



### Chapter 6 Health Records

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#### Access to health records (page 255)

The Information Commissioner's Office (ICO) has published a code of practice for dealing with subject access requests, available at: [http://www.ico.org.uk/news/latest\\_news/2013/new-ico-subject-access-code-of-practice](http://www.ico.org.uk/news/latest_news/2013/new-ico-subject-access-code-of-practice) (accessed 16 September 2013). In the code, the ICO advises that the information supplied to the requester must be in an 'intelligible' form; in other words the information must be understandable by the average person. This means that when providing access to medical records, GPs should ensure that acronyms, codes and test results are put into an intelligible form for patients. Complex words and terms should also be explained.

The guidance also states that practices should make sure they know whether the person asking for the information wants it for themselves or for others.

#### Content of health records (page 231)

Building on earlier work on the standard of healthcare records, the Royal College of Physicians, in collaboration with the Health and Social Care Information Centre, published *Standards for the clinical structure and content of patient records* in July 2013. (<http://www.rcplondon.ac.uk/resources/standards-clinical-structure-and-content-patient-records> (accessed 15 July 2013)). The document provides a set of generic standards to allow clinical information to be recorded in healthcare records in a consistent way. The standards support increased interoperability of healthcare records which it is hoped will improve individual patient care by allowing faster access to accurate and up-to-date information by clinical staff across the NHS. Increased interoperability of records will also help to meet the Secretary of State for Health's challenge for the NHS to be 'paperless' by 2018. The standards, approved by the Academy of Medical Royal Colleges, will also support ambitions for higher quality data for service delivery, commissioning, audit and research.

#### Enabling patients to access electronic health records (page 257) Looking towards the future (page 261)

The Department of Health Information Strategy *The power of information: Putting all of us in control of the health and care information we need*, published in 2012, stated that by 2015 'all NHS patients will have secure online access, if they want it, to their personal GP record' (<http://informationstrategy.dh.gov.uk/about/the-strategy> (p.91) (accessed 13 April 2013)). Following this, in 2013, the Royal College of General Practitioners (RCGP) launched *Patient Online: The Road Map* (<http://www.rcgp.org.uk/patientonline> (accessed 13 April 2013)). Patient Online describes access by patients to a number of online services, including their GP record. It provides advice for GP practices on the implications of implementing Patient Online and guidance about information governance and safeguarding issues. NHS England expects all general practices in England to offer Patient Online by 2015.



The BMA is supportive of the principle of patients having easier access to their records, although this presents a number of ethical challenges. These include the risk of coercion for example from an abusive partner or competent children being placed under pressure to share their record with parents. The BMA has emphasised that a phased approach should be taken so that the impact can be evaluated and implementation is evidence based.

### **Shared detailed care records (page 239)**

The BMA has produced guidance on sharing and accessing local shared electronic patient records. The document provides some high level principles which represent best practice in terms of allowing records to be shared in order to facilitate patient care whilst maintaining high standards of confidentiality. The guidance is available on the BMA website: [bma.org.uk/ethics](http://bma.org.uk/ethics)