

Practice guidance Offering patients prospective record access

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# 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

How to set-up	How to redact
access in	info in your
your system	system
RCGP guidance	Contact us

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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- 2. Clinical and patient safety
- 3. Prospective record access
  - 3a. Setting up your clinical system
  - 3b. Redaction
- 4. Preparing for future commitments











#### Introduction

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



Clinical safety

RCGP

guidance

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Joint

statement







### Existing contract commitments



RCGP

guidance

**Clinical safety** 

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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### NHS

NHS

### Clinical and patient safety

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.



Royal College of General Practitioners

A toolkit to support the provision of GP online services

Introduction	$\oplus$
Setting up Patient Online services	$\oplus$
Registering new applicants for Patient Online	$\oplus$
Record access	$\oplus$

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### Clinical and patient safety

Third-party and sensitive information

### 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

RCGP Joint guidance Statement









### Clinical and patient safety

Patients perceived to be at risk of coercion

### 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.



Click here to download the full RCGP guidance on coercion

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### Prospective record access



#### Checklist



Brief staff. Ensure they understand that, when appropriate, information should be <u>redacted</u> 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

 $\checkmark$ 

 $\checkmark$ 

 $\checkmark$ 

Promote prospective access to newly registering patients.

Start planning for full records access

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### Setting up your clinical system

EMIS	Microtest
setup	setup
TPP	Vision
setup	setup
RCGP	Joint
guidance	statement
Clinical safety	Contact us

### 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.

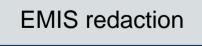
Available system functionality	Detailed coded record	Prospective record	Full record
EMIS Web	$\checkmark$	$\checkmark$	$\checkmark$
Microtest Evolution	$\checkmark$	$\checkmark$	$\checkmark$
TPP SystmOne	$\checkmark$	$\checkmark$	$\checkmark$
Vision	$\checkmark$	×	×



**EMIS** Web

> 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.



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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 Deactivate Application Applications Patient S.	
Registration - 1068 (84) Lab Reports - 9	0 (44) <u>Medicine Management</u> - 49 (14) <u>Tasks</u> - 13 (3)
Emis	Emis - Patient Facing Services
× Document Sharing	Pauerits vim nut be able to access tare record data orimie.
✓ Patient Facing Services	Core summary care record
× <sub>EPMS</sub>	O Use core summary care record settings
Managed Referrals	Core summary care record will give patients access to allergies and medication.
	Detailed coded record         Image: Static coded record will allow you to choose which services patients can access.         Allergies         Image: Allergies         Image: Static coded record text from:         Image: Static coded record will allow you to choose which services patients can access.         Allergies         Image: Static coded record will allow you to choose which services patients can access.         Allergies         Image: Static coded record text from:         Image: Static coded record text from:

Navigate to the patient facing services tab

- FMIS 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





**EMIS** Web

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

- Laboratory test results
- Immunisations
- Problems

**Consultations** from the date entered.

**EMIS** redaction





#### 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 C
Activate Deactivate Application Applications Patient S.	
Registration - 1068 (84) Lab Reports - 90	) (44) <u>Medicine Management</u> - 49 (14) <u>Tasks</u> - 13 (3)
Emis	Emis - Patient Facing Services
<ul> <li>Document Sharing</li> <li>Patient Facing Services</li> <li>EPMS</li> <li>Managed Referrals</li> </ul>	Patients with not be able to access care record data online.         Core summary care record         Ise core summary care record settings         Core summary care record will give patients access to allergies and medication.         Detailed coded record         Ise detailed coded record will allow you to choose which services patients can access.         Allergies         Image: Medications         Image: Laboratory test results         Image: Documents         Image: Display free text from:         Image: Display free text from:
	☑ Only show consultations from:     ☑ Onlog show consultations from:       ☑ Display free text from:     ☑ 01.04.2019

Navigate to the patient facing services tab

- FMIS 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

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Online Patient Services				devsys	🌲 Dr D Disorderly 👻	MICCOTEST Health Solutions	Mosaic
		A N	o patient has b	een selected			Ø.
Online Users	*	() Practice Services	i -				
Register Online User	+						
Edit Online User	Ø	Practice Commu	nication				
Edit Online User (Test)	ß	-					_
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Patient	迹	Partial Clinical Record					
Practice	÷	Please indicate which re-	ords are to be	made availab	le		
Practice Services	Ċ		Laborato	ory Test Result	s 🔽 Documents ( C	linical and Administrativ	e)
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Microtest provides a comprehensive stepby-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 <u>Y:\CAP GP - Microtest\PROJECTS\GPSoC-R -</u> <u>Patient Facing Services (TWR)\The Waiting Room</u> <u>2 (TWR2)\PFS\_User\_Manual.docx</u>

#### **Microtest redaction**





#### TPP SystmOne

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.

