

Guidance on the amendment of medical and social care records following a request from a person receiving care

Guidance from the National Information
Governance Board for Health and Social Care

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About this Guidance

The National Information Governance Board for Health and Social Care (NIGB) is a statutory body established as part of the Health and Social Care Act 2008 to provide advice and guidance on, and support improvements in, the use of information in health and social care.

We have heard from patients who were having difficulties in getting changes they wanted made to their medical records. We felt these represented a broader issue and so we have produced this guidance which we hope will help not only the public but also health and social care professionals.

This guidance was produced by a working group of NIGB members and medico-legal experts. The working group heard evidence from members of the public, GPs, Caldicott Guardians and from other staff responsible for health and social care records, all of whom had experience of this issue.

The document discusses the purpose of records, how we believe that disputes over their content occur, and what the law says about records. It also gives guidance about what you should do if you feel you want amendments made to your records.

You can find more information about the NIGB and our work at www.nigb.nhs.uk .

CONSULTATION

Summary

The position of the National Information Governance Board for Health and Social Care (NIGB) is that records kept by bodies delivering health and social care are held in trust for a number of people who have a legitimate interest in their use.

The patient or service user, who is the “subject” of the record, has an over-riding personal interest in the record being an accurate reflection of the consultation and, in health records, the process of diagnosis and also reflecting his or her views.

Our advice to people who dispute the content of their record and want to get amendments made is as follows:

1. Explain your concerns to the person who made the entry. If they are no longer available then contact either:
 - a. The clinician or social care worker who currently holds the record.
 - b. The Chief Executive of the hospital which holds the record.
 - c. The senior partner of the GP Practice which holds the record
 - d. The Director of Adult or Children’s Social Services at your local authority.

Good communication is very important in dealing with this problem, especially where opinions are involved. All the interested parties should try to resolve the issue quickly. *For more details see “What to do if you are concerned about the content of your records” – page 10.*

2. You should always expect that where you disagree with the content of your record a note to this effect will be added. *For more details see “What you should expect to happen” – page 10.*
3. Whilst there may be rare circumstances when it will be agreed by the parties concerned that it would be appropriate for an entry in a record to be completely removed this will not usually be the case (later in the document we explain in details why this is). When an entry is removed without trace there must be a clear justification and this, along with the fact that an entry has been removed, must be recorded in the record. *For more details see “About deleting entries from records” – page 07.*
4. Remember that records contain opinions and an opinion is not wrong just because you disagree with it. *For more details see “How Problems Occur” – item (c) The difference between ‘fact’ and ‘opinion’ – page 06.*
5. If you feel that your request is not being dealt with appropriately you should use the NHS/Social Care complaints procedure. *For more details see “If you do not feel that your concerns have been properly dealt with” – page 11.*
6. If your complaint using either the NHS or Social Care Complaints Procedure is unsuccessful you could also complain to the Parliamentary and Health Service Ombudsman (health) or Local Government Ombudsman (social care). *See “If you do not feel that your concerns have been properly dealt with” – page 11.*

7. If you are still dissatisfied you should complain to the Information Commissioner. See *“If you do not feel that your concerns have been properly dealt with” – page 11.*

What are records for?

There are many definitions of what a health or social care record is, but for the purpose of this guidance we consider a ‘record’ to be information related to the provision of health or social care which identifies the patient or service user personally. Records can be kept in a variety of different ways including on a computer, on paper or a mixture of both. In most cases records are held by a professional or team providing care or by the organisation they work for. In some cases, for example maternity and child immunisation records, they may be held by the person receiving the care or their representative.

Originally records were kept by individual doctors and social workers as personal records of what had been discussed with the patient or service user, what actions had been taken, together with their professional opinions, examination findings, test results and other reports.

The way health and social care is now delivered involves teams of people rather than individuals and so depending on the services that you have used in both the NHS and social care you may have several records in several different places, some or all of which may be linked. These records, as well as keeping their original purpose, are now also used by team members to communicate with each other about a patient or service user. A fact-sheet produced for doctors by the Medical Protection Society explains this point very well:

“Adequate medical records should enable you or somebody else to reconstruct the essential parts of each patient contact without reference to memory. They should therefore be comprehensive enough to allow a colleague to carry on where you left off.”¹

This description is equally applicable to social care records.

