Details of this previous name are held inside this envelope. It must be opened only if a senior clinician considers it in the best interests of the patient and/or

the public to access previous clinical information. The decision must be clearly documented in the confidential section of the health and social care record.

11. TRACERING OF HEALTH AND SOCIAL CARE RECORDS

- 11.1 Accurate recording and knowledge of the whereabouts of all records is essential if the information they contain is to be located quickly and efficiently. It is very inconvenient and potentially dangerous when records cannot be found. One of the main reasons why records are lost or misplaced is because their next destination is not recorded anywhere.
- 11.2 All records must therefore be traced when removed from their place of storage. Electronic tracing is available in the east of the county and must be used. Manual tracing is currently used in the west.
- 11.3 It is the responsibility of the person sending records to another location to complete a tracer. Receipt may be confirmed on the electronic tracer system.
- 11.4 Details on a tracer system must be completed with the following minimum details:-
- date of transfer;
 - patient/client name;
 - patient/client reference number;
 - number of volume(s) sent;
 - person, unit, department or place to whom record is being sent;
 - name of person booking record out.

12. RETENTION OF HEALTH AND SOCIAL CARE RECORDS

- 12.1 All NHS records are classified as public records, and retention must be in accordance with legislative requirements and existing central government guidelines.
- 12.2 At present all records are generally retained by the Trust. However, it is not necessary to keep every piece of paper received in connection with patients. Trusts are expected to determine, in connection with their health professionals, which elements should be considered as a permanent part of the record and which should be transient and discarded as their value ceases.
- 12.3 Staff must ensure that there is a year sticker on the outside of each set of case notes indicating the year of the most recent documented episode of care.
- 12.4 Any case notes used in research and not to be destroyed should be marked accordingly by the appropriate clinician. The case notes will be stored separately in the case note library and traced accordingly.
- 12.5 Department of Health Circular HSC 1999/053 'For the Record – Managing Records in NHS Trusts and Health Authorities' sets out the minimum retention periods for all NHS records. The table below shows the minimum requirements for the types of health records held by the Gloucestershire Partnership NHS Trust.

12.6

Pre 1948 records	Should by now have been transferred for permanent preservation or destroyed. Any pre-1948 records which still exist should be considered for permanent preservation.
Admission books	For permanent preservation.
Art work / artefacts produced as part of therapy	Not mentioned by HSC 1999/053 and still under consideration.
Children and young people	Until the patient's 25 th birthday, or 26 th if young person was 17 at conclusion of treatment; or 8 years after patient's death if death occurred before 18 th birthday.
Death registers (i.e. register of deaths kept by the hospital)	For permanent preservation.
Clinical diaries	Not mentioned by HSC 1999/053, but very important. To be retained for a minimum of 7 years.
Clinical records (general)	8 years after conclusion of treatment or 8 years after death.
Laboratory records	Local decisions should be made with regard to the

	permanent preservation of these records in consultation with relevant health professionals and places of deposit.
Mentally disordered persons (within the meaning of the Mental Health Act 1983)	20 years after no further treatment considered necessary; or 8 years after the patient's death if patient died while still receiving treatment.
Patient involved in clinical trials	15 years after conclusion of treatment. EEC Note for Guidance: Good Clinical Practice for Trials on Medicinal Products in the European Community, Section 3.17 (see Pharmacology and Toxicology 1990, 67, 361-372)
Pharmacy Inpatient – dispensing – continuation sheets Outpatient prescriptions Discharge prescriptions Supply of controlled drugs - Requisitions from wards and depts - Completed pharmacy registers	 2 years 2 years from date of dispensing 2 years from date of dispensing 3 years from date of last entry
Photographs	These documents must be considered for permanent preservation but the advice of the chief archivist is that an appropriate place of deposit is to be obtained before any final decision is made.
Private patient records admitted under Section 58 of the NHS Act 1977 or Section 5 of the NHS Act 1946	Although technically exempt from the Public Records Acts, it would be appropriate for such records to be treated as if they were not so exempt.
X-ray films (including other image formats for all imaging modalities)	General x-rays – hard copies kept for 3 years. Special interest x-rays kept indefinitely.
X-ray reports (including other image formats for all imaging modalities)	Hard copies kept as for x-rays. Electronic copy of report kept indefinitely.

