DR P J COX DR A M PARRY DR R HAMILTON
Tideswell Surgery
Parke Road
Tideswell
Buxton
Derbyshire
SK17 8NS

TIDESWELL SURGERY
ACCESS TO RECORDS POLICY
NUMBER TS/025(TSSHB053)

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Developed by:	Carol Lacey
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2	1.10.2014	Staff Update and review

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Medical Records

A medical record consists of information:

- relating to the physical or mental health or condition of the individual
- that has been made by or on behalf of a health professional in connection with that individual's care
- that is a combination of fact and opinion.

The medical record is therefore likely to include:

- clinical notes
- nursing notes
- correspondence between health professionals
- written reports for third parties
- investigation requests and results
- clinical audit data (if the patient is identifiable from them).

Parts of the medical record may be kept on a computer, whilst other parts may be kept in manual records.

Employers' Duties

The practice has a duty to:

- keep records in a safe and accessible manner
- have a procedure for providing patients with access to their records
- protect patient confidentiality by verifying the identity of all people requesting access to records
- ensure that as from April 2013 the practice complies with relevant Care Quality Commission requirements relating to record keeping.

Employees' Duties

Employees have a duty to:

- follow the practice's procedure for providing access to records
- explain the procedure to patients who wish to gain access
- ensure that all entries into medical records are factual, legible and up to date
- ensure no opinions about a patient's behaviour or temperament are expressed in the record unless they could have a bearing on care and treatment.

Good Practice in Record Keeping

Health professionals should work on the basis that a patient will request access to their records at some point in time, and therefore keep records in a manner that will make access easy to provide.

The General Medical Council's Good Medical Practice guidance states that doctors should keep:

clear, accurate, legible and contemporaneous records which report the relevant clinical findings, the decisions made, the information given to patients and any drugs or other treatment prescribed.

Other good practice in record keeping includes:

- writing legibly
- sticking to the facts wherever possible
- avoiding expressing opinions about the patient's behaviour or temperament unless it could have a bearing on treatment
- noting any wishes expressed by the patient about future disclosure to third parties, eg if a patient wants a particular consultation or illness to be kept confidential even if he or she grants access to a third party in the future
- keep records in a manner that makes it easy for a patient to have access in the future
- flag any information that should not be disclosed at the time it is entered into the record, to save time and avoid mistakes at the time when access is requested.

Some older records that were not subject to previous access legislation may have been written in the expectation that the patient would never see them. These may contain information, such as opinions about the patient, that may be upsetting. The health professional does not have the right to withhold this information. However, he or she can offer to delete any upsetting non-relevant information after the patient has had access.

What Constitutes Access?

Patients can request access to their medical records that:

- are about them and from which they can be identified
- consist of information relating to their physical or mental health or condition
- have been made by or on behalf of a health professional in connection with their care.

The patient can access their records regardless of how long ago the records were made and where they are stored (eg computer or manual).

Access may take the form of:

- reading/viewing the record
- obtaining a permanent copy of the record to keep.

If a patient is viewing their record, a health professional should be available to explain any terms that the patient does not understand. If the patient is receiving a copy of their record, it should be accompanied by an explanation of any unintelligible terms.

Who Can Request Access?

Access to a person's medical record can be requested by:

- the patient in question
- a parent, if the patient is a child who has given their consent, or lacks capacity to do so, provided it does not go against the child’s best interests
- a child if he or she is deemed to have capacity to do so
- a person appointed by a court to manage a patient's affairs because the patient is not capable
- a person holding a personal welfare lasting power of attorney (this power of attorney can only be used when the patient lacks capacity; as there are different types of power of

attorney contact your defence organisation for advice if a request is made for disclosure of records)
- a third party with the patient's written consent.

If a person appointed by a court to manage a patient's affairs requests access to the patient's medical records, access should be restricted to the information this person needs to carry out his/her functions.

Access to Children's Records

According to the GMC's 0–18 years guidance on access to medical records by children, a young person has the right to access their medical records and allow or prevent access by other people (including their parents) when they are deemed to "have capacity". In Scotland, anyone aged 12 or over is legally presumed to have capacity.

