Care Quality Commission
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Dear colleague.

The review of people's medical records plays an important role in CQC's inspections and the wider regulation of health and social care services. This letter explains how and why CQC accesses medical records as part of its regulation of health and social care providers, which include primary medical services.

CQC reviews medical records because at times it is a necessary way of helping us understand the quality of people's care and ensuring that we achieve our purpose of making sure people receive safe, effective, compassionate, high quality care, and encouraging services to improve.

CQC has powers under the Health and Social Care Act 2008 to access medical records for the purposes of exercising its functions (which includes checking that registered providers are meeting the requirements of registration). The exercise of these powers is fully informed by CQC's responsibilities under the Data Protection Act 1998, the Human Rights Act 1998 and the common law duty of confidentiality.

We fully recognise the particular sensitivities surrounding the confidentiality of patient medical records in general practice. The relationship between GPs, practice nurses and patients is often a close and long-lasting one, with a very strong expectation of confidentiality. All CQC inspection teams, which include GPs, are fully trained in confidentiality and all CQC staff work to a Code of Practice on Confidentiality.

It is vital that we respect and protect the privacy and dignity of patients, and maintain their trust in CQC and in the confidentiality of their records. Whilst we do not ask for patient consent to review records, practices can anonymise records: most GP practice computer systems can anonymise records and where this is not possible, records can also be anonymised manually. Where records are not anonymised, CQC will consider whether notification is practicable, in line with its guidance

In general practice in particular, examples of necessary reviews of medical records include making sure that:

- actions recorded in the significant event analysis to improve patient care were carried out;
- care for people with learning disabilities is reviewed regularly, that care plans are in place and that people are getting safe, good quality care;
- information has been shared properly between a GP and a hospital;
- pathology results are reviewed and acted on and recommendations in letters from hospital have been implemented (we have inspected practices when there has been a back log of letters which have not been read and pathology results which have not been reviewed, resulting in poor, unsafe care);
- people with long term conditions (such as diabetes), the homeless, mothers and children, people with dementia and the elderly have care plans, that there is evidence of patient centred care and that their care is reviewed regularly;
- patient consent has been obtained for minor surgical procedures; and
- safeguarding concerns are being appropriately acted on, looking closely at the experiences of children and young people who need help or protection and the quality of services being provided to looked after children. The structured sampling of case records across all health services allows inspectors to assess the response to children in different circumstances and how those services work together to keep children safe. Where the sampling raises questions about specific areas of service provision in the area, we follow up on this as part of the inspection. In this way the findings follow the journey of the child and recommendations focus on those services where improvements are needed.

In summary, our approach to this aspect of our work is sensitively and carefully handled by ensuring the following:

- inspection teams work to clear guidelines when carrying out a review of medical and care records in all sectors;
- inspectors are guided by our Code of Practice on Confidential Information to determine if reviewing patient records is necessary;
- CQC's inspection teams of general practice include GPs who, in addition to the Code of Practice followed by inspectors, are fully trained in confidentiality;
- whilst inspectors can access medical records consistent with the legislation, all inspection teams of general practice will involve clinicians, who can provide a clinical interpretation;
- the purpose of the review is always explained to practice staff;
- the number of records our inspection teams look at will vary depending on the evidence we see in the practice and within the medical records (for example, where we have concerns about a particular aspect of care, we may ask to look at more records, such as where patients report not being given appropriate information and advice about their condition or we identify concerns that test results are not being followed up in a timely way);

- we ask the provider for the records, we do not demand log ins or passwords;
- a template has been developed for inspection team members to use to record evidence when looking at medical records;
- we have also provided some examples in the Key Lines of Enquiry and prompts where it is most likely that our inspection teams will find it necessary to look at medical records in order to make a judgement about the quality of care; and
- any concerns about an individual clinician are referred to the appropriate person or body e.g. the GMC or the NMC.

I would like to reiterate that reviewing these records can help CQC ensure that we achieve our purpose of making sure people receive safe, effective, compassionate, high quality care, and encourage services to improve.

Yours sincerely

David Behan
Chief Executive