- 12.7 Guidance on retention times for Social Services records is available at:
www.gloucestershire.gov.uk/media/word/Records%20Management%20Policy1.doc
These are generally in line with NHS retention times, but there is a statutory requirement for case records relating to children who have been placed to be retained until the 75th anniversary of the child's birth or for 15 years after death if the child dies before age 18.
- 12.8 The Trust does not currently destroy any records. However, should any destruction take place, it would be essential to ensure that:
- 12.8.1 there is consultation with the relevant health professional body or records committee and actions clearly minuted;
 - 12.8.2 any other local need is considered;
 - 12.8.3 the value of the records for long-term research purposes has been assessed, in consultation with an appropriate place of deposit.
- 12.9 Disposal does not just mean destruction. It can also mean the transfer of records from paper onto microfilm or computer or from one user to another. It could involve depositing it with an organisation which wishes to carry on using it e.g. a hospital or local authority Record Office, the Public Records office or another bona fide research body. The approved place of deposit for public records in the county is the Gloucestershire Records Office, Clarence Row, Alvin Street, Gloucester, GL1 3DW.

13. CONFIDENTIAL WASTE RELATED TO HEALTH AND SOCIAL CARE RECORDS

- 13.1 All confidential waste related to Health and Social Care Records must be disposed of in a confidential manner.
- 13.2 Confidential waste includes any information obtained on paper during a working day related to Health and Social Care Records and which is no longer required. For example:-
- draft copies of letters;
 - PAS print-outs;
 - written communications;
 - notes written on 'post-it' notes, etc.
- 13.3 Small quantities of confidential waste may be shredded locally.
- 13.4 Identifiable bags issued for the collection of confidential waste must be used for the disposal of larger quantities of confidential waste.
- 13.5 Where the destruction service is provided by a contractor, it is the responsibility of the Trust to satisfy itself that the methods used throughout all stages, including transport to the destruction site, provide satisfactory safeguards against accidental loss or disclosure.
- 13.6 A brief description should be kept of everything that has been destroyed, when, and by whom and, where a contractor is used, they should be required to sign confidentiality undertakings and to produce written certification as proof of destruction.

14. MAILING OF RECORDS

14.1 Records should always be transported by a secure method.

14.2 Records must be traced out before being sent anywhere.

14.3 Records must not be sent in internal transit envelopes.

14.4 Records transported by internal post (system used within Gloucestershire NHS community)

14.4.1 Security wallets with the security tab system should be used if possible.

14.4.2 If wallets are not available:

- packages must be securely sealed;
- the previous address must be erased completely or covered with self-adhesive labels;
- the package must be clearly marked 'confidential';
- the package must be clearly marked for the person for whom it is intended or addressed to the department head, ward manager, etc and marked 'safe haven.

14.5 Records transported by external post.

14.5.1 Security wallets with the security tab system should be used if possible.

14.5.2 If wallets are not available:

- new strong envelopes or packaging must be used;
- packages must be securely sealed;
- the previous address must be erased completely or covered with self-adhesive labels;
- the package must be clearly marked 'confidential';
- the package must be clearly marked for the person for whom it is intended;
- the package should be sent by registered mail.

15. HANDLING DAMAGED RECORDS

- 15.1 Notes which are clearly damaged (i.e. clearly marked by blood or other such substance that makes the record a health risk) should be removed from circulation immediately and taken to the Health Records Manager or Departmental Manager.
- 15.2 The Manager, with a named senior clinician, both wearing protective gloves, will assess the extent of the damage.
- 15.3 If the record is irretrievably damaged, the Data Protection Officer is to be advised and will oversee the ensuing process.
- 15.4 The affected documentation must be photocopied and a new folder created if necessary.
- 15.5 Photocopies of an original record will be stamped/written "This is a true record of the original" and then dated and signed by the people in 15.2 and 15.3.
- 15.6 It must be recorded on the inside of the new folder that copies have been taken. The following details are to be included:
 - why this process was undertaken;
 - date;
 - name, signature and designation of the person overseeing this process;
 - details of the number of pages copied.
- 15.7 The damaged record will be treated as confidential waste and the process recorded in the new file to include:
 - process of destruction;
 - date;
 - signatures of people in 15.2 and 15.3.
- 15.8 Any patient whose record is damaged and destroyed should be informed.