Enter text to search Search Clear	Summary Record Access
<ul> <li>Map of Medicine</li> <li>MIG</li> <li>Mobile Working</li> <li>Multiple Clients</li> <li>Name Formatting</li> <li>NDTMS</li> <li>MHS 111</li> <li>NHS Pathways</li> <li>Notice Board</li> <li>Online Services</li> </ul>	Detailed Coded Record     Detailed Coded Record     Detailed coded record access     By default the detailed coded record will include    all consultations
<ul> <li>Global Settings</li> <li>Appointment Booking</li> <li>Appointment Cancellation</li> <li>Medication Requesting</li> <li>Online Messaging</li> <li>Parental Access</li> <li>Patient Communication</li> </ul>	By default the online record will include O 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 SystmOnline  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

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.

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TDD redection





### NHS

#### Enabling prospective access in your clinical system

Vision

### At present, Vision does not provide the functionality to offer prospective record access

As of 01 December 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.

Click here for information on setting up detailed coded records (DCR)

No, fu	Il record access is not ye	et 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

#### Vision redaction







EMIS redaction	Microtest redaction
TPP	Vision
redaction	redaction
RCGP	Joint
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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.

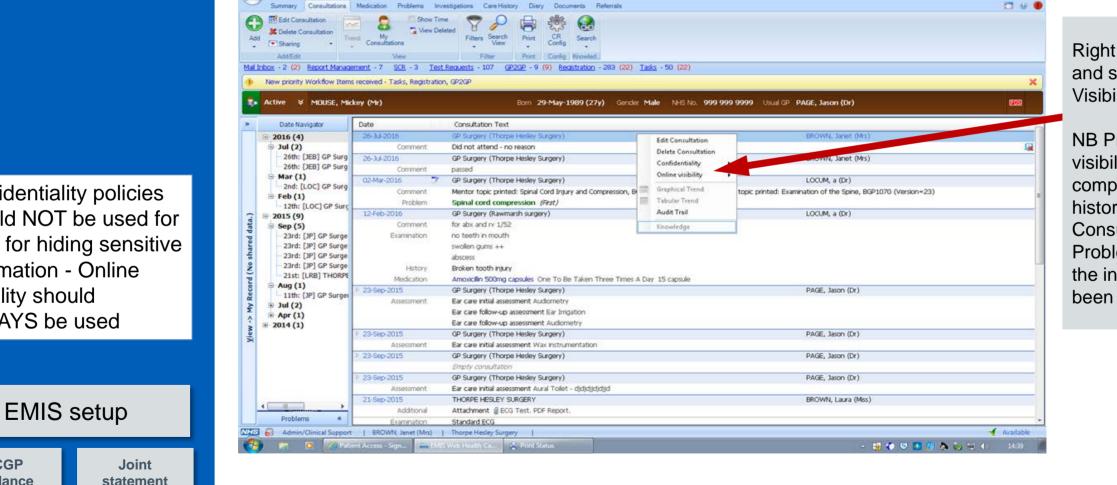
Where this information is contained within a record it must be redacted. The process for redacting information is different for each GP clinical system.

Confidentiality policies should NOT be used for hiding sensitive information



#### **EMIS** Web

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



**Redacting Sensitive Information from Online View** 

EMIS Web Health Care System - THORPE HESLEY SURGERY - 6861

Right Click on Entry, and select Online Visibility.

a x

**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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Microtest Evolution

