



# Record Access guidance for GPs

## Sharing records with patients: an evolving process

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The main purpose of patient records is as a tool to provide high-quality care. Patients have had the right to view their health records for many years, although normally few choose to do so unless there is a problem or a complaint. However, the changing culture of involving patients in their care, coupled with familiarity with new technologies, is likely to increase the demand for patients to view their electronic records in the future. Clinicians already share records with patients in many ways, for example turning the screen to face the patient or inviting the patient to check prescribing details. In addition, the white paper published in England in July 2010, *Equity and Excellence: liberating the NHS*, encourages patients to access their records. It sets out assurances that they will be given more control of their records and what is recorded in them.

The Royal College of General Practitioners report, *Enabling Patients to Access Electronic Health Records: guidance for health professionals* ([www.rcgp.org.uk/get\\_involved/informatics\\_group.aspx](http://www.rcgp.org.uk/get_involved/informatics_group.aspx)), has been developed in order to help GPs wishing to implement Record Access for patients in their own practices. This leaflet summarises the main points and gives advice on how to get started.

Record Access may provide most benefit to patients if it is used as an integral part of the care process. If patients access their records in the context of joint decision making in partnership with their health professionals, the result can lead to improvements in their care. It is important that

health professionals understand that new ways of working with patients become possible with electronic records. However, it is essential to apply these safely and effectively. The advice in this guidance has been agreed by the General Medical Council (GMC), the defence societies, the Information Commissioner's Office and the British Medical Association (BMA), who have endorsed it on the basis of it being a discussion paper.

Some specialist services have been using patient-held records for many years, notably maternity services. Others have facilitated access to electronic test results and letters, such as renal clinics. Suddenly enabling access to the complete GP record seems daunting and may even require a complete change in traditional methods of record keeping. A stepwise approach may help to avoid some pitfalls.

Many health professionals have concerns about Record Access, such as:

- Will it increase the length of consultations?
- Will I need to change the way I write my records?
- What about inappropriate patient access to third-party information?
- What about the potential for litigation?

The full RCGP Record Access report addresses these concerns in detail. This shortened version provides an overview and quick guide, helping GPs to gain confidence in the process. It also suggests ways of managing the risks.

# RCGP Record Access report – shortened version

## PRINCIPLES OF RECORD ACCESS

Patients have the right of access to their own health records. The NHS Constitution in England states that patients should be given appropriate information and opportunities to exercise increased control over the healthcare decisions that affect them. They should be encouraged to access their own health records and use them to improve their health and care.

## RECORD ACCESS BENEFITS

Record Access should:

- enable patients to understand the information in their records
- help them make use of that information
- be linked with targeted health information and decision support
- lead to discussions between patients and health professionals, encouraging a more open and honest relationship.

For example, by linking information to appropriate sites the record can offer patients a portal to a range of facilities with advice on improving health, managing disease and evaluating the care they receive.

Record Access should not:

- be a substitute for information communicated by health professionals when caring for patients
- be compulsory
- cost anything to the patient
- impact adversely upon the effectiveness or quality of the record.

If patients feel that they do not understand something or that something has gone wrong, they have easy access to their data and there is no evidence of increased litigation. Patients can also share their record with family members or carers as they choose.

## RECORD ACCESS GOVERNANCE

In the UK, under the Data Protection Act 1998 and Access to Medical Reports Act 1988, patients (including 'Gillick competent' children) or anyone authorised by the patient are entitled to access their records. This includes reports supplied by a medical practitioner for employment, insur-

ance or other purposes. Parents, or those who have parental responsibility for children who are deemed not 'Gillick competent', are entitled to access a child's medical records in the child's best interests. There are provisions under the Mental Capacity Act 2005 in England and Wales for access to records of patients who lack capacity.

The Information Commissioner states that having access to electronic records does not replace formal rights of access under the Data Protection Act and patients can still request formal access in the usual way.

The two key exceptions for access to information are where it:

- is likely to cause serious harm to the physical health, mental health or condition of the patient or any other person
- may relate to, or be provided by, a third person who can be identified from the information and has not consented to the disclosure.

There is some evidence that doctors may be more likely to consider data to be damaging to a patient than a patient might. Health professionals experienced in Record Access suggest that there are very few items that will need to be withheld. Occasionally, it could be the health professional him or herself who might come to serious harm if the patient had Record Access. The final decision on whether to grant access should rest with the patient's health professional.

## COPYING LETTERS TO PATIENTS

The NHS Constitution 2009 includes a pledge to share any letters sent between clinicians with their patient. This is gradually being adopted across the NHS and is generally accepted by patients and health professionals, with a few exceptions. The Central Consultants and Specialists Committee of the BMA has published guidance for its members on copying letters to patients. This states that, although copying letters to patients is not a contractual obligation for doctors, it can bring benefits. Examples include:

- providing reassurance that clinical correspondence has taken place
- ensuring that misunderstandings can be corrected or explained

- providing a valuable written point of reference for patients who are unable to remember complex important information
- having a therapeutic potential for patients with mental illness.