In recent times there has been a change in the culture of health and social care delivery and patients and service users expect to be more involved in decisions about their care. The patient or service user makes informed choices rather than being directed by the professional. This also changes the nature of the record. It increasingly becomes a shared resource where patients and service users view and often provide input to the record. Both professional guidelines and the law reflect this as for some time they have allowed people to access the content of their records.

The boundaries between health and social care are blurred and so it is not unusual to find some information about health in a social care record and vice versa.

Accurate records are important in ensuring continuity of care and patient safety. They may also be required for legal purposes; if, for example, a patient wanted to pursue a claim following a traffic accident. They are also vital to both the service user

and the service provider if a complaint or negligence claim is made.

In healthcare there are a variety of approaches to the use of records and access to them. Currently some clinicians tell their patients what they have recorded in the record and some have embraced technology and embarked on major projects to allow patients to access the whole of their electronic record from their home computers. Other than in exceptional cases, the Data Protection Act 1998² gives patients and service users the legal right to see the content of their records.

In social care, it is usual for the content of the social care record to be agreed with the service user wherever possible. Where agreement cannot be reached then the service user can ask to include their comments in the record. Most local authorities are very open about allowing service users to add comments to their records.

How Problems occur

There can be several reasons why patients and service users disagree with the content of their records.

(a) The record is factually incorrect

No system is completely exempt from errors and health and social care records are no exception. Occasionally mistakes will be made – the records of people with the same name and similar dates of birth could be exchanged without it being noticed, test results could get filed in the wrong record, or an erroneous entry could be made by a professional.

(b) The facts are correct but the patient wants certain parts of the record removed

People are naturally anxious that highly sensitive information will not be accessed or shared without their full consent. Some may want to avoid this by having parts of their medical or social care history permanently deleted and, on occasion to have no trace of the deletion left in the record.

(c) The difference between “fact” and “opinion”

Health and social care records contain not only factual information but also opinions, judgments and decisions reached on the basis of the information known to health and social care professionals at the time.

Particularly in healthcare, reaching a diagnosis is often a process rather than a single event and professionals need to be able to record their impressions at a particular time, even if the “facts” are not totally clear. When reading a medical record, it can be easy for clinical opinion and fact to be confused, and professionals should explain to patients that some entries may be there, not as given or confirmed facts, but as an aid to diagnosis and treatment. This is especially important if patients/service users disagree with an entry in a record, and wish to express, and have recorded, their own view.

(d) Information given by, or concerning, another person

Records may include information reported by or relating to another person (a “third party”) and which is thought by the clinician or social care professional to be sufficiently important that it should be included in the record. The details of health and social care professionals which are recorded in the record are not considered to be third party information.

Where third party information is included in the record it should be clearly marked as such. Clinicians and social care staff should, where appropriate, seek to find out whether the information is correct during a consultation with the patient or service user. Where professionals feel that the information is not accurate or that it has been reported maliciously, they may feel it is appropriate to remove the information from the record where it has not already been used for decision-making. The Data Protection Act 1998 generally requires that third party information is not normally revealed to the subject of the record without the consent of the third party.

About deleting entries from records

Where something is incorrect it is sometimes thought that it should be completely erased so that no one can tell that it was ever there. This is rarely possible with health and social care records.

The organisations which advise, support and issue guidance for doctors nationally, along with the Information Commissioner’s Office and the National Information Governance Board for Health and Social Care all accept that the content of a health or social care record should not be changed without explanation.

Records are a history of the interactions of the patient or service user with those providing care or treatment and their primary purpose is to support the interests of the patient or service user. They contain the information and opinions provided by the patient or service user and the judgments, opinions, advice, treatment and care provided by the professionals.

