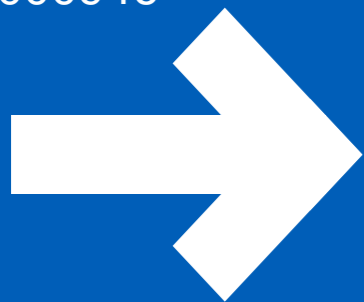


Practice guidance

Offering patients prospective record access

Version 1.1
11 November 2019
Ref: 000946



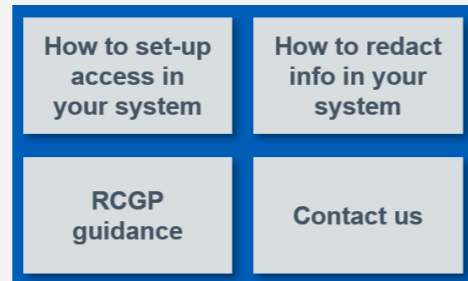
[Click here to go to a fully accessible version of this guide](#)

Using this interactive guide

This guide has been developed to allow you to easily navigate to the information you need, whether it is contained in the guide itself or linked to a website.

All buttons and images can be clicked on.

Quick links at the bottom left of each page



Navigation buttons at the bottom of each page. The home button takes you to the contents page.



Examples of other links within this guide



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1. Introduction and record access contract commitments

2. Clinical and patient safety

3. Prospective record access

3a. Setting up your clinical system

3b. Redaction

4. Preparing for future commitments

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This document provides the interpretation and guidance on the GMS Contract 2019-2024 commitment 5.10 (ii).

The approach has been agreed by NHS England and BMA General Practitioners Committee (GPC) in England and is supported by both organisations.

5.10 NHS England and GPC England have agreed eight specific improvements, backed by agreed contract changes, in areas where it is realistic to make early progress, given available functionality:

- (ii) *all patients will have online access to their full record, including the ability to add their own information, as the default position from April 2020, with new registrants having full online access to prospective data from April 2019, subject to existing safeguards for vulnerable groups and third party confidentiality and system functionality*



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Since 2014, patients have had the right to view limited parts of their record, these have been included in previous contracts.

Prospective records access, and in the future full records access build on these.

Prospective record access April 2019

From April 2019 new patients registering with a practice should be offered full online access to the digital record for their prospective information, starting from the date of their registration for online services, where patients wish to have access.

In addition to the detailed coded records (DCR) which is currently available, access to a full patient record includes

- free text consultation notes and
- documents i.e. hospital discharge letters, referral letters etc

Detailed coded record April 2015

Included

- Demographics
- Allergies/adverse reactions
- Medication
- Immunisations
- Test results
- Coded problems, diagnoses, procedures
- Coded referrals and letters received
- Other codes (ethnicity, QOF etc)

Excluded

- Free text
- Letters and attachments
- Administrative items

Summary information April 2014

Summary in patients' GP records e.g.

- Allergies/adverse reactions
- Medications

as outlined on the GMS contract.

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Prospective access to full records from a set date is subject to the same safeguarding requirements and management of third-party information as applied when patients have access to their detailed coded record (DCR)

When recording third party information, and if it is unknown to the patient, GP practices will need to ensure that this information becomes redacted from patient view.

Practices should also ensure that information is recorded in a way which makes it easy for the patients to understand it.

Guidance on safeguarding, sensitive data, and data recording is already available within the records access section of the RCGP toolkit available at www.rcgp.org.uk/patientonline.



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Extract from the RCGP guidance on sensitive information

GP records sometimes contain information that is confidential information about a third party which the patient must not see. There may also be information that may harm the patient, a diagnosis, abnormal result or opinion that the patient is not aware of. It may also contain information that the patient believes is mistaken or wants to have removed from the record. For brevity we refer to all such information as 'sensitive data'.

Patients or their proxies may ask for entries to be altered or removed if they disagree with them or find them upsetting or offensive. However, all health professionals have a right (and a duty) to make complete records of facts and their professional opinions about their patients' health, indicating clearly which are facts and which are opinions.

