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The College

Access to Health Records Act 1990 College guidance

The College is concerned to keep members informed of the unfolding implications of this Act.

Information about the Act can be obtained from:

(i) *Access to Health Records Act 1990: a Guide for the NHS*, published by the NHS Management Executive in 1991 and obtainable from:
Health Publications Unit
No. 2 Site
Manchester Road
Heywood
Lancs OL10 2PZ

and

(ii) *The Access to Health Records Act 1990* (HMSO price £2.10)

Members need to ensure that records are accurate and appropriate. They should assume that records will be shared with the patient; should ensure that trainees appreciate this new situation; and should consider how best to organise records consistent with good care, while facilitating their rapid perusal, if necessary, for material which should not be shown to the patient.

The medical profession generally seems to view the Act with equanimity but there may well be an important impact on psychiatry, if only with record taking practice. How Courts might interpret certain areas is unclear and greater clarity may result only from either evolving accepted practice or from case law.

This paper covers some information on the Act and records some points of Discussion raised so far in the College.

Information

The Access to Health Records Act 1990 originated from a Private Members Bill which received Government support during its passage through Parliament. It received Royal Assent on 13 July 1990 and the Act imposed a statutory deadline of 1 November 1991 for its provisions to be brought into effect by health authorities. In essence the Act gives individuals the right of access, subject to certain exemptions, to information about themselves recorded in manually held records.

Health professionals already had the discretion to give patients access to their health records and clearly it is intended that this continues. While this Act gives patients a new right of access to their records, it appears that the Department of Health intends that reliance on its provisions should only be needed in those cases where individuals who were previously patients wish to see former records and where current patients have not been satisfied by informal access. The Department of Health recommends that this new right should not detract from the need to record what is in the best interests of patients. All professionals are advised to compile records on the assumption that they will be accessible by patients.

This Act should be considered in conjunction with previous legislation, including the Data Protection Act 1984 (which gives patients access to health records held on a computer), The Access to Personal Files Act 1987 (which gives individuals a right of access to records not held on computers by local authorities) and The Access to Medical Reports Act 1988 (which provides that an employer or insurance company cannot seek a medical report on an individual for employment or insurance purposes from the doctor responsible for the individual's care and treatment without the individual's knowledge and consent).

For this legislation a health record is any record containing 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, and which has been made by or on behalf of a health professional in connection with the care of that individual. The Act is not confined to health records held by the NHS and applies equally to private health sector and to health professionals' private practice records.

This Act places obligations on the holders of records. Health professionals are defined by the Act as including registered medical practitioners, registered dentists, registered nurses and health visitors, clinical psychologists, psychotherapists, occupational therapists and many other health practitioners with professional qualifications. The right of access is afforded to the patient and also to persons authorised in writing by the patient to make an application. Parents will usually have the right of access where the patient is a child but the guide acknowledged that . . . "there will be a need for the rights of

the child to confidentiality to be balanced against the parental responsibility to ensure that only accurate and non-prejudicial information is recorded about the child".

It is anticipated that in the majority of instances a request for access will be made orally and that, ordinarily, the health professional principally responsible for clinical care will show the records to the patient for inspection and discussion, subject to non-disclosure of information which might cause serious harm or identification of third parties. This form of information request does not constitute an application under the Act. Formal access is afforded in two ways. Either the applicant may be allowed to inspect the record or relevant part of it or he or she may be entitled to inspect an extract setting out such a part of the record as the patient is entitled to see. In either case the applicant may be supplied with a copy of the record or extract. A fee (currently £10) may be charged when the patient is no longer receiving current care and the record has not been added to in the last 40 days. In this instance access must be provided within a period of 40 days. Where a record has been added to within the previous 40 days then access must be given within 21 days from the date of application.

There are three circumstances set out by Section 5(1) where access is not to be given to the whole of the health record. These are:

1. the case where, in the opinion of the hold of the record, giving access '... would disclose information likely to cause serious harm to the physical or mental health of the patient or any other individual'
2. where giving access would, in the opinion of the holder of the record, disclose '... information relating to or provided by an individual other than the patient, who could be identified by that information' and
3. where the relevant part of the health record was made before the commencement of the Act on 1 November 1991.

Not withstanding these exemptions access can be given where the third party, who would be identified, has consented. If the third party is a health professional involved in the care of the patient then this exemption does not apply.

It is also important to realise that retrospective revelation of records may be necessary. The third exemption, above, does not apply if, in the opinion of the holder of the record, access needs to be given to part of the record made before 1 November 1991 if that is necessary to enable the reader to understand that part of the record to which access is being given.