The delivery of care and treatment is often complex and is based on trust between the person receiving the care or treatment and the professionals providing it. Often decisions around care or treatment are taken based on what happened or was done previously and so being able to see the whole record, and if any amendments have been made what these were and why they were made, is important to both the patient or service user and the professionals.

Practically, removing one or more entries from a record may be compared to taking a chapter out of a book – the following chapters can often not make sense.

If an entry in the record can be removed with no trace this can make subsequent

action by professionals difficult to understand and the record cannot be relied on. This may create two problems. The first is that if something goes wrong the patient might not be able to show that they were given poor advice, care or treatment and equally the professional might not be able to show that they did provide good advice, for example, on the side effects of drugs. The second is that not having the relevant facts available about a person's care or treatment may, in certain circumstances such as emergency care, increase the risk to the patient.

There are benefits to both the patient or service user and those providing care in maintaining a complete history in a record. This has to be taken into account when a request is made to delete or change something in it. Normally, where an entry is 'removed' from a paper record this is normally done by drawing a line through it and adding a comment to indicate why it is being removed. The section on Electronic Records explains how this is dealt with in electronic records.

Electronic systems allow an entry to be checked on screen before it is actually recorded in the record. This means that a person can realise that there is an error and change or delete the information on screen before it has actually been recorded in the electronic record. Our guidance applies to information which has been recorded in a record. In this situation we are clear that an entry has not yet been made in the record and so our guidance on deleting and changing electronic records does not apply.

Where records are kept on paper there may be rare circumstances when it will be agreed by the parties concerned that it would be appropriate for an entry to be completely removed from the record however in view of the risks previously discussed this will be unusual. Whenever this is done there must be a clear justification and this, along with the fact that information has been removed, must be recorded in the record so that if it is warranted by the situation or necessary as part of the consultation, the patient can be asked about the nature of the deletion.

The patient or service user should be told when an entry has been removed from their record and agree to its removal other than when the removal is to rectify a minor clerical error.

Electronic Records

All disputes over the content of records should be handled in the same way however, electronic records do afford new benefits and challenges. When information is changed in an electronic record, systems generally show the original and changed information, or keep the original information in an audit trail. It is important to understand that information can, and should, never be completely removed from an electronic record and the associated audit trail.

In some systems, for example, the NHS Summary Care Record³ which will contain essential health information to support safer care in an emergency, the content of the record is drawn from other records, for example, GP records. We expect that processes will be put in place to deal with errors and comments in

this type of record and to ensure that the principles contained in this guidance can be met.

One potential development in electronic records is the possibility in the future of limiting access to certain sensitive information. In the context of the NHS Summary Care Record this has been referred to as “sealed envelopes”. These are intended to give patients control over information that they consider to be sensitive and which they do not want accessed without their specific consent.

Use of health information from records for purposes other than for the provision of care and treatment

In 2007 the Care Record Development Board published a report on what is called the ‘secondary uses’ of patient information⁴ – this is the use of patient information for purposes other than the direct delivery of care and treatment, for example, managing the NHS or carrying out research.

We have considered what should be done if information which is sent to an electronic national system for secondary uses is subsequently found to be incorrect and is corrected in the system used for the direct delivery of care.

We believe that where it is possible to derive the identity of the patient from the information then a process should be in place to correct the error or if that is not possible then to anonymise or delete the record in the secondary system. To be clear, we accept that there may be a need to delete entries from electronic systems which are used solely for secondary purposes. We believe that information can, and should, never be completely removed from an electronic record and the associated audit trail of electronic systems which are used to deliver care and treatment.

Where it is not possible to identify the patient and thus the only implication is on statistical information we believe that the organisation holding the information should decide whether it would be practicable to change information. The Information Centre for Health and Social Care may wish to produce guidance on this.

What to do if you are concerned about the content of your records

We are clear that records kept by bodies delivering health and social care are held in trust for a number of people who have a legitimate interest in their use.

The patient or service user, who is the “subject” of the record, has an over-riding personal interest in the record being an accurate reflection of the consultation and, in health records, the process of diagnosis and also reflecting his or her views.

