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COUNCILS FOR ENGLAND AND WALES

Access to Health Records
- The Legal Requirements

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CONTENTS

ACCESS TO HEALTH RECORDS

1. INTRODUCTION

1.1 History

Secrecy has been a trademark of the medical profession over the centuries, and is often claimed to be for the benefit of patients who would not trust their doctor with their most intimate details, unless they could be sure that their trust would not be breached by disclosure to the outside world. Sometimes, the practice has been admitted to be for the benefit of medical practitioners, who fear the loss of some of their mystique and respect, if their procedures are put under close scrutiny.

The traditional doctor/patient role has been of the humble undemanding patient placing themselves in the hands of the doctor and leaving them to make all decisions. Doctors correctly anticipated that providing patients with information would facilitate patient demands to become involved in decisions about their own care. It has certainly had the effect of making the doctor's duties have become more complex, requiring them to explain, inform, involve and gain the consent and co-operation of the patient.

1.2 Access to Whom

Respect for the confidences of patients is a central tenet of medical practice and is enshrined in the Hippocratic Oath and repeated in current guidance to doctors from the General Medical Council.

Medical records or the information within them will be shared by the medical practitioner with;

- other health professionals in the team,
- coroners,
- social workers (under some circumstances),
- health care administrators,
- NHS complaints procedure staff,
- parents of children,
- those carrying out medical research and their co-workers and administrators and
- the courts.

Community pharmacists are now suggesting that they should be given access to patient files.

1.3 Circumstances in which Patients Desire Access to Medical Records

Not surprisingly patients question the need to protect their confidentiality by keeping information from them, particularly;

- when the treatment or procedure does not have the desired outcome,
- when deaths occur,
- when there is a dispute about the cause of a medical condition (accidents, previous treatment, etc.),
- when there is dispute about diagnosis, e.g. mental health, or
- when the patient/doctor relationship breaks down.

1.4 The Introduction of Legislation

The courts have supported the medical profession and consequently there is no clear common-law right for patients to see their own health records.

In response to growing demands from patients (and in order to comply with European law) it was left to Parliament to legislate to allow patients access to information about their own diagnosis and treatment. Legislation was finally introduced in the 1980's.

In January 1980 the Council of Europe published a Convention that was designed to protect privacy. One of the principles espoused was that data subjects should have certain rights of access to data held about them. The corresponding UK legislation was the Data Protection Act 1984, which gives rights in relation to information stored in automated forms. In the meantime, the Supreme Court Act 1981, provided litigants with the means to gain 'discovery' of evidence that they need in order to make or pursue a legal claim.

The Access to Medical Reports Act 1988 is limited in its scope and applies only to health reports supplied for employment or insurance purposes. Not until 1990 was legislation introduced which provided access to patients to their own medical records - the Access to Health Records Act.

Over the same period the Access to Personal Files Act 1987 was enacted. This applies to files held by housing and local authorities. This Act is relevant to health care professionals, because some of those files, particularly those held by social services departments, will contain confidential health information. People have the right to see what is in these files, although any health professional who has provided information will need to confirm that there is no health ground for withholding the information. The common practice by health authorities of claiming that information cannot be provided unless the source agrees is a generalisation, which is not always legally supportable.

2. THE LEGISLATION

2.1 The Data Protection Act 1984 and the Data Protection Principles.

The Data Protection Act applies only to automated information. It was introduced by the UK Government in an attempt to comply with the European Convention on Data Protection, although there has been criticism of how effectively this has actually been complied with. The Data Protection Principles from the European Convention are detailed in a Schedule to the Data Protection Act and detail good practice for computer users. The Act itself is not a 100% reflection of those principles.

The seventh Principle relates to access to information by the data subject (the person that the material relates to) and states:
'An individual shall be entitled -

(a) at reasonable intervals and without undue delay or expense -
  (i) to be informed by any data user whether he holds personal data of which that individual is the subject;
  and
  (ii) to access any such data held by a data user;
  and

(b) where appropriate, to have such data corrected or erased.'

