08 February 2016

Consultation on the Code of Practice on Confidential Information

The College welcomes the opportunity to respond to the Care Quality Commission’s consultation on the Code of Practice on Confidential Information. However, we would like to highlight that our comments must be viewed as provisional in the light of the forthcoming publication of Dame Fiona Caldicott’s data security standards which are expected shortly.

The Royal College of General Practitioners (RCGP) is the largest membership organisation in the United Kingdom solely for GPs. Founded in 1952, it has over 52,000 members who are committed to improving patient care, developing their own skills and promoting general practice as a discipline. We are an independent professional body with expertise in patient-centred generalist clinical care.

Patient trust concerning confidential personal information is essential to our work as general practitioners. For this reason, the RCGP welcomes the Care Quality Commission’s consultation on their code of practice. Listed below are our responses to the questions raised by the consultation document, each containing suggestions for improvement.

1. The Code explains the ‘necessity test’ that CQC uses whenever we have to make a decision about whether we need to obtain, use or disclose confidential personal information.
We believe that the necessity test has been properly explained. The consultation document provides clear and insightful case study examples of how it can be applied in care home and hospital settings, though we would appreciate an example that illustrates how it would be applied in general practice.

The code of practice is not clear however, about how much access an inspector to a patient’s record has during an investigation. For example, if an inspector is granted access to a patient’s medical record whilst investigating a GP practice, we do not know whether the inspector is able to access the entire medical record, or just the element that is being inspected.

More clarification is needed on this issue. It is our suggestion that when an inspection takes place, it is clear from the outset how much information about the patient the inspector is able to access.

2. The Code explains how CQC uses its statutory powers to obtain confidential personal information, including medical records and personal care records, and how it may obtain confidential personal information in other ways.

The statutory powers overall are explained well, but more clarification into how they affect general practice is required.

On page 12 of the consultation document it is stated that “any objections, concerns, opinions and expectations expressed by the individuals or their family, carer or representative may be considered”. This does not always apply to general practice, as when access to primary care records are required, the patient may be unaware that this access is to take place. If the patient is not aware that their record will be accessed, they will therefore not be in a position to express any objections, concerns, opinions or expectations.

We suggest therefore that there should be an additional clause. This clause would specify that when access is granted to a patient’s medical records, any further activity should include a requirement to communicate this intention to the individual or their representative.

3. We have explained the different ways in which CQC uses confidential personal information to help us carry out our regulatory work, for example using care records to make judgements about care services.

We believe there is a need for better communication with the general public regarding access to primary care medical records. For example, we suggest the production of publicity materials that can be displayed in GP surgeries and practice websites, outlining the CQC’s ability to access patient records.
We welcome the audit trail that is referred to on page 21 of the consultation document. We suggest that this can be improved by creating an agreed national system for inspectors to use when accessing medical notes, as opposed to the current method of accessing files using the practice manager’s login. Similarly, whenever an inspector accesses a file, an audit entry should be placed in the medical record to show the date of access, its purpose, and the name of the inspector in order to promote transparency.

4. We have explained how CQC handles and stores confidential personal information, keeps it safe, and disposes of it securely when it is no longer needed.

The storing of confidential information, and how it is handled, has been clearly explained in the document.

We suggest however that a further entry should be added to the patient’s primary care medical record that explains whether the information has been stored elsewhere. If so, the note should also provide detail on when the information was stored, and the date that it will be destroyed.

5. Sometimes, CQC needs to disclose confidential personal information to other organisations to protect people from harm or unsafe care.

Whilst the explanation of disclosure is clear, we have concerns about the level of anonymity that the code of practice provides.

We feel it would be beneficial for there to be a further section that describes how such disclosures would be anonymised. For example, if a patient was referred to as ‘a man living in South London’ this would be an appropriate level of anonymity. However, if the patient was referred to as ‘a 96 year old retired MP living in South West London’ this would also be anonymised, but not to a level that would make the patient unidentifiable.

We propose therefore that guidance is produced to ensure as that patient details are anonymised to the appropriate level.

In conclusion, we believe that the consultation document has mostly been clear in its explanations of the issues raised in questions 1-5, but more work is needed to show how the code applies to general practice. With these suggestions in mind, the RCGP is keen to work with policymakers, specialised service providers and others to improve patient care in this area, and would welcome the chance to submit further evidence to the committee.