Our guidance on disputes over the content of records is clear:

- The Data Protection Act 1998 gives you a right to expect that records about you will be accurate, and so where there are factual errors in your record you should expect that these will be corrected.
- The first thing you should do is to explain your concerns to the person who made the entry. If they are no longer available then contact either:
 - A. The clinician or social care worker who currently holds the record.
 - B. The Chief Executive of the hospital which holds the record.
 - C. The senior partner of the GP Practice which holds the record
 - D. The Director of Adult or Children’s Social Services at your local authority.

Good communication is very important in dealing with this problem, especially where opinions are involved. All the interested parties should try to resolve the issue quickly.

- If you are worried about approaching them you should seek help from your local Patient Advice and Liaison Service (PALS)⁵. Every NHS Trust has a PALS to provide confidential advice and support to patients, families and their carers. As one of their roles is to provide confidential assistance in resolving problems and concerns quickly you may find that they are able to help you in finding a satisfactory solution. You can use NHS Direct (0845 4647 or www.nhsdirect.nhs.uk) to find out the contact details of your nearest PALS. Your local Citizens Advice Bureau can also advise on NHS and social care complaints.

What you should expect to happen:

- In all situations where you disagree with the content of your record a note to this effect will be added.
- If information about you is factually incorrect this will be corrected and a note added explaining what was corrected, by whom and when. ‘Corrected’ does not mean deleted without trace.
- If you are contesting an opinion in your record you must remember that an opinion is not incorrect just because you or another professional disagree with it. You should also note that opinions can change or vary

and that the preservation of previous opinions (even if ultimately shown to be wrong) can be important in understanding the care process. However, if after discussion you still feel the opinion is inappropriate a note will be added explaining your concerns.

The social services departments that we surveyed all made it clear on their web pages that they would do this. In healthcare both the Medical Defense Union and the Medical Protection Society have agreed that this is an appropriate way of addressing such a problem and we believe this model reflects best practice.

At the time of writing this document (May 2009) the Department of Health guidance⁶ advises clinicians that they should agree to add a comment to a record if the patient requests it and has used the NHS Complaints⁷ procedure and complained to the Information Commissioner. We disagreed with this approach. Our opinion is that patients should not have to use any complaints procedure to get a comment added to their record. We have advised the Department of Health that it would be appropriate to revise its guidance on this and it has agreed to do this.

If you do not feel that your concerns have been properly dealt with:

- From the 1 April 2009, there is now a single set of regulations governing health and social care complaints, The Local Authority Social Services and NHS Complaints (England) Regulations 2009⁸.
- You can find information about the Health and Social Care complaints procedure by calling NHS Direct on 0845 4647 or from their website www.nhsdirect.nhs.uk. Your local authority will also be able to provide you with information about the Social Care Complaints Procedure or you could visit www.direct.gov.uk. Your local Citizens Advice Bureau can also advise on NHS and social care complaints.
- The local Patient Advice and Liaison Service (PALS) can advise you on how to make a complaint to the NHS organisation which holds your records or on using the NHS Complaints Procedure. The PALS can refer you to the Independent Complaints Advocacy Service (ICAS) if you need assistance or support in making a complaint. Again, NHS Direct can give you the contact details of your local PALS.
- If you are unhappy with the outcome of your local complaint you can refer the matter to the Parliamentary and Health Service Ombudsman or the Local Government Ombudsman (social care). You can also complain to the Information Commissioner who can rule that any erroneous information is rectified, blocked, erased or destroyed. You should note that the Information Commissioner's Office specify that they will only get involved after you have contacted the 'organisation concerned and give it an opportunity to put things right'.⁹

“Significant Damage or distress”

The Data Protection Act 1998 is concerned with ‘processing information’ and this includes holding and using information. If you feel, and can demonstrate, that some of the information in your record is causing you substantial unwarranted damage or distress then section 10¹⁰ of the Act allows you to write to the organisation concerned, quoting section 10, and ask that they stop processing the information which you believe is causing you unwarranted damage or distress. If they refuse and you do not accept their reasons you can take the matter to court to get the processing stopped.