APPENDIX A – GUIDELINES ON DISCLOSURE

This appendix is based on Annexes B & C in the Department of Health document “Confidentiality: NHS Code of Practice” (November 2003), which can be found at www.doh.gov.uk/ipu/confiden/protect/copy3.pdf. Its purpose is to provide guidance on the circumstances in which health records can be disclosed.

The section on disclosure to the Police is based on training material produced by the Avon IM&T Consortium at http://www.avon.nhs.uk/imtconsortium/secur_conf/Trainers_Pack/default.htm

1. ISSUES TO CONSIDER

Is it confidential?

It is generally accepted that information provided by patients to the health service is provided in confidence and must be treated as such so long as it remains capable of identifying the individual it relates to.

When an individual has died, it is unlikely that information relating to that individual remains legally confidential. However, an ethical obligation to the relatives of the deceased exists, and health records of the deceased are public records and governed by the provisions of the Public Records Act 1958. This permits the use and disclosure of the information within them in only limited circumstances.

Health records are for health care

It is very important that reasonable efforts are made to ensure that patients understand how their information is to be used to support the healthcare and that they have no objections. (This is explained in a Gloucestershire NHS Health Community Leaflet ‘Your Information’.) Where this has been done effectively, consent can be implied, providing that the information is shared no more widely and that “need to know” principles are enforced. It is particularly important to check that patients understand and are content for information to be disclosed to other organisations and agencies contributing to their health care.

The Report of the Victoria Climbié Inquiry stated that it is reasonable to expect the free exchange of information within the NHS.

There is an Information Sharing protocol between the county’s NHS Trusts, PCTs, Education and Social Services and NHS Direct. Section 6 sets out the justifiable purposes for sharing person-identifiable information between the agencies. It is available at: <http://www.gloucestershirepartnership.org.uk/partnership/foi/infosharing.pdf>.

Consent Issues

Competence to consent

If a patient’s disabilities and circumstances have prevented them from becoming informed about the likely uses of their information, extra care must be taken to ensure that

information is provided in a suitable format or accessible language and to check that it has been understood.

If a patient has a difficulty communicating their decision (to consent or object) it is important to check for a clear and unambiguous signal of what is desired by the patient.

Children and young people

Young people aged 16 or 17 are presumed to be competent for the purposes of consent to treatment and are therefore entitled to the same duty of confidentiality as adults. Children under the age of 16 who have the capacity and understanding to take decisions about their own treatment are also entitled to make decisions about the use and disclosure of information they have provided in confidence. (This is called Gillick competence).

Where patients are unable to give consent

If the patient is unconscious or unable due to mental or physical condition to give consent or communicate a decision the health professional must make a decision about the use of information, taking into account the patient's best interests and any previously expressed wishes and being informed by the views of relatives or carers as to the patient's likely wishes.

If it is not practical to locate or contact an individual for consent, the threshold for disclosure in the public interest may be lessened where the likelihood of detriment to the individual concerned is minimal.

If the patient is incapacitated, the situation must be judged on its merits and great care taken to avoid breaching confidentiality or creating difficulties for the patient.

Common law and disclosure in the public interest

There are exceptions to the duty of confidence that may make the use or disclosure of confidential information appropriate. Statute law requires or permits disclosure in certain circumstances, and the Courts may also order disclosure. Case law has also established that confidentiality can be breached where there is an overriding public interest.

Staff are permitted to disclose personal information in order to prevent and support detection, investigation and punishment of serious crime and/to prevent serious harm to others where they judge the public good that would be achieved by the disclosure outweighs both the obligation of confidentiality to the individual patient and the broader public interest in the provision of a confidential service.