S 21 of the Data Protection Act 1984 gives a right of access to personal data.

'(1) Subject to the provisions of this section, an individual shall be entitled -
(a) to be informed by any data user, whether the data held by him includes personal data of which that individual is the data subject; and
(b) to be supplied by any data user with a copy of the information constituting any such personal data held by him.'

(and an explanation where any of the information in (b) above is unintelligible.)

S21 of the Data Protection Act also provides that:
(2) Requests must be in writing and a fee of £10 is payable.
(4) The information holder must be satisfied as to the identity of applicant.
(5) The information holder must not disclose information relating to another.
(6) There is a 40 day time limit for compliance.
(8) Breaches of duty can be challenged in court.
(9) The Secretary of State can order release of information on behalf of those without the mental capacity to apply on their own behalf.

The Data Protection Act is only concerned with regulating the use of personal data which is defined in s1(3) of the Act as:

'data consisting of information which relates to a living individual who can be identified from that information (or from that and other information in the possession of the data user), including any expression of opinion about the individual, but not any indication of the intentions of the data user in respect of that individual.'

S22 provides that inaccurate data can be challenged.

2.1.1 Limits of Access under the Data Protection Act

- It only applies to automated data.
- It does not cover data held on word-processors unless records are specifically stored on the word-processor, rather than just being produced on it.
- It applies only to registered data users.
- It does not apply to information about someone who has died.

2.1.2 The Importance of the Data Protection Act

- It applies to records which do not fall into the definition of health records, including:
  - complaints records;
  - information held or provided by health or professional bodies which are not strictly health records, including employment records; and
  - opinions noted about the individual.
- It is not limited in terms of when the material was obtained, so long as it is currently stored.
- The rights of data subjects can be enforced through the courts and compensation can be claimed for any failure to meet the requirements of access, correction of inaccurate information, or unauthorised disclosure of information.
- The individual has the right to complain to the Data Protection Registrar in the event that there appears to have been a breach of any data protection principles, in addition to any claim made in the court for damages arising from consequential losses.
- S24 of the Data Protection Act permits a court to order rectification and even erasure of inaccurate data from records.
- Increasingly health records are held on computer and access to them can be gained under the Data Protection Act .

2.2 The Access to Medical Reports Act 1988

This piece of legislation applies only to reports supplied by a medical practitioner for employment or insurance purposes. It obliges those who are commissioning reports to seek the consent of the subject and gives the subject the right to see the report, before it is sent to the employer or insurer. The subject of the report also has the right to veto the report's release, or to append their own comments on matters felt to be inaccurate.

The provisions of the Act do apply to reports which are not held in an automated form, so whether typed, hand-written or taped, the subject may obtain access.

The wording of this Act is such that it clearly covers reports issued by GPs. However, the definition of medical report s2 as;
'a report relating to the physical or mental health of the individual prepared by a medical practitioner who is or who has been responsible for the clinical care of that individual',
has led to controversy as to whether it applies to reports specially commissioned from an independent doctor. However, the definition of 'care' in s2(1) of the Act is a wide one and includes;
'examination, investigation or diagnosis for the purposes of or in connection with any form of medical treatment.'
Clearly, such a report should only be prepared after an examination of the subject. As all doctors have an ethical obligation to recommend those they examine, to have any treatment that seems necessary, all examinations are potentially in connection with treatment and may therefore come within the Act.

2.2.1 Important Aspects of the Access to Medical Reports Act

- The consent of the subject is required before a report can be commissioned - s3(1)(b).
- The subject has the right to see the report before it is sent to those who have commissioned it, i.e. the medical practitioner must offer to supply access to it before it is sent (but note there may be a fee for the supply of a copy - s4(1)). The subject can still apply to see the report after it has been sent and the doctor preparing the report must retain a copy for at least 6 months in order to facilitate this - s6.
- The subject can veto the report in its entirety or append their own comments to it - s5.
- The person or organisation commissioning the report must inform the subject of these rights - s3.