However, section 10 is a complex part of the Data Protection Act 1998. It does not apply to records which have to be kept by law and many records, for example GP records and social care records, are required to be kept by law. Some people may want to use this part of the Data Protection Act 1998 to have factually correct information which they do not wish seen removed from their record. If you want to take this step you should have exhausted all other avenues to get your record amended and also have considered the impact that removing the information could have on your care and treatment, including future decisions that might need to be taken. Ideally you should have discussed the impact with a professional who understands the content of your record.

Every NHS and social care organisation will have one or more people responsible for overseeing how the information they hold is handled. They may be called the Caldicott Guardian, the Information Governance Manager or the Data Controller. They may be helpful to you in this.

Guidance for health and social care professionals

In all situations where the patient or service user disagrees with the content of their record a note to this effect should be added to the record.

Most examples of disagreements over the content of records seem to be caused by opinions in the record. Relevant guidance to those recording their opinion in records reminds professionals that they should always remember that patients and service users do have a legal right of access to their records. We fully support this position and also suggest that you should also consider how any comments you add might be viewed by their subject and also might reflect on you in the future.

We recognise the challenges of providing treatment and that differential diagnosis often blurs into opinion. For this reason we believe that when you are recording an opinion you should clarify that it is opinion.

We believe that wherever possible what is recorded should be discussed with the patient in order to reduce the possibilities for dispute.

Occasionally, you will need to include in the record information which third parties have reported to you in confidence. Where this is the case, you should only

include such information in the record if you believe it is sufficiently serious and important for the individual's care to warrant including it in the record. Third party reported information should be clearly labelled as such. You should seek to evaluate the validity of the information, if appropriate, when you have subsequent contact with the patient.

In the previous section we have been very clear that the first thing that someone who is concerned about the content of their record should do is to talk to the person who created the record or the person who now holds it. It is clear that good communication with people on what the information means, its context, why it has been recorded and how "fact" may be different from "opinion" are key in resolving most concerns. It is important that you give adequate weight to the view of the patient and record when and how it conflicts with your own.

If information in a record is found to be factually inaccurate professional guidelines are that when dealing with paper records the entry should normally remain in the record, but be scored through with a single line and an entry added indicating the problem and any implications of it. Where the problem is that reports or results have been included in the wrong record, then whilst these should be placed in the correct record you should still add a note to the record explaining what had happened and where the report or results can be found should it be needed. You do, however, need to ensure that you maintain the confidentiality of the person whose information was mis-filed. The same principles apply to an electronic record, with clear entries being made to identify the changes made.

There will be occasions when you are asked to completely remove some of the content of the record and we have explained in previous sections (page 7) why we feel that this should only be done in exceptional circumstances. It is important that this is discussed with the patient/service user.

Patients may not appreciate that making changes to an electronic record leaves traces which cannot be completely removed. You may need to explain that this fact can protect the interest of both parties in the event of unresolved disagreement.

Where information is shared with partner agencies it is good practice to have an agreed policy about how amendments to shared records will be managed.

The approach above is emphasised in professional, regulatory and ethical guidance, all of which stress the importance of accurate information and good communication. Both the Medical Defence Union and the Medical Protection Society agree that where there is disagreement which cannot be resolved, adding a note to the record which explains the contention is the best way of dealing with the issue.

Annex 1 - What the law and professional guidelines say about records

Health and social care professionals are required by professional guidance and guidelines, often by their contract of employment and sometimes by the law to keep records. It is not possible or sensible to receive either healthcare or social care without some records being kept.

The Data Protection Act 1998 is the main relevant legislation. The Act refers to 'processing' data. This covers collecting, storing, accessing, using or changing information. The Act:

- Allows patients and service users access to their records.
- Requires that information held is accurate and, where appropriate, is kept up to date.
- Gives patients and service users the right to have factual inaccuracies in their records put right.
- Can be used to request that an opinion which is factually incorrect is modified or removed from a record, but an opinion cannot be regarded as factually incorrect just because someone else, even another doctor or social worker, disagrees with it.
- Can be used to request that the processing of information is stopped when it is causing significant unwarranted damage or distress (see below for further information on section 10).