Section 4 relates specifically to patients who are children (being persons under the age of 16 years). This provides that children who, in the view of the responsible health professional, are capable of understanding what the application is about, may prevent a person having parental responsibility from having access to the record. Where the patient is not capable of understanding the nature of the application the holder of the record is entitled to deny access if it were not felt to be in the patient's best interests.

Section 5(3) & (4) prevents a person other than the patient having access to parts of a record when the holder believes that the patient gave the information, or underwent an examination yielding information, expecting that this would not be disclosed to the applicant.

Section 8 of the Act gives the applicant a right of action in the High Court or County Court if it is thought that the holder of the record has failed to comply with any requirement of the Act.

Discussion

While the College wishes to alert members early on to the available factual guidance it also wishes to update members periodically on developing views and practice. Particular points in recent discussion include the following.

(a) Inaccuracy and offensive perjorative comments are clearly inappropriate and case note audit with this in mind could be helpful.
(b) All health professionals contributing to the psychiatric health record need to appreciate the position.
(c) Health authorities, Trusts and individual practitioners need to give careful thought to using a modified record format which allows information derived from different sources (from the patient, from other health professionals and from third parties) to be presented in separate sections.
(d) The handling of information from third parties is a particular problem. While recording such information separately in the record will be useful, care will still be needed in incorporating conclusions from such information into formulations, management plans, care plans and documentation for the care programme approach.
(e) the problems of intellectual incapacity and of who should have access to what information with the incapable patient require further consideration.
(f) Members will need to exercise careful judgement when deciding whether information should be withheld on clinical grounds, particularly in the case of a patient suffering from a paranoid illness. It would be very helpful if

the College could collect information concerning the occasions when this particular exemption is used; members are asked to forward such information to the Registrar.

(g) The implications for recording discussions with carers need consideration.

(h) Experience will show whether some GPs may not consult with the previously involved psychiatrist before giving the patient access to psychiatric correspondence.

(i) Full consideration needs to be given to the fact that after the patient's death any person with a legal claim against the estate (such as a person pursuing a claim against the patient in the case of an accident) would have the right of access to the health records.

(j) It is not clear that proper consideration has been given to the potentially great amount of time involved for doctors in sifting/editing records for compliance with the Act and in explaining records to patients. Members are encouraged to monitor carefully this work load.

These guidelines were produced by Dr R. Jones, Secretary of the Public Policy Committee. They are based on a document prepared by Dr Richard Williams, for the Child and Adolescent Psychiatry Specialist Section's Newsletter. The original version is available from the College.

Approved by the Executive and Finance Committee November 1991

The profession of adult psychotherapist in the NHS

Psychotherapy specialist section executive committee

Introduction

Adult psychotherapy services in the NHS vary widely across the country. Some districts provide a full service but many have no specialist psychotherapy services or only minimal resources.

Increasing demands for treatment are not being met, with long waiting lists a universal problem. This is of relevance with the orientation towards a consumer led service following the Health Service reforms. The demand cannot be met by the efforts of interested general psychiatrists alone. There has been a gradual expansion of the number of consultant psychotherapists, but little expansion of clinical teams to work with them. If psychotherapy services are to meet requirements they will need to be augmented by an increasing use of non-medical practitioners. If each of the 208 Health Districts in England and Wales is to have a psychotherapy service it will be necessary for the numbers of non-medical practitioners to be expanded to provide trained and experienced psychotherapy practitioners who will staff the service under the direction of the consultant psychotherapist. A small number (about 20) of posts have been designated in adult psychotherapy on an ad hoc basis by the Department of Health and pay and conditions are often based on the child psychotherapists' scale.

The Working Party of the Psychotherapy Section of the College in its discussion document 'The Future of Psychotherapy Services', has recommended that each Health District should have a small team of psychotherapists responsible for the provision of clinical services, consultation, supervision and teaching. A consultant psychotherapist or consultant psychiatrist with special responsibility for psychotherapy is envisaged as a senior member of the team, so that issues of medical responsibility can be addressed appropriately, liaison with consultants in other medical specialties developed and the training of junior psychiatrists, in line with the College's requirements, met. Such a team will also include professionals from other disciplines including psychology, social work and nurses trained in psychotherapy. The adult psychotherapist could make an important contribution to the work of the District team.

The document proposes (following Cawley) that non-medical psychotherapists might be involved at three different levels of clinical function; the basic level would be equivalent to a counsellor with a preliminary training in psychotherapy. The intermediate level would be a practitioner from an existing health care profession who has specialised in psychotherapy, having taken a minimum of a two year part-time course. The third level would be the specialist psychotherapist with an extensive training. It is at this level of specialist psychotherapy that the organisation of a new profession for non-medical practitioners could be advantageous for mental health services as a whole.

The new profession should include both practitioners trained in psychodynamic methods and cognitive behavioural approaches.