2.2.2 Exemptions

As usual with UK law, there are exemptions to these rights. These are detailed at s7 and are:

- where the medical practitioner considers that disclosure would cause serious harm to the mental or physical condition of the subject - s7(1),
- when the report contains information about the practitioner's intentions towards the patient - s7(1),
- where disclosure would reveal information from or about a 3rd party, unless that 3rd party consents, or unless the 3rd party is a medical practitioner who has provided information in that capacity - s7(2).

2.2.3 Limits

- The Act apples only where reports are prepared for insurance and employment purposes, and then only to the report and not to any material used to prepare the report.
- The Act came into force on 1 Jan 1989. It does not apply to reports made before that date.

2.3 The Access to Health Records Act 1990.

This covers manual health records made since 1 November 1991 and creates a right of access to health records for patients and their representatives.

2.3.1 Minimum Rights of Access

The most important thing to note about this Act is that it provides minimum rights of access. The guidance to the Act[1] put out by the DoH confirms this on the first page.

'The DoH's policy has long been that as a matter of principle, patients should be allowed to see what has been written about them.'
and
'NHS Bodies should encourage informal voluntary arrangements whereby patients or those caring for them....are allowed to se their records at the discretion of the health professional.... The new Act does not prohibit such arrangements and it would be in keeping with the underlying principle of greater access to personal health information not to rely upon the provisions of the Act to secure this.'

The Act should not be used to limit what is made available to patients, and for this reason, it should be read in the context of the Code of Practice on Openness in the NHS.

[1] Access to Health Records Act 1990 A Guide for the NHS - page 2

However, all too often, GPs and Health Authorities refuse requests for access because they say the Act does not allow it. This is wrong. The Act does not prevent access in circumstances other than those specifically detailed within the Act.

The rights contained in this Act must be seen against the backdrop of the following.

- Doctors have a professional duty to *'keep clear, accurate and contemporaneous patient records which report the relevant clinical findings, the decisions made, information given to patients and any drugs or other treatment prescribed.'* [2] Failure to do so can be a disciplinary matter.
- Medical records are owned by the person or organisation who compiles them, the GP, Trust (or health authority in default), dentist etc.

It is worth noting that the provisions of the Act applies across the board, not just to NHS records, but those of private practitioners as well.

2.3.2 Who can Apply for Access?

S3(1) of the Act lists who may apply and includes:

- the patient;
- a person authorised in writing by the patient;
- those having parental responsibility for a child;
- a person appointed by the court to manage the affairs of adults who are incapable of making an application on their own behalf;
- the personal representatives or anyone having a claim arising from the death of a patient.

See page 10 for further details on the problems which can arise when application is made for access to the records of children, mentally incapacitated adults and the dead.

2.3.3 Who To?

The application must be made to the holder of the record, as defined in S1(2) of the Act. Hospital records can be accessed on application to the Trust concerned. Applications should otherwise be made to the health professional holding the record, e.g. dental practitioners. In the case of a GP record, application should be made to the GP in question, or to the Health Authority when the patient has no GP.

[2] Guidance from the General Medical Council issued in October 1995

2.3.4 To See What?

The records covered by the Act are defined in S1(1)(a), as being;
'information relating to the physical or mental health of an individual who can be identified from that information, or from that and other information in the possession of the holder of the record'
prepared
'by or on behalf of a health professional in connection with the care of that individual.'

This includes medical records, correspondence and communications held on those records, test results and X-rays.

2.3.5 Prepared by Whom?

S2(1) of the Health Records Act 1990 defines a health professional as being any of the following:
(a) a registered medical practitioner;
(b) a registered dentist;
(c) a registered optician;
(d) a registered pharmaceutical chemist;
(e) a registered nurse, midwife or health visitor;
(f) a registered chiropodist, dietician, occupational therapist, orthoptist or physiotherapist;
(g) a clinical psychologist, child psychotherapist, or speech therapist;
(h) an art or music therapist employed by a health service body; and
(i) a scientist employed by such a body as a head of department.