All GP systems have a method of preventing data being visible to patients with online record access. This is generally known as data redaction. Before record access is switched on all the data (detailed coded or full record access) that the patient will see should be checked for sensitive data that needs to be redacted. It is helpful to establish a practice record keeping policy about recording and redacting new entries of potentially harmful and confidential third party data even if they do not currently have online record access.



Click here to view the full RCGP guidance records access

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Extract from the RCGP guidance on coercion

Coercion is the act of governing the actions of another by force or by threat, in order to overwhelm and compel that individual to act against their will. Online services of all types are vulnerable to coercion.

In the context of GP online services, coercion might result in patients being forced into sharing information from their record, including login details, medical history, repeat prescription orders, GP appointment booking details and other private, personal information.

This is not a new issue. Practices will already have processes in place to manage instances of suspected coercion related to paper-based and face-to-face services. But GP online services creates new and additional opportunities for coercive behaviour that must be addressed by practices.



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Click here to download the full RCGP guidance on coercion

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Checklist

- ✓ Brief staff. Ensure they understand that, when appropriate, information should be [redacted](#) at the time it is entered into the patient's record.
- ✓ Update new patient registration process to include sign-up for prospective access in addition to appointments and repeat prescriptions.
- ✓ [Setup clinical system](#)
- ✓ Promote prospective access to newly registering patients.
- ✓ [Start planning for full records access](#)

Setting up your clinical system

The default requirement is that GP practices will set up a GP online service account, including full record access, for all new registrants

- GP practices will need to enable full record access within their clinical system’s organisational settings, where the functionality exists (see table below)
- The records only need to show information recorded from the date that the patient registered at the practice. This can be set within the organisational settings or for individual patients
- GP practices should not enable record access for individual patients if there are any safeguarding / safety concerns.

Each clinical system has different steps for enabling records access and redacting information. This guide includes instructions for each clinical system.

Available system functionality	Detailed coded record	Prospective record	Full record
EMIS Web	✓	✓	✓
Microtest Evolution	✓	✓	✓
TPP SystemOne	✓	✓	✓
Vision	✓	x	x

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TPP setup	Vision setup
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Patients will only see their record from the date entered.

If a patient has previously had access to their detailed coded record (DCR) the historical part of their record will no longer be available.

EMIS redaction

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Prospective full record only

Scanning Documents Audit Trails Prescription Printing Legacy Data Mapping Patient Archive EMAS Manager Non-Patient Data Transfer Launch BC Client

Activate Application Deactivate Application Save Settings

EMAS Applications Patient S...

Registration - 1068 (84) Lab Reports - 90 (44) Medicine Management - 49 (14) Tasks - 13 (3)

Emis - Patient Facing Services

Patients will not be able to access care record data online.

Core summary care record

Use core summary care record settings
Core summary care record will give patients access to allergies and medication.

Detailed coded record

Use detailed coded record settings
Detailed coded record will allow you to choose which services patients can access.
Allergies and medication are mandatory for the detailed coded record

Allergies

Medications

Laboratory test results

Display free text from: 01-Jan-1900

Documents

Only show documents from: dd-MMM-yyyy

Display free text from: dd-MMM-yyyy

Immunisations

Problems

Display free text from: dd-MMM-yyyy

Consultations

Only show consultations from: dd-MMM-yyyy

Display free text from: 01.04.2019

Navigate to the patient facing services tab

- [EMIS ball >](#)
- [System Tools >](#)
- [EMAS Manager >](#)
- [Patient Facing Services](#)

Then tick the buttons

- [Use detailed coded record](#)
- [Laboratory test results](#)
- [Immunisations](#)
- [Problems](#)
- [Consultations](#)

Add the date from which prospective access starts in each of the [Display free text from](#) date fields.

Add a date in the [Only show consultations from](#) field



Patients will see their detailed coded record (DCR), plus

- Laboratory test results
 - Immunisations
 - Problems
 - Consultations
- from the date entered.

EMIS redaction

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Prospective full record and retrospective detailed coded record

Scanning Documents Audit Trails Prescription Printing Legacy Data Mapping Patient Archive EMAS Manager Non-Patient Data Transfer Launch BC Client

Activate Application Deactivate Application Save Settings

EMAS Applications Patient S...