The definition of serious crime is not entirely clear but would include:

- murder,
- manslaughter,
- rape,
- treason,
- kidnapping,
- child abuse,
- serious harm to the security of the state or to public order,
- crimes that involve substantial financial gain or loss.

In contrast, theft, fraud, or damage to property where loss or damage is less substantial would generally not warrant breach of confidence.

Disclosures to prevent serious harm also warrant breach of confidence and include:

- risk of child abuse or neglect,
- assault,
- traffic accident,
- spread of infectious disease,
- serious fraud or theft involving NHS resources.

Administrative Law

The NHS deals with confidential patient information in order to carry out specific functions. Such powers are often set out in statute.

Data Protection Act 1998

Under the DPA processing personal health information for legitimate medical purposes satisfies a condition in each schedule without needing to obtain patient consent.

Human Rights Act 1998

This establishes a right to 'respect for private and family life' and creates a general requirement to protect the privacy of individuals and preserve the confidentiality of their health records.

Health and Social Care Act 2001: Section 60

This makes it lawful to disclose and use confidential patient information in specific circumstances where it is not currently practicable to satisfy the common law confidentiality requirements. It provides a power to ensure that patient identifiable information needed to support essential NHS activity can be used without the consent of patients. The power can only be used to support medical purposes that are in the interests of patients or the wider public, where consent is not a practicable alternative. The Health Service (Control of Patient Information) Regulations 2002 were the first regulations to be made under Section 60 of this Act and support the operations of cancer registries and the Public Health Laboratory Service in respect of communicable diseases and other risks to health.

Legal restrictions on disclosure

Sexually transmitted diseases – All necessary steps must be taken to secure any information capable of identifying an individual examined for any STD (including HIV and AIDS) except:

- where there is explicit consent to do so;
- for the purpose of communicating it to a medical practitioner in connection with the treatment or prevention of the disease; and
- for the purpose of such treatment or prevention.

Legally required to disclose

The courts, including coroner's courts, and some tribunals and persons appointed to hold inquiries have legal powers to require that information that may be relevant to matters within the jurisdiction be disclosed.

Legally permitted to disclose

Legislation may create a statutory gateway that allows information to be disclosed by an NHS body where previously it might have been unlawful to do so e.g. section 115 of the Crime and Disorder Act 1998

2. EXAMPLES OF DISCLOSURE

Model B1 - Healthcare Purposes

1) To NHS Staff involved in the provision of healthcare

Where information has to be shared widely to provide healthcare, additional efforts to ensure that patients are effectively informed should be made.

2) To social workers or other non-NHS staff involved in the provision of healthcare

The test of what would satisfy the requirement to effectively inform should be more demanding than where disclosure is limited to NHS staff as the breadth of the information disclosure is not as obvious to patients and their consent cannot be assumed. Disclosure may lead to confidential information being held outside the NHS in the records of partner organisations. Patients need to be made aware of this and partner organisations also need to be aware that holding health records imposes particular duties and obligations.

3) To clinical auditors

The evaluation of clinical performance against standards or through comparative analysis, with the aim of informing the management of services, is an essential component of modern healthcare provision. Every effort should be made to ensure that patients are aware that audit takes place and that it is essential if the quality of care they receive is to be monitored and improved.

4) To parents, i.e. those with parental responsibility for patients, and guardians

Young people aged 16 or 17 are presumed to be competent for the purposes of consent to treatment and are therefore entitled to the same duty of confidence as adults. Children under 16 who have the capacity and understanding to take decisions about their own treatment are also entitled to decide whether personal information may be passed on and generally to have their confidence respected.

The key issue here is the 'competence' of the child. If the child is competent then their consent is required to disclose and use information. Staff should encourage children to involve parents, particularly where significant decisions need to be made, but should respect the choice made. However, where a child has refused to consent to treatment for a life threatening condition, staff should inform parents and seek their consent (consent for treatment purposes may be given by parents where a child objects).