When a parent requests access to their child's records, the child's consent should be sought if they are capable of giving consent.

Any information that the child gave in confidence should not be disclosed without the child's consent.

If two people have parental responsibility for a child, one can be given access without the other being informed. For example, if a child lives with its mother, the father can obtain access without the mother being informed.

All mothers have automatic parental responsibility. Fathers of children only have it in the following circumstances:

- if he and the mother were married at the time of the conception, birth or some time after; this responsibility is not lost if the mother and father later divorce
- if he and the mother were never married but he has a parental responsibility agreement with the mother that is registered with the High Court, or a parental responsibility order from the court.

Other people may gain parental responsibility by court order or by being appointed guardian upon the death of the parents.

Who Grants Access

Technically the access is granted by the practice's data controller. This may be the senior partner, practice manager or reception manager. The request for access must be made to this person.

In practice, any decisions about what to disclose should be made by the health professional currently or most recently responsible for the patient's clinical care. Therefore, the data controller should seek advice from the health professional before arranging for access to be granted.

Applications for Access

There is nothing in law to stop a patient's principal health professional showing the patient their records informally, provided no other provisions of the Data Protection Act 1998 preventing disclosure are breached.

Given that informal access may inadvertently breach the Data Protection Act 1998, it is prudent to require all requests for access to be made formally.

A formal application for access should be made in writing and should enclose the **appropriate fee**.

If a patient requests access to their own records, their identity should be verified before granting access. In practice, many patients are well known to the practice team. If not well known, the practice should ask to see photographic identification before access is granted.

If a patient gives consent for a third party to access their record, the following should be verified:

- that written consent has really been given (if necessary contact the patient)
- that the person requesting access is indeed the person with the patient's consent.

Time Limits

Access must be granted within 40 days of receiving the request and the fee. If possible, it should be granted sooner than this.

If the application does not include enough information to verify the identity of the requester or the consent provided by a patient to the requester, the 40–day time limit does not apply until sufficient information has been provided.

Information that Cannot be Disclosed

The following information cannot be disclosed:

- information within the record that relates to an identifiable third party, unless the third party gives consent or is a health professional
- information that would cause serious harm to the patient or another person
- if a third party is seeking access with consent, information that the patient previously asked or expected not to be disclosed
- information subject to legal professional privilege between a patient and their legal advisor
- information restricted by a court, as it relates to current family and child court proceedings
- information about a person being born as the result of fertility treatment
- information prohibited by legislation concerning adoption reports and records, statements of a child's special educational needs and parental order records and reports.

Where the patient's record contains one or more of these types of information, access to the rest of the record should still be granted, but the prohibited information withheld. This can be done by:

- removing the relevant records and reports
- blanking out information that would allow a third party to be identified
- blanking out other information that must be withheld.

There is no obligation to tell the patient/requestor that some of the record has been withheld.

Some older records that were not subject to previous access legislation may have been written in the expectation that the patient would never see them. These may contain information, such as opinions about the patient that may be upsetting. The health professional does not have the right to withhold this information. However, he or she can offer to delete any upsetting non-relevant information after the patient has had access.

Providing Access

When an access request has been made and the requestor's identity (and any consent issues) verified, the practice should make an appointment for the person to view their records or receive their copy. Where possible, this should take place in the surgery.

The following arrangements should be made.

For patients viewing records:

- a private room, such as a consulting room, set aside for an appropriate period of time (an hour unless the records are particularly long and will require a longer time to view)
- a health professional available to explain any terms that the person does not understand (or cannot decipher)
- a brief meeting with the person before they view their records, to explain that there is someone on hand to explain or answer questions and to explain that they can request an amendment to their record if it contains inaccuracies
- a brief meeting when the person has finished viewing their records to check whether they have any unanswered questions.

For patients receiving a copy of their records:

- a private room in which the person can be presented with their copy of their records
- an accompanying explanation of any illegible or unintelligible terms/entries
- information about how and when to contact a health professional to ask any questions about the record.

Making Amendments to Records

If a patient disagrees with any entry into the medical record, either on a point of accuracy or opinion, he or she has the right to have their record amended.