S2(4) confirms that the Act applies to private medical practitioners as well as to those operating in the NHS.

Note the proviso that the record must have been made **'in connection with the care of the individual.'** Care is defined at s11 as including; 'examination, investigation, diagnosis and treatment'. The Access to Health Records Act can be used to obtain access to notes kept by medical practitioners who have examined the subject for the purpose of preparing a report, but who otherwise have not treated the subject.

2.3.6 Requisite Period?

The record holder is required to make access available or supply copies on request, within 40 days of the application, unless the records have been added to within the previous 40 days, in which case they must be produced within 21 days of the application.

2.3.7 Limits

- This Act only applies to records made after 1 November 1991.
- The record must have been made by, or on behalf of, a health professional.
- Access cannot be given under this Act to information which is covered by the access provisions of the Data Protection Act 1984.
- The Act does not cover NHS Complaints Procedure records, notwithstanding that making a complaint is one way of trying to resolve disputes over access.

But it **does** apply to the records of a dead person.

2.3.8 Exemptions to the Duty to give Access.

- Where in the opinion of the holder of the record, disclosure may cause **serious harm** to the physical or mental health of the patient or any other individual.
- Where the record relates to or has been provided by a third party unless that third party consents. However this exemption does not apply where the third party is a health professional who provided information in their professional capacity. There is no requirement that GPs or consultants who have contributed to the record should consent to disclosure, although the record holder is entitled to seek the professional view of a relevant medical practitioner as to whether access would cause serious harm to the mental or physical health of the patient, or whether disclosure is in the best interests of a child.

2.3.9 Other rights - Correction

Sometimes patients consider that misleading information about them has been entered on their notes. S6(1) of the Act gives a right to ask for the record to be corrected. On receiving such a request (in writing) the record holder must consider whether the record is inaccurate, misleading or incomplete, and if so, they are required to make the appropriate correction.
If the holder does not consider the record to be inaccurate the subject has the right to have a note of their own observations inserted on the file or record.

The decision whether to correct or not is left to the judgement of the health professional concerned. There is no independent objective test as to whether the information is accurate or not, but the health professional must act reasonably or risk a challenge through the courts.

Government guidance[3] states:
'Care must be taken not to simply obliterate information, which may have significance for the future care and treatment of the patient or for litigation purposes.'

2.3.10 Disputes and Enforcement.

There are two routes to challenge the failure of a health professional or body to comply with their obligations under the Act:

- Through the courts S8(1). A court can order compliance, but there is no provision for any award of damages or compensation. An application can be made to either the county court or to the High Court when the applicant has
  'taken all such steps to secure compliance with the requirements as may be prescribed by regulations made by the Secretary of State' -s8(2)
  Specific regulations have not been issued.
- By means of a complaint through the NHS Complaints Procedure. Complaints procedure guidance[4] states that complaints can be made about any aspect of an application to obtain access to health records, but that patients still have the right to take matters to a court if they remain dissatisfied with the outcome of an investigation.

It appears that either route can be used. It is not strictly necessary to exhaust the complaints procedure before applying to the court, although it may be more desirable to do so.

2.4 PRACTICAL PROBLEMS

2.4.1 Access to Children's Records

The Act provides for access to be made available:
'where the record is kept in England and Wales, and the patient is a child, to a person having parental responsibility for the patient' - s3(1)(c).
Parental responsibility is stated to have the same meaning as at S3 of the Children Act 1990. This covers;

- both natural parents when they were married,
- the mother of a child born out of marriage or both parents when they both agree to this,
- any person who the courts have granted parental responsibility to, and
- social services, where a child is in care.

[3] Access to Health Records Act 1990 A Guide for the NHS - page 21
[4] Complaints Listening..Acting..Improving March 1996

S4 of the Act then goes on to detail further requirements, that of consent of the child, or the best interests of the child. Two circumstances are addressed:

a) Where the application is made by a child (under 16), or with written authorisation from the child, the holder of the record must be satisfied that the child is capable of understanding the nature of the application before giving access - s4(1).

b) Where the application is made by person having parental responsibility for a child, the record holder must establish whether the child is capable of understanding the nature of the application and
   - if so only give access if the child consents - s4(2)(a)
   - if not, only give access if the health professional considers that it is in the child's best interest to do so -s 4(2)(b).