5) To carers without parental responsibility

Carers often provide valuable healthcare and, subject to complying with the best practice outlined, every effort should be made to support and facilitate their work. Only information essential to a patient's care should be disclosed and patients should be made aware that this is the case. However, the explicit consent of a competent patient is needed before disclosing information to a carer. The best interests of a patient who is not competent to consent may warrant disclosure.

Model B2 - Medical purposes other than healthcare

6) To researchers

The use of anonymised data is preferable for research purposes. Where systems that are capable of providing anonymised data sets for researchers do not yet exist, the use of identifiable patient information to support research may well be appropriate and necessary but normally requires explicit patient consent. Whilst patients are generally aware and supportive of research it is not reasonable to assume that they are aware of and consent to each and every research subject or proposal.

All research in the NHS or other research involving NHS patients, their tissue and/or data must meet appropriate standards of research governance, including ethical approval from an appropriate ethics committee – a mandatory requirement for all NHS supported research.

If a patient cannot be contacted to obtain consent, it should not be assumed that their medical details can be used for research purposes.

In some exceptional circumstances, where the research subject is of such significance or a patient cannot be located in order to seek consent, the public interest may justify disclosure.

Where explicit consent has not been gained and the public interest does not justify breaching patient confidentiality, the research project needs support under section 60 of the Health & Social Care Act 2001. The Patient Information Advisory Group (PIAG) Secretariat can help clarify uncertain cases.

7) To NHS managers and the Department of Health, e.g. commissioning, prescribing advisors, financial audit, resource allocation etc.

The use of anonymised data is preferable for management purposes but this is not always practicable. Systems that are capable of providing anonymised data sets for management purposes should be developed. Where they do not yet exist, the use of confidential information to support these activities may well be appropriate and necessary, but care should be taken to determine the minimum requirements.

Explicit consent is required unless there is (rarely) a robust public interest justification and, in the absence of either, support is required under section 60 of the Health & Social Care Act 2001.

8) To Occupational Health professionals

Staff may be referred to an occupational health department, e.g. as a result of sickness absence or a perceived failure to meet work targets.

This could in turn require disclosure of patient information. Explicit consent should be obtained before disclosing.

When clinicians are themselves “the patient” the powers of professional regulatory bodies to require disclosure of their health records may apply. See section 9) below.

Medical purposes other than healthcare (continued)

9) To bodies with statutory investigative powers – GMC, Audit Commission, The Health Service Ombudsman, CHAI

GMC assessors are entitled to access confidential patient health records under the powers given to them by virtue of the Medical Act 1983 (as amended by the Professional Performance Act 1995 and the Medical Act Amendment Order 2000). Similarly, the Audit Commission Act 1998 provides auditors appointed under that Act with the powers to access health records and, where necessary, patient-identifiable information to further their investigations.

It is for Audit Commission auditors and GMC assessors to decide what level of information is necessary for them to fulfil their functions, e.g. access to a complete record containing patient-identifiable information, selected parts or just anonymised information. If staff have concerns about the level of information requested, good practice would be to seek and document the reasons why this is needed.

Patients should be informed that disclosure has been required.

The Health Service Ombudsman has the same powers as the Courts to disclose information but see their work as falling under “medical purposes”. Any request for information from them should be complied with without necessity of obtaining a court order.

10) To NHS Complaints Committees

It is unlikely to be practicable for complaints committees to undertake their work without access to relevant parts of a complainant’s medical record, and anonymisation is not practicable. The use of identifiable information is therefore necessary and appropriate.

However, the explicit consent of the complainant, and any other patients whose records may need to be reviewed, is required prior to disclosure. It may be necessary to explain to a complainant that their complaint cannot be progressed if they refuse to authorise disclosure.

In some circumstances, where the trust of patients in NHS care or patients may be at risk, the public interest may justify disclosure to complaints committees.

11) To Cancer Registries

The United Kingdom Association of Cancer Registries (UKACR) is a “generic” organisation working of behalf of a number of different registries which all serve a common purpose.

UKACR has been granted temporary support under Section 60 of the Health and Social Care Act 2001 to obtain patient identifiable information for use on cancer registry database, without the consent of patients.