However, it is good practice to include their amendment alongside the original entry rather than deleting the original entry. It is important that the entire record (including inaccuracies) can be seen, to fully explain the treatment history. For example, inaccuracies may have led to diagnoses and treatments that would not make sense if the original inaccuracy was deleted.

Any amendment must:

- be given equal weight with the original entry
- be attached securely to the record (not a post-it note)
- note who requested the amendment
- note when the amendment was made.

Deceased Patients' Records

The records of deceased patients are not covered by the Data Protection Act 1998. The Access to Health Records Act 1990 covers manual records of deceased patients that were made since 1 November 1991 (30 May 2004 in Northern Ireland).

Access to records made before these dates should only be granted if this is necessary to make sense of later records.

Any person with a claim arising from the death of the patient can request access to information that is:

- covered by the act
- directly relevant to their case.

Information should be withheld if it:

- would cause serious harm to somebody's physical or mental health
- identifies a third party without their consent
- was given on the understanding that it would be kept confidential.

As most records of deceased patients are held by the PCT, Central Services Agency or NHS/Health Board, the practice should advise the person to make a request to the organisation in question. The organisation holding the records will make contact with the patient's healthcare team to inform of any decisions about disclosure.

Fees for Access

The following fees can be charged for providing access and copies of records. These are the maximum fees set out by the Secretary of State.

Access to and/or copies of records held totally on computer	£10
Access to records at least in part held manually where copies are requested	£50
Access to records held manually where no copy is requested and at least some of the record was made in the 40 days prior to the request	No charge
Access to records held manually where no copy is requested and the record has not been added to in the 40 days prior to the request	£10

Essential Standards Compliance

As from April 2013, general practice primary healthcare providers who carry out “regulated activities” under the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 will have to be registered with the Care Quality Commission in order to practice. To do this they will have to comply with Guidance about Compliance: Essential Standards of Quality and Safety, published by the CQC in March 2010.

The Essential Standards contain the outcomes the CQC expect service users to experience if a provider is compliant with the regulations. Within this guidance providers of regulated primary care services must comply with the requirements of Regulation 20 and Outcome 21: Records.

Regulation 20 states that the registered person must ensure that service users records, which may be in paper or electronic form, are properly managed and are:

- kept securely and can be located promptly when required
- retained for an appropriate period of time
- securely destroyed when it is appropriate to do so.

To support the regulations the Essential Standards contain a number of outcomes and guidance “prompts”.

Prompt 21A states that the service should have clear procedures that are followed in practice, monitored and reviewed, to ensure personalised records and medical records are kept and maintained appropriately for each service user.

The prompt also states that:

- service users, or others acting on their behalf, and relevant staff, should be aware of how they can access, and where appropriate, contribute to the record

- where a request for access to a record is made, all legislation and guidance in respect of Freedom of Information Act 2000 and the Data Protection Act 1998 should be followed by all staff
- records should be securely stored and transferred internally between departments and externally to other organisations, when required
- protocols should exist with other organisations for secure information sharing
- service users should be assured that safe and secure records management arrangements will continue to be in place for the legally required period should the registered provider close operations.

Compliance with the Essential Standards replaces compliance with previous sets of standards, such as Standards for Better Health, but does not replace other statutory or professional guidance. Some of the evidence that providers use to demonstrate they meet other standards or laws can also be used to show compliance with the CQC standards. It is important, however, that providers develop additional systems which show how they deliver positive outcomes for people who use services and capture information about how people experience the services they provide.

Training

All staff should receive training in:

- the practice's access procedures
- how to handle a request for access.

The data controller should have training in:

- legal aspects of access and disclosure
- handling patient and third party requests
- good practice in identity-checking.

Health professionals involved in providing access should receive training in:

- the practice's access procedures
- patients' rights to explanations and amendments
- handling an access meeting
- handling disagreements and concerns about entries in the record.

List of Relevant Legislation

- Health and Social Care Act 2008
- Health and Social Care Act 2008 (Regulated Activities) Regulations 2010
- Data Protection Act 1998
- Access to Health Records Act 1990
- Access to Health Records (Northern Ireland) Order 1993