It does NOT:

- Give the right to ask for entries which are professional *opinions* to be amended unless they were based on factually incorrect information (unless using section 10 – see page 12).
- Allow people to specify that their records are kept on one medium rather than another e.g. paper rather than electronic. Equally it does not give the right to specify where in the UK records will be stored, other than that they must be stored securely.

Section 10 of the Act allows people to request that an organisation stops processing information which it holds about them on the grounds that the processing is likely to cause the person substantial unwarranted damage or distress. However, this is a complex part of the Data Protection Act 1998 and there are several exemptions from section 10. Requests made under the provisions of section 10 must demonstrate why processing is causing unwarranted damage or distress and are considered on a case by case basis.

A 'Good Practice Note'¹¹ from the Information Commissioner's Office confirms that the Data Protection Act 1998 covers any expression of opinion about an

individual but it does not lay down specific rules about what should or should not be recorded, other than it should be the minimum necessary for the purpose.

The guidance explains that opinions should not include irrelevant material but that neither believing that an opinion contains irrelevant material, or that an opinion has failed to take into account information believed to be important, are reasons for using the Data Protection Act 1998 as the basis for asking for an opinion to be removed from a record.

There is no legislation which deals directly with disagreements over professional opinions which are not factually incorrect.

The Access to Health Records Act 1990¹², which applied to records compiled after 1 November 1991, gave patients the legal right to have a comment added to any entry in their health record that they disagreed with. This right was lost when the act was replaced by the Data Protection Act 1998 which only deals with issues around factual inaccuracies. This discrepancy was identified as the Data Protection Act 1998 was going through Parliament and the Department of Health agreed to issue guidance on adding comments to records.

At the time of writing this document (May 2009) the Department of Health guidance advises clinicians that they should agree to add a comment to a record if the patient both requests this and has used the NHS Complaints procedure and has complained to the Information Commissioner. We disagreed with this approach. Our opinion is that patients should not have to use any complaints procedure to get a comment added to their record. We have advised the Department of Health that it would be appropriate to revise its guidance and it has agreed to do this.

Both the Medical Defence Union and the Medical Protection Society (who offer doctors advice and indemnity) advise that adding a note explaining the patient's concerns or to offer the patient the opportunity to add an addendum to the records is an appropriate way of dealing with any dispute over an opinion in a record and maintains good doctor-patient relationships.

Annex 2 - Members of the Working Group

- Ian Hayes (Working Group Chair) - Public member of the NIGB.
- Dr Gillian Braunold – GP and Clinical Director for the Summary Care Record, NHS Connecting for Health.
- Dr Nick Clements – Corresponding advisor of the NIGB, Medical Protection Society.
- Dr John Holden – Corresponding advisor of the NIGB, Medical Defence Union. (The MDU has not endorsed this document.)
- Rabbi Sylvia Rothschild - Public member of the NIGB.
- Dr Michael Wilks - Public member of the NIGB.

The members of the Working Group are very grateful for the help and support of those who provided evidence to them:

- The patients and members of the public, who provided very helpful evidence both by email and by attending in person but asked for their details to remain confidential.
- Dr Stella Clark, Fife Primary Care Trust Medical Director and Caldicott Guardian.
- Dr Emyr Jones, Consultant Physician, Medical Director and Caldicott Guardian at Doncaster and Bassetlaw Hospitals NHS Foundation Trust.
- Dr Richard Fitton, GP and Caldicott Guardian at Hadfield Medical Centre, Glossop.
- Mr Stuart Dutfield and Mr Alan Hadfield for allowing the group to consider *The Joy project*, which was funded by a legacy in memory of Mrs Joy Dutfield.
- Johan Taylor, Practice Manager at Marple Cottage Surgery, Stockport.
- Dr Mary Hawking, GP at Kingsbury Court Surgery, Dunstable.
- Sarah Egleton, Head of Health Records, Norwich University Hospitals NHS Foundation Trust.
- A number of other healthcare professionals, who asked for their details to remain confidential in order to protect the identity of their patients.
- Penny Hill, NIGB Public member, Electronic Social Care Records Implementation Board member.