Model B3 - Non-medical purposes

12) To hospital chaplains

Spiritual care cannot be practicably provided without access to some confidential patient information and this form of care is strongly desired by a proportion of patients. It therefore meets the tests of necessity and appropriateness. However, the explicit consent of patients is required before confidential information is disclosed to chaplains.

Where a patient is not competent to consent to disclosure, e.g. due to unconsciousness, the decision rests with those responsible for the provision of care acting in the best interest of the patient. The views of family members about what the patient would have wanted should be given considerable weight in these circumstances.

13) To non-statutory investigations, e.g. Members of Parliament

If an investigation is appropriately authorised, disclosure will meet tests of necessity and appropriateness. The minimum necessary information should be disclosed.

There is a balance to be drawn between ensuring that a patient had understood and properly consented to a disclosure of information and needlessly obstructing an investigation. Careful consideration of any written authorisation and prompt action are key, e.g. where an MP states, in writing, that s/he has a patient's consent for disclosure this may be accepted without further resort to the patient.

14) To government departments (excluding the Department of Health which requires information for medical purposes – see Model B2)

Government departments require a range of information to carry out their functions. There needs to be a statutory gateway to permit desired information disclosure and government departments should ensure that tests of appropriateness and necessity are satisfied.

15) To the Police

The informed consent of the patient should be gained, if possible. If it cannot be gained or if gaining it would be prejudicial to the situation, staff should consider whether there is a duty or power under law to share information. If there is a legal duty, disclosure is mandatory and consent is not necessary. If there is a legal power, relevant information can be disclosed. However, it is not mandatory and staff should consider seeking consent or informing the individual.

Legal duty

- **Prevention of Terrorism Act (1989) and Terrorism Act (2000)**

If information (including personal information) about terrorist activity is gained, the Police must be informed.

- **The Road Traffic Act (1988)**

Staff have a statutory duty to inform the police, when asked, the name and address of drivers allegedly guilty of an offence. Clinical information must not be disclosed.

- **Court Order**

Where the courts have made an order, the required information must be disclosed.

Legal power

- **The Police and Criminal Evidence Act (1984)**

This Act creates a power to pass on information to the Police if it is believed that someone may be seriously harmed or death may occur if the police are not informed.

- **The Crime & Disorder Act (1988)**

Information may be required on an individual if there is a need for strategic cross-organisational planning to detect, prevent or reduce crime and disorder that an individual may be involved in. A nominated officer for the Trust will deal with these.

- **Children in Need**

Under Section 47 of the Children Act (1989) a Local Authority must make enquiries (which might be through the Police) necessary to decide whether they should take any action to safeguard or promote the child's welfare. In such a situation, staff should firstly confirm it is a section 47 enquiry and then release relevant information, unless 'to do so would be unreasonable in the circumstances of the case'. The parent or child does not have to be approached for consent or to be informed, although staff may choose to do this if appropriate.

If staff suspect a child is being abused but there is no request for information, they have a legal power to disclose information to Social Services (under 'vital interest' conditions of the Data Protection Act and/or the Police (under the Police & Criminal; Evidence Act). Staff should consider whether gaining consent or informing the child and parents would be beneficial or detrimental to the situation. If detrimental, disclosure without consent is permitted.

- **Where gaining consent may be prejudicial to enquiries**

The Police may seek personal information under an exemption of the Data Protection Act. A Section 29(3) exemption is used when making enquiries which are connected with the prevention and detection of crime or the apprehension or prosecution of offenders and the view of the Police is that seeking consent or even informing the individual(s) about the transfer of data will prejudice the enquiry or they may destroy evidence or abscond. A section 29 exemption allows information to be provided by organisations without gaining consent.

- The police need to produce a Section 29(3) form which must be signed by a Police Inspector who has decided to serve the exemption.
- Staff do not have to supply information and staff may still decide to seek consent or inform.
- Staff should not feel pressurised to give information because the police have requested it. It is reasonable to ask why the information is needed and what is required before making a decision. Whilst the police have no general right of access to health records there are a number of statutes which require disclosure to them and some that permit disclosure. These have the effect of making disclosure a legitimate function in the circumstances they cover.