## RECORD ACCESS – PRACTICAL CONCERNS

The RCGP Record Access report provides further detailed guidance, which is summarised here. The full report goes on to provide a number of use cases, illustrating with scenarios the issues that may arise from Record Access:

- *Preparing for Record Access*

Most clinicians are doing Record Access already: turning the screen round to face patients, asking them to check details of prescriptions and printing out results or letters for patients to take home. By sharing records with patients you are inviting them to contribute to the quality and accuracy of their records. You should be prepared for patients to bring up unexpected issues: they may see things that have been described in a different way to the clinicians.

Some systems allow password access to individual patient records. This can be done either remotely from the patient's home or through touch screens in the waiting room. Other systems have yet to develop this level of software, which will be a major constraint to allowing patients to embark on full access.

On an individual level, this can be progressively developed during consultations. Patient access can be introduced in a phased manner in the practice in order to ensure confidence in both patients and clinicians.

As a practice, you could start by allowing patients remotely to order repeat prescriptions, then move on to viewing test results. You could choose one or two patients with a long-term condition who are getting regular repeat blood tests, and invite them to view online rather than come into the surgery or phone in.

When accessing records for the first time, the patient should feel that his or her GP is supportive. It may be useful to give the patient an extended appointment after a few days. This is in order to check with the patient that he or she finds it useful, and has not uncovered any cause for anxiety. It would also be an

opportunity to establish ground rules on how the patient will access the records. For example, should they email any queries to the practice rather than individual clinicians? What do they do about asking for corrections? What is the mechanism for disagreements or alterations?

- *Security, registration and authentication*

Practices will need to make decisions about how this is done by practice staff: whether full verification of identity is required or whether the individual is already well known to the practice. It is the responsibility of the practice to allocate passwords safely and ensure that there is no possibility of coercion or abuse. The final decision whether to grant access to any patients rests with the clinician.

- *Informing patients of the implications of Record Access*

This includes risks such as viewing a diagnosis that they do not agree with or seeing comments on a clinical letter that spell things out in a stark manner.

- *Language and interpretation*

Clinicians need to write records with the knowledge that patients are able to read them. This also applies to hospital records. Although many clinicians already copy letters to patients, not all patients expect this to happen. GPs need to be cautious, especially where the letters contain much detail and possibly information about family members, for example marital difficulties or allegations of abuse.

- *Including speculation in the record*

Speculation is an important part of medical records and is clinically essential in structuring diagnostic tests and treatments. Experience from clinicians already using detailed Record Access shows that Record Access does encourage honesty, which can occasionally lead to uncomfortable conversations with patients. However, experience also confirms that many patients welcome and expect openness, and that health professionals are best advised to share these options and decisions with patients.

- *Patient contributions to the health record*

This could be as simple as starting with checking that details are correct or verifying accuracy, for example adverse drug reactions.

- **Workload**

Practices will need to consider the implications of tidying up content to deal with third-party information, errors and the small number of patients who might wish to attend frequently. A phased implementation plan will allow the speed of this process to be controlled.

- **Litigation**

Record Access has the potential to improve discussions between patients and health professionals, encouraging a more open and honest relationship. If patients feel that they do not understand something or that something has gone wrong, they have easy access to their data. There is no evidence of increased litigation.

## **INFORMING PATIENTS OF THE IMPLICATIONS OF RECORD ACCESS**

Patients should be given information about the benefits and risks of accessing their records. An example would be, if the information is available, giving test results with an accompanying explanation. An agreement that the patient has read and understood the processes necessary to take part in Record Access should be obtained from each patient and kept in the patient's record. There should also be a mechanism for patients to change their mind about having access, the parts they access or the access rights granted to others.

Patients may wish to share their records with family members or others by giving them direct access. Where that is the case, they should be made fully aware of the associated risks and understand that they become responsible

for any consequences arising from their decisions to share confidential information, particularly if considering sharing that information through social networking sites. The possibilities for coercion and the resultant consequences should always be borne in mind. The safety of the patient should be paramount. Some of the issues outlined in this leaflet are explained in the accompanying information sheet for patients.

## **TRAINING**

The process of sharing records with patients requires new knowledge, attitudes and skills from health professionals and patients. Record Access requires a culture change. Training would be beneficial as part of ongoing professional development.

## **CONCLUSION**

The emerging evidence is that health records can be safely shared with patients and can improve their care. Sharing records with patients has significant potential benefits with regard to relationships, understanding, health outcomes and safety. We are all at an early stage in the development of this approach to clinical care. Uncertainties are understandably widespread amongst health professionals. Detailed implementation of Record Access requires careful consideration, including effects on practice workload as well as benefits to patient care. We will need to keep a watching brief on the next stages and learn lessons from the development of Record Access in order to improve care and ensure that the relationship between the GP and the patient can flourish.

[www.rcgp.org.uk/get\\_involved/informatics\\_group.aspx](http://www.rcgp.org.uk/get_involved/informatics_group.aspx)