Annex 3 – The Remit of the Working Group

Purpose:

- a) To produce a report to the NIGB, which will be made public, outlining the current position, identifying any improvements needed and making appropriate recommendations.
- b) Following acceptance of the recommendations by the NIGB to produce the necessary advice and guidance to be issued by the NIGB.

Context:

In carrying out its review the Working Group will follow the principles which the NIGB operates under, particularly that allowing people who use health and social care services appropriate control over and access to their own information, and its use, which is central to the role of the NIGB.

Exclusions:

The work of this group excludes:

- The records of deceased patients
- Disputes raised by a third party
- Errors identified through performance assessment or clinical audit.

The exclusions raise a number of different issues and may require further consideration in the future.

Future work:

The Group will consider how the proposed guidance and principles for health records might apply to social care records.

Terms of Reference:

1. To review the legislation and professional guidelines related to disagreements over the content of clinical records.
2. To understand the clinical governance issues associated with making changes to records or adding notes regarding the accuracy of information in records.
3. To understand the implications and differences for paper and electronic records.
4. To understand whether the implementation of the NHS Care Records Service presents any opportunities or affords any difficulties in this area.
5. To seek input from patients and clinicians to provide practical examples of and make suggestions around this matter.

6. To consider whether the correction of errors should include information already extracted and in anonymised or pseudonymised form, for example in the Secondary Uses Service.
7. To consult with the Information Commissioner's Office.
8. To involve the Information Standards Board in regard to data quality.

CONSULTATION

Annex 4 - References

- ¹ Medical Protection Society, Medical Records Factsheet - <http://www.medicalprotection.org/uk/factsheets/records>
- ² Data Protection Act 1998 - http://www.opsi.gov.uk/acts/acts1998/ukpga_19980029_en_1
- ³ NHS Summary Care Record - <http://www.nhscarerecords.nhs.uk/what-will-change/summary-care-record>
- ⁴ Report of the Care Record Development Board Working Group on the Secondary Uses of Patient Information. August, 2007. Available at <http://www.connectingforhealth.nhs.uk/crdb/workstreams>
- ⁵ Patient Advise and Liaison Service (PALS) - <http://www.pals.nhs.uk/>
- ⁶ Department of Health Guidance on Access to Health Records - http://www.dh.gov.uk/en/Managingyourorganisation/Informationpolicy/Patientconfidentialityandcaldicottguardians/DH_4084411
- ⁷ NHS Complaints - <http://www.nhs.uk/aboutNHSChoices/contactus/Pages/Howtocomplaincompliment.aspx>
- ⁸ The Local Authority Social Services and NHS Complaints (England) Regulations 2009. Available at http://www.opsi.gov.uk/si/si2009/uksi_20090309_en_1
- ⁹ Information Commissioner's Office, "Data Protection Act 1998 – When and How to Complain", p. 4, at http://www.ico.gov.uk/upload/documents/library/data_protection/practical_application/dp_how_to_complain_final.pdf
- ¹⁰ Data Protection Act 1998, Section 10 - http://www.opsi.gov.uk/ACTS/acts1998/ukpga_19980029_en_3#pt2-l1q10
- ¹¹ Information Commissioner's Office, "Good Practice Note" - http://www.ico.gov.uk/upload/documents/library/data_protection/practical_application/gpn_recording_and_retaining_professional_opinions%20v1_290408.pdf
- ¹² Access to Health Records Act 1990 - http://www.opsi.gov.uk/acts/acts1990/ukpga_19900023_en_1

Other References

Medical Defence Union advice on medical records and reports - http://www.themdu.com/section_GPs_and_primary_care_professionals/topnav_Advice_centre_1/nav_Medical_records_and_reports_9.asp

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CONSULTATION