2.4.2 Access to the Records of the Dead

The duty of confidentiality survives death. The Act makes provision at s3(1) that an application for access to a health record, or to any part of a health record of a dead person, may be made by;

- the patient's personal representative and
- any person who may have a claim arising out of the patient's death,

unless the record includes a note, made at the patient's request, that he did not wish access to be given on such an application - s4(3)

Requests are often turned down on the basis that the applicant has not established that they are the personal representative, but record holders are not always clear about what personal representatives are. There is no definition in the Act. However, in probate law a personal representative is treated as being the person who is entitled to the grant of probate, or is the executor of the deceased's will.

Similar problems arise when an application for access is made on the basis that a person may have a claim arising from the death. This category is not defined in the Act either. The Fatal Accidents Act 1976 details people having claims in order of priority as:

- spouse,
- parents of a person who never married,
- common-law spouse or former spouse,
- parents or those treated as parents by the deceased,
- child or person treated as a child by the deceased,
- brothers, sisters, aunts, uncles or their offspring.

The wording of the Access to Health Records Act indicates that any or all of these people can make an application for access. It is not necessary to show that legal proceedings have commenced.

Occasionally problems arise, when one or more of the deceased's relatives ask for access to the records, but other relatives oppose the application. Record holders cannot refuse access to the records to any person entitled to see them, on the basis that others with the same entitlement do not wish them to be released. It is good practice to ask clients who are asking for access, if the application is in accordance with the wishes of other interested parties.

Note: In cases where the Coroner has ordered an inquest, the original records may be passed to the Coroner. The Coroner will usually grant an application by the personal representatives for a copy of the records.

2.4.3 Mentally Incapacitated Adults

Where the patient has not the capacity to either make the application or instruct someone to apply on his/her behalf, s3(1) of the Act allows an application to be made only by a person appointed by the courts, but does not define the type of order which will be acceptable. Access should be given to a person with a registered enduring power of attorney, or who has been appointed Receiver, or on a direction of the court itself.

Where access is refused to the records of a person who has not the mental capacity to apply themselves, or to authorise someone else to do so on their behalf, it may be appropriate to:

- check the basis upon which the decision has been reached that the patient is incapable of giving consent to the application made on her/his behalf;
- explain to the record holder why disclosure is in the best interests of the mentally incapacitated person;
- ask the record holder to consider releasing the information in line with guidance, citing the Code of Openness;
- advise the patient's carer or relative to make an application to the Court of Protection for an order that the records be disclosed or to be appointed as Receiver.

2.5 CHARGES

The general proposition that there should be no charge is laid out at 3(4) of the Act. However two exceptions are then detailed as follows:

- S3(4)(a) - where access is given to a record or part of a record, none of which was made after the beginning of the period of 40 days immediately preceding the date of the application, a fee can be levied not exceeding the maximum prescribed under s21 of the Data Protection Act 1984 (£10); and

- S3(4)(b) - where a copy of a record or extract is supplied to the applicant, a fee can be levied not exceeding the cost of making the copy and (where applicable) posting it to him.

Put more simply.

- Access to records which have been added to in the last 40 days does not attract a charge.
- If the record has not been recently added to, a maximum charge of £10 applies on an application for access.
- If access is requested in the form of copies of the material, charges must be no more than the actual cost of making the copies and if applicable, posting them to the applicant.

NHS Guidance[5] contains the following gem;

' The Act allows a fee of up to £10 to be charged, when the record has not been added to in the last 40 days. This was intended to encourage the voluntary access arrangements referred to in the Foreword and assumed that records in such circumstances would be more readily available. A patient receiving ongoing care whose records have not been updated in the last 40 days could overcome the liability for a fee either by exercising his rights following the next booked appointment or by seeking a new appointment solely to ensure that his records are added to in a way which will allow access under the Act without a fee. Holders of records should determine their policy on fees in respect of patients receiving on going care who are between appointments.'