Registration - 1068 (84) Lab Reports - 90 (44) Medicine Management - 49 (14) Tasks - 13 (3)

Emis - Patient Facing Services

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Immunisations

Problems

Display free text from: dd-MMM-yyyy

Consultations

Only show consultations from: dd-MMM-yyyy

Display free text from: 01.04.2019

Navigate to the patient facing services tab

- [EMIS ball >](#)
- [System Tools >](#)
- [EMAS Manager >](#)
- [Patient Facing Services](#)

Then tick the buttons

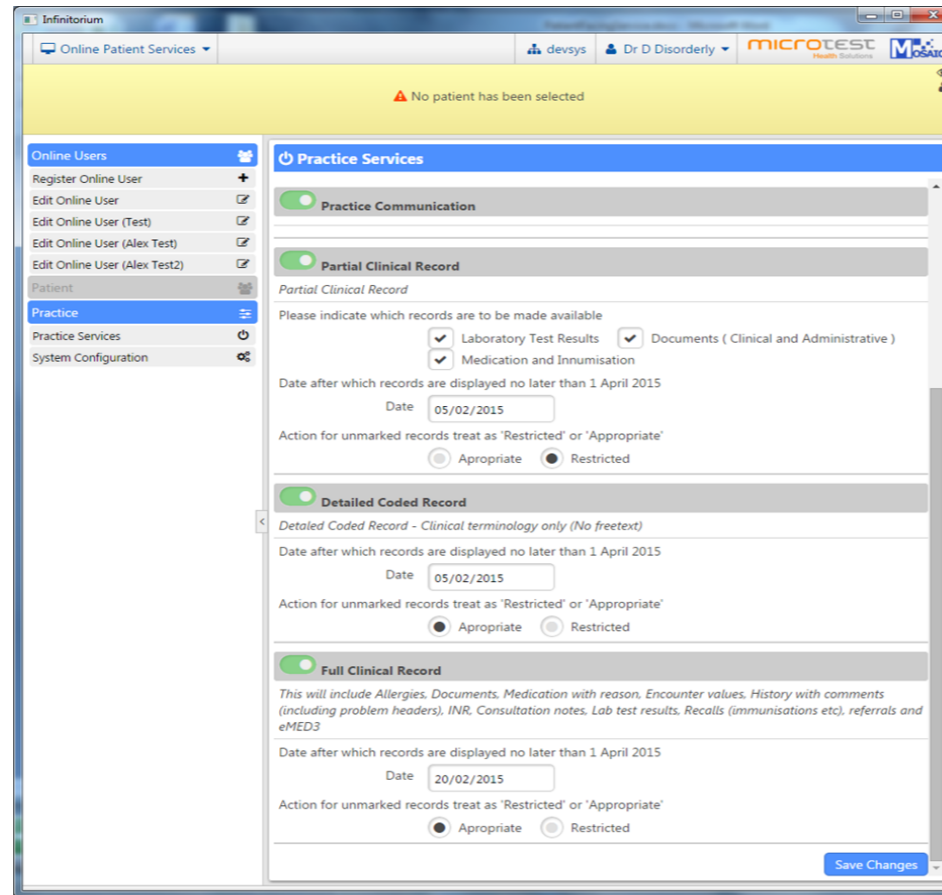
- [Use detailed coded record](#)
- [Laboratory test results](#)
- [Immunisations](#)
- [Problems](#)
- [Consultations](#)

Add the date from which prospective access starts in each of the [Display free text from](#) date fields.

DO NOT add a date in the [Only show consultations from](#) field, as this will restrict all access until after that date.



Microtest Evolution



Microtest provides a comprehensive step-by-step guide called ***Patient Facing Services (PFS) - User Manual Microtest Evolution.***

Online access for patients to make appointments, order medication, communicate with the practice and view records are called “Patient Facing Services”

This guide is available in each system at [Y:\CAP GP - Microtest\PROJECTS\GPSoc-R - Patient Facing Services \(TWR\)\The Waiting Room 2 \(TWR2\)\PFS User Manual.docx](Y:\CAP GP - Microtest\PROJECTS\GPSoc-R - Patient Facing Services (TWR)\The Waiting Room 2 (TWR2)\PFS User Manual.docx)

Microtest redaction

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TPP SystemOne

Patients will only see their record from the date entered.