Microtest setup



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







Continued

#### Redaction

#### TPP SystmOne (1)

SystmOne GP: RENWICK, Kay ('Other' Community Health Service) at NHS England PFS Practice - Patient Record o X Patient Appointments Reporting Audit Setup Links Clinical Tools Workflow User System Help 02 Nov 1979 (36 v) F A N Other Q 1 Anytown, Anywhere Search Task Appts Home 000000000 GMS 🖬 🖗 🎬 🎯 🚳 Ø 🖸 🖉 Start Consultation Next Event Event Details Pathology Drawing Auto-Consultation Settings 间 🖉 🤻 💞 📅 🧑 📓 🙎 New Journal Clinical Administrative - X 📋 🗪 👧 Ŧ 🖉 Ŧ - 7 7 7 🖉 🚽 🙀 + 🖉 🎯 🗑 Custom Filter R Patient Home Select here to hide Major Active Problems Show in the online record 0 Minor Active Problems Do not show in the online record or unhide Inactive Problems Summary & Family History information -Tue 30 Sep 2014 00:00 - Surgery: ANDERSON, AM (Dr) (GP Senior Partner) Ø Quick Glance Seasonal influenza vaccination contraindicated (XaZ0j) (Ongoing Episode) ΔΔ New Journal Mon 09 Feb 2015 00:00 - Surgery: ANDERSON, AM (Dr) (GP Senior Partner) Ø Read Code Journal (19) Serum fasting total cholesterol (XaLux) 6 mmol/l (Ongoing Episode) **NB** Applying Medication Repeat Templates Fri 26 Jun 2015 09:14 - Surgery: Unknown Staff Member **Privacy Settings** Current Home Address: Mulberry Cottage, Fore Lane, Bicker, Boston PE20 3AZ Unknown Vaccinations Communications & Letters "X" will not hide 19:03 - Surgery: RENWICK, Kay ('Other' Community Health Service) Recalls Online message from RENWICK, Kay to RAJA, Anantarjot (Mrs): Cervical Screening The practice has granted RAJA, Anantarjot (Mrs) access to the following services: from online view Detailed Coded Record Reminders Online message from RENWICK, Kay to RAJA, Anantarjot (Mrs): Sensitivities & Allergies The practice has removed RAJA, Anantarjot (Mrs)'s access to the following services Pathology & Radiology Detailed Coded Record Numeric Results Identity Verification Vouching (personal) by RENWICK, Kay Cause of Death Recorded during online services registration Thu 03 Dec 2015 19:03 - Surgery: RENWICK, Kay ('Other' Community Health Service) SystmOne Incoming Record Sharing consent changed to: Yes SystmOne Outgoing Record Sharing consent changed to: Yes Thu 10 Dec 2015 11:29 - Surgery: RENWICK, Kay ('Other' Community Health Service) 22 Journal Entries 💌 📊 0 0 0 0 0 🖺 0 0 🔒 0 0 0 0 0 🕑 0 0 0 😰 0 0 4 🍞 🤱 Changed Search features 11:37 **H** []] е W Ø ^ 👯 🗐 ଏ× =

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

#### **TPP** setup





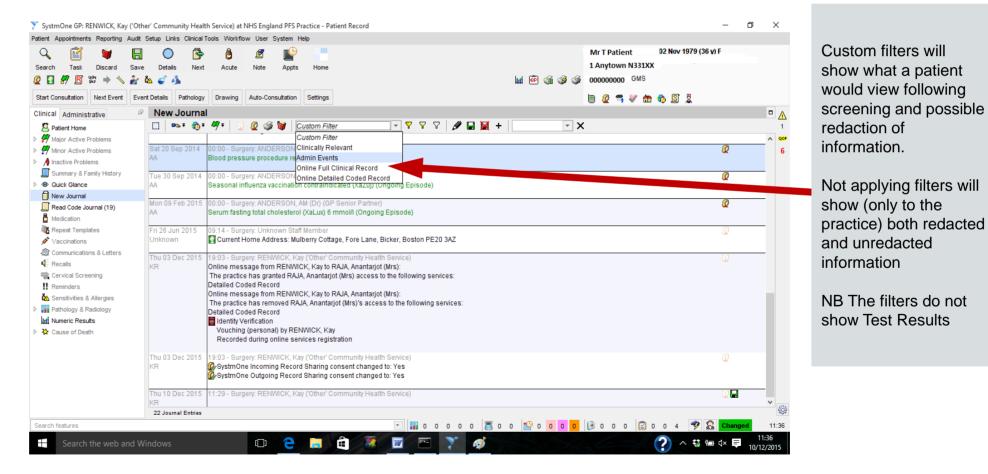
here



TPP SystmOne (2)

#### How to review what the patient will see

New Journal – TPP Patient Record >Clinical Tab>New Journal



#### **TPP** setup

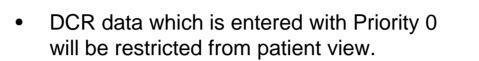




### NHS

#### Redaction

#### Vision



• The DCR Review App allows this to be reviewed for each patient

Allo	w patient access
Not	e: Summary Care Record (SCR) avalent settings are not affected by ings here.
	√ Al
	Problems
	V Diagnosis
	✓ Medications
	✓ Risks & Warnings
	V Procedures
4	✓ Investigations
	✓ Examinations
	V Events & Recalls
Imp	ortant Information
	ites to patient's DCR may take > 24 hours
	ty zero items will not be shown or to the patient

#### Vision setup







NHS

## Further information

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

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

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

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A toolkit to support the provision of GP online services

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Registering new applicants for Patient Online	$\oplus$
Record access	$\oplus$
Clinical care	$\oplus$
Clinical exemplar 1: diabetes mellitus	$\oplus$
Clinical exemplar 2: end of life care	$\oplus$
Clinical exemplar 3: dementia	$\oplus$
Clinical exemplar 4: inflammatory arthritis	$\oplus$
Clinical exemplar 5: mental health	$\oplus$
Acknowledgements	$\oplus$