All these charges are discretionary and can be waived by the record holder. However, some record holders apply excessive administration and photocopying charges, apparently to deter applications for access. This strategy can backfire, if the charges levied are so high that the applicant instead opts to physically view the record s/he can ask the record holder to make someone available to provide any necessary explanation. The Act makes no provision for charges to be levied for this service and the cost to the record holder in releasing qualified personnel for what may be a significant period, may lead the record holder to decide to waive or review those charges.

It is interesting to note that the Code of Guidance on Openness in the NHS re-states the principle that there should be no charge for access to information and recommends that charging should be exceptional.

[5] Access to Health Records Act 1990 A Guide for the NHS - page 9

The actual charges for copies must be reasonable and no more than the cost to the record holder in making them. It is useful to note that the current County Court photocopying allowances for solicitors stands at 25 p a copy. Trusts and other record holders may have difficulty in establishing that the actual costs to them of providing copies, exceeds the level that solicitors are allowed to claim.

2.6 HOW TO APPLY FOR ACCESS

The first step is to identify the correct legislation under which the application must be made. Access to computerised material is expressly stipulated to be excluded from the provisions of the Access to Health Records Act. However, it seems that access to health reports prepared for insurance or employment purposes can be made under the Access to Health Records Act.

S11 of the Access to Health Records Act and s21 of the Data Protection Act stipulate that applications should be made in writing. In order to save time, the applicant should:

- provide sufficient information so that the subject of the record can be easily identified, including any patient identification number;
- establish their own credentials, for example by providing a copy of a written authorisation from the patient; and
- enclose any fee which may be required.

3. GUIDANCE

3.1 The Code Of Practice On Openness In The NHS

This was produced in 1995 with the stated aim of allowing greater access to information about the NHS generally. Its scope is not limited to health records. It applies to all NHS bodies, including health authorities, NHS trusts, GPs, dentists, opticians, community pharmacists and CHCs. It is worth noting that this guidance does not apply to the NHS Executive which, like other government departments, has to comply instead with the Code of Access to Information.

The basic principle of the Code of Practice on Openness in the NHS is that the NHS should respond positively to requests for information. Although the Code contains details of some information which may be withheld, it states categorically that NHS bodies cannot rely upon the contents of the Code to deny access to personal health records to which an individual has rights of access by virtue of statutory provisions.

The list of information which must be provided includes, *'information about how people can have access to their own personal health records.'* For example, leaflets and posters, detailing rights of access and who to apply to. NHS bodies must also publish the name of the person responsible for the provision of information and how to complain if the information is not provided.

3.2 The Patient's Charter

The only 'rights' stipulated in the Patient's Charter are those which previously existed in law. The Charter adds nothing to the access to health information legislation. This Government has plans for a new NHS Charter.

4. OTHER ISSUES

4.1 Confidentiality

Doctors and other medical professionals have a duty of confidence to their patients. This duty colours their perceptions of access requirements. The courts do enforce this duty where necessary. Article 8 of the European Convention on Human Rights, which will shortly become directly enforceable through the UK courts, enshrines a right to respect for a citizen's private life. This should not have any impact on the right of access by a patient to his/her medical records, but may cause health professional to carefully consider requests by others for access to these files.

4.2 Discovery in Legal Proceedings

There has been a lot of confusion about what information a patient is entitled to if he or she is contemplating making a claim through the courts.
The Supreme Court Act 1981 permits an application to the court for an order for discovery of certain documents and other information, if the court is satisfied that:

- they are required for the purpose of pursuing a legal claim,
- an action will ensue, or is in progress and
- there is some prospect of success.

The court will not make an order if it considers that the potential litigant is on a 'fishing expedition'.