If a patient has previously had access to their detailed coded record (DCR) the historical part of their record will no longer be available.

TPP redaction

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Organisation Preferences

Enter text to search Search Clear

Map of Medicine
MIG
Mobile Working
Multiple Clients
Name Formatting
NDTMS
NHS 111
NHS Pathways
Notice Board
Online Services
Global Settings
Appointment Booking
Appointment Cancellation
Medication Requesting
Online Messaging
Parental Access
Patient Communication
Patient Record Access
Self Registration
SystemOnline Messages
Panic Button
Pathology
Pathways
PHE Surveillance
Prescribing

Summary Record Access
 Enable summary patient record access

Detailed Coded Record
 Enable detailed coded record access
By default the detailed coded record will include all consultations
 consultations from the date of consent onwards
Default date detailed coded record will be visible from 01 Nov 2015

Full Clinical Record
 Enable full clinical record access
By default the online record will include all consultations
 consultations from the date of consent onwards
Default date record will be visible from 27 Sep 2016
 Allow patients to request access to their records via SystemOnline

Audit Information
 Allow access to patient record audits

Test Results
Patient message for new test results You have a new test result that you can view.

Sharing Information
 Enable viewing consent to share settings

Restore Defaults Ok Cancel

To setup default practice settings, navigate to the patient record access section

- Setup
- Users & policy
- Organisational Preferences >
- Online Services >
- Patient Record Access >

Then tick the buttons

- *Enable full clinical record access*
- *Consultations from the date of consent onwards*

Add the date from which prospective access starts in the *Default date record will be visible from* date field.



At present, Vision does provide the functionality to offer prospective record access

As of 01 October 2019, the Vision system does not have the following functionality.

- Prospective record access
- Full record access
- Correspondence and documents access.

As such, GP Practices using the Vision system will not be able to offer prospective record access or full record access to their patients, until this becomes available.

No, full record access is not yet available from the Vision system, we only offer DCR at present.	
- Allergies:	Yes
- Adverse reactions:	Yes
- Medications:	Yes
- Immunisations:	Yes
- Problems:	Yes
- Consultations:	Yes
- Test results:	Yes
- Free text:	No – earmarked for next year
- Documents:	No – earmarked for next year

[Click here for information on setting up detailed coded records \(DCR\)](#)

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Redaction

Patient access to any element of their record is subject to appropriate safeguards. These are designed to ensure that access to records

- does not cause harm to the patient
- that legal confidentiality obligations for the non-disclosure of third-party information are adhered to.

Where this information is contained within a record it must be redacted. The process for redacting information is different for each GP clinical system.