Non-medical purposes (continued)

16) To the courts, including a coroner's court, tribunals and enquiries

The courts, some tribunal and persons appointed to hold enquiries have legal powers to require disclosure of confidential patient information.

Care needs to be taken to limit disclosure strictly in terms of the relevant order, the precise information requested to the specified bodies and no others. It is permitted to make ethical objections known to a judge or presiding officer, but unless the order is changed compliance is necessary.

17) To Sure Start Teams

Sure Start aims to both provide new services and to reshape and add value to existing services in order to improve the life chances of young children. It is delivered through local partnerships involving local service providers from health, education, social services and other public services, the voluntary sector and local parents and community representatives. Some of Sure Start's activities are healthcare provision, but others are not. NHS bodies have a statutory gateway to support disclosure to Sure Start teams under the NHS Act 1977 where this supports healthcare.

Disclosure to a health professional within a Sure Start team to directly and only support healthcare is covered by Model B1. However, where disclosure is also for non-medical purposes (e.g. educational support), it is covered by Model B3 and explicit parental consent is necessary.

If confidential patient health information is to be held within the records of partner organisations, parents need to be made aware of this prior to any disclosure. Receiving organisations also need to be aware that holding health information imposes particular duties and obligations with regard to confidentiality.

18) To the media

Under normal circumstances there is no basis for disclosure of confidential and identifiable information to the media. There will be occasions however when NHS organisations and staff are asked for information about individual patients. Examples include:

- Requests of updates on the condition of particular patients, e.g. celebrities;
- In distressing circumstances, e.g. following a fire or road traffic accident;
- In circumstances where a patient or patient's relatives are complaining publicly about the treatment and care provided.

Where practicable, the explicit consent of the individual patient(s) concerned should be sought prior to disclosing any information about their care and treatment, including their presence in a hospital or other institution. Where consent cannot be obtained or is withheld, disclosure may still be justified in the "exceptional" public interest.

In distressing circumstances, care should be taken to avoid breaching the confidentiality of patients whilst dealing sympathetically with requests for information. Where a patient is not competent to make a decision about disclosure, the views of family members should be sought and decisions made in the patient's best interests.

Where information is already in the public domain, placed there by individuals or by other agencies such as the police, consent is not required for confirmation or a simple statement that the information is incorrect. Where additional information is to be disclosed, e.g. to correct statements made to the media, patient consent should be sought but where it is withheld or cannot be obtained disclosure without consent may still be justified in the public interest. The patients concerned and/or their representatives should be advised of any forthcoming statement and the reasons for it.

There is a strong public interest in sustaining the reputation of the NHS as a secure and confidential service but there is a competing interest in ensuring that the reputations of NHS staff and organisations are not unfairly and publicly maligned. Disclosures need to be justified on a case by case basis and must be limited to the minimum necessary in the circumstances. In some circumstances a "dignified silence" in the face of media enquiry, may be the best approach for the NHS to take, depending on the nature of the case involved.

19) To solicitors

Most contacts from solicitors are for subject access requests to health records for compensation claims which may include:

- Insurance claims against third parties e.g. following road traffic accidents (RTAs); and
- Work related claims e.g. for disability awards, early retirement etc.

There may also be requests for prosecution purposes in cases of, for example drink driving, RTAs, GBH and murder enquiries etc.

Ideally disclosure should be limited to relevant to the incident concerned. However, if disclosure of the full record is required this should be complied with as long as it is clear that the patient understands that full disclosure will take place and has consented.

On occasions when clinicians or NHS organisations face legal challenges, solicitors acting on behalf of a client may require access to a third party's record. In such cases, explicit consent should be sought from any person or persons to which it relates. However, if a patient refuses consent, disclosure may still be warranted in the public interest or where a Court Order to support disclosure without consent has been received. It may be possible for a solicitor to make a public interest argument but this would be difficult to judge and best left to the Courts to decide.

In all cases a patient should be notified of the disclosure.