It is important to note that the fact that legal proceedings are contemplated, does not permit a record holder to deny access which would otherwise be required by law. However, the extent and type of disclosure under access to medical records legislation may be insufficient for the purpose of establishing liability. For example:

- Access to health records made before 1 November 1991 may be crucial;
- It may not be sufficient to have copies of the notes. Access to originals may be required, e.g. if there is a suspicion that they have been tampered with, or are incomplete;
- A court can order disclosure even where the health professional concerned considers that disclosure could cause the patient serious harm, etc.

In practice information can often be obtained without a court order, when the defendant or potential defendant is satisfied that there is a genuine reason for the request, or if they are aware that in all the circumstances of the case, the court would make an order requiring them to disclose the information requested.

4.3 The NHS Complaints Procedure

As detailed above, complaints about breaches of the Access to Health Records Act can be taken through the courts, or through the NHS complaints procedure, although the Guidance[6] stipulates that complaints about failures to provide other information should not be considered under the complaints procedure, but under the Code of Openness in the NHS or by way of a complaint to the Health Services Ombudsman, whichever is appropriate in the circumstances. The same guidance states that complaints records should be kept separate from health records, no doubt to avoid the possibility that these would have to be produced on request. It is ironic that, notwithstanding all the guidance exhorting openness, a patient complaining about a breach of the access to health records legislation should be unable to access the complaints file.

4.4 Retention of Records

Access can only be given to records which are in existence at the time they are requested. NHS bodies are subject to DoH guidance on the length of time that health records should be retained prior to destruction.

4.4.1 GP Records

- GP records[7] should, as a general rule, be retained for a period of 10 years after conclusion of treatment or death of the patient.
- Children's and maternity records should be retained for 25 years and
- The records of patients with a mental disorder must be retained for 20 years after treatment or ten years after death.

4.4.2 Dental Records

Dental practitioners are required to retain records for a minimum period of two years[8].

4.4.3 Other Health Records

- Other health records must be kept for at least 8 years after conclusion of treatment or death.
- Obstetric and children's records must be retained for a minimum of 25 years, or 8 years after the death of a child.
- The records of mentally disordered patients have to be kept for at least 20 years from the date of treatment[9].

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[6] Complaints Listening..Acting..Improving March 1996 -page 5
[7] FHSL(94)30
[8] The National Health Service (General Dental Services) Regulations 1992
[9] HC(89)20

5. FUTURE DEVELOPMENTS

5.1 Implementation of European Directive 95/48

In October 1998, European Directive 95/46/EC covering data protection issues will come into force. This will expand the scope of data protection and personal privacy protection in line with Article 1 of the EU Directive, which states that: *'Member States will protect the fundamental rights and freedoms of natural persons and, in particular, their right to privacy with respect to the processing of personal data.'* Whereas the Data Protection Act governs the use of personal data held in computerised forms, the Directive will also apply to data held in other forms which is likely to include taped material. The Directive will apply only to 'sensitive' data. However, this will include data concerning an individual's health and will include a right of access. It is not yet clear how the British Government intend to introduce the provisions of the Directive, or whether they will seek to exercise the right to specify additional exemptions to the application of the Directive for reasons of 'substantial public interest'.

5.2 Freedom of Information Legislation

This Government intends to introduce a Freedom of Information Act. It is proposed that this will give a legally enforceable right to records and information of any date held by a public authority in connection with its public functions. It is hoped that this will lead to a change in the culture of secrecy. In the meantime, the Code of Practice on Access to Government Information, which the Act will replace, provides that *'the approach to the release of information should in all cases be based on the assumption that information should be released except where disclosure would not be in the public interest.'*

The Code commits government departments and public bodies to publish or otherwise make available, *'explanatory material on their dealings with the public, including such rules, procedures, internal guidance to officials, and similar administrative manuals as will assist better understanding of action in dealing with the public, except where publication could prejudice any matter which should properly be kept confidential under Part II of the Code.'*

Thus where a CHC finds that the way that access requests are dealt with is causing problems for applicants, they can ask to see the copies of any internal policies and procedures which are being applied.

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