Confidentiality policies should NOT be used for hiding sensitive information

EMIS
redaction

Microtest
redaction

TPP
redaction

Vision
redaction

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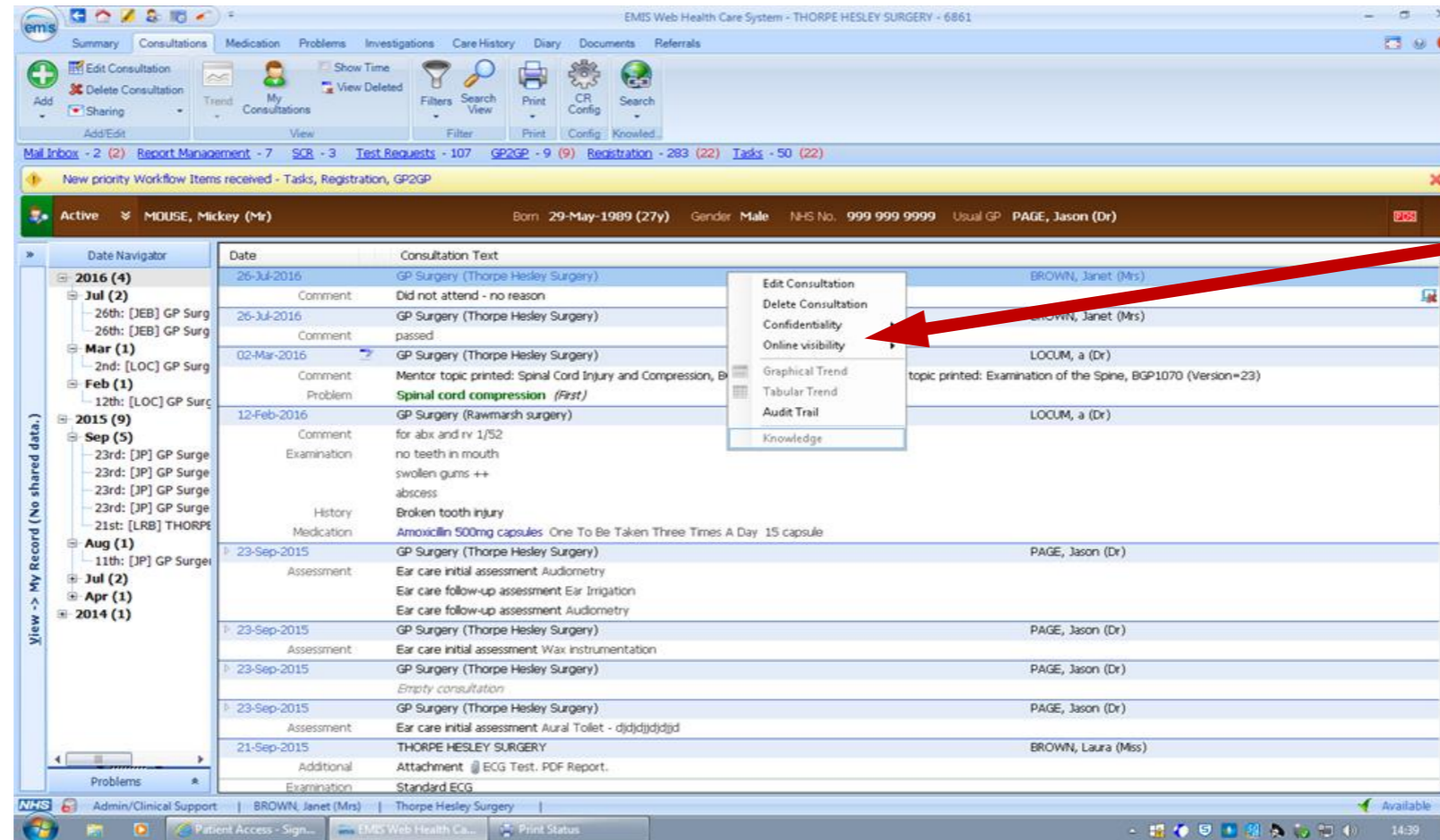
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Redacting Sensitive Information from Online View

Confidentiality policies should NOT be used for used for hiding sensitive information - Online visibility should ALWAYS be used



Right Click on Entry, and select Online Visibility.

NB Preventing online visibility can only be completed in care history of Consultations. Problems will not show the information has been redacted

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Rather than redacting information in the physical patient record, information can be restricted from the patient view in patient facing services.

Information on how to do this is contained in the ***Patient Facing Services (PFS) - User Manual Microtest Evolution***, please refer to the following sections

- Partial clinical record
- Detailed coded record
- Full clinical record
- Restriction by date
- Default action for unmarked records

The ***Patient Facing Services (PFS) - User Manual Microtest Evolution*** is available in each system at

[Y:\CAP GP - Microtest\PROJECTS\GPSoc-R - Patient Facing Services \(TWR\)\The Waiting Room 2 \(TWR2\)\PFS_User_Manual.docx](Y:\CAP GP - Microtest\PROJECTS\GPSoc-R - Patient Facing Services (TWR)\The Waiting Room 2 (TWR2)\PFS_User_Manual.docx)

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Redaction

TPP SystemOne (1)

Redact information from the Patient New Journal View – this can be selected and deselected here

The screenshot shows the 'New Journal' view in SystemOne. The interface includes a top navigation bar with options like 'Patient', 'Appointments', 'Reporting', 'Audit', 'Setup', 'Links', 'Clinical Tools', 'Workflow', 'User', 'System', and 'Help'. Below this is a toolbar with icons for 'Search', 'Task', 'Discard', 'Save', 'Details', 'Next', 'Acute', 'Note', and 'Appts'. A patient summary box on the right shows 'A N Other', '02 Nov 1979 (36 y) F', and '1 Anytown, Anywhere'. The main area displays a list of journal entries. A red arrow points to the 'Do not show in the online record' checkbox for the entry dated 'Sat 20 Sep 2014'.

Select here to hide or unhide information –

NB Applying Privacy Settings "X" will not hide from online view

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Continued



How to review what the patient will see

New Journal – TPP

Patient Record >Clinical Tab>New Journal

The screenshot shows the SystemOne software interface for a patient record. The 'New Journal' window is open, displaying a list of journal entries. A red arrow points to the 'Custom Filter' dropdown menu, which is open and shows options like 'Clinically Relevant', 'Admin Events', 'Online Full Clinical Record', and 'Online Detailed Coded Record'. The patient information at the top right indicates 'Mr T Patient' born '02 Nov 1979 (36 y) F' with address '1 Anytown N331XX' and GMS number '000000000'.

Custom filters will show what a patient would view following screening and possible redaction of information.

Not applying filters will show (only to the practice) both redacted and unredacted information

NB The filters do not show Test Results

TPP setup

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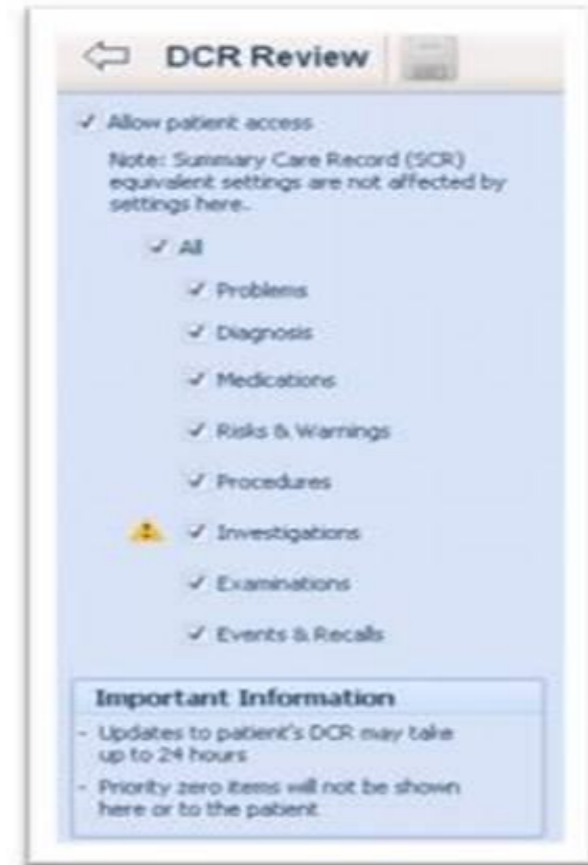
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- DCR data which is entered with Priority 0 will be restricted from patient view.
- The DCR Review App allows this to be reviewed for each patient



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Further information

This guide discusses the considerations and provides guidance on the issues surrounding Prospective Record Access

- Prospective record access at <https://www.england.nhs.uk/publication/patient-access-to-records-online-prospective-record-access/>
- Best practice guidance is available at www.rcgp.org.uk/patientonline
- patient information at www.nhs.uk/gponlineservices
- programme information at www.england.nhs.uk/GP-online-services

If you require further information please contact us at pcdt@nhsx.nhs.uk



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Clinical exemplar 1: diabetes mellitus	+
Clinical exemplar 2: end of life care	+
Clinical exemplar 3: dementia	+
Clinical exemplar 4: inflammatory arthritis	+
Clinical exemplar 5: mental health	+
Acknowledgements	+

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