Practice guidance

Offering patients prospective record access

Version 1.2
09 December 2019
Ref: 000946

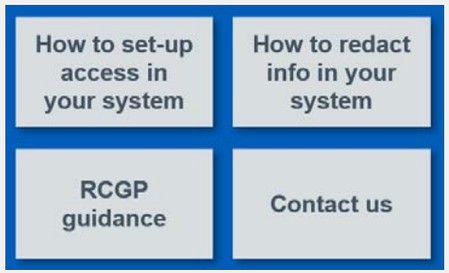
Click here to go to a fully accessible version of this guide

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

Click here to download the full RCGP guidance on coercion

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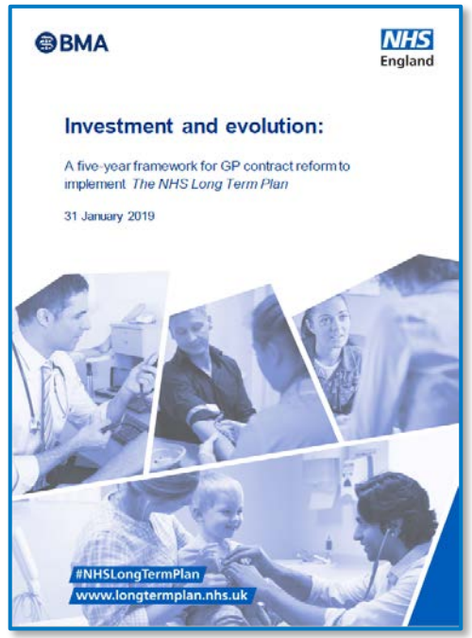
Contents

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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Existing contract commitments

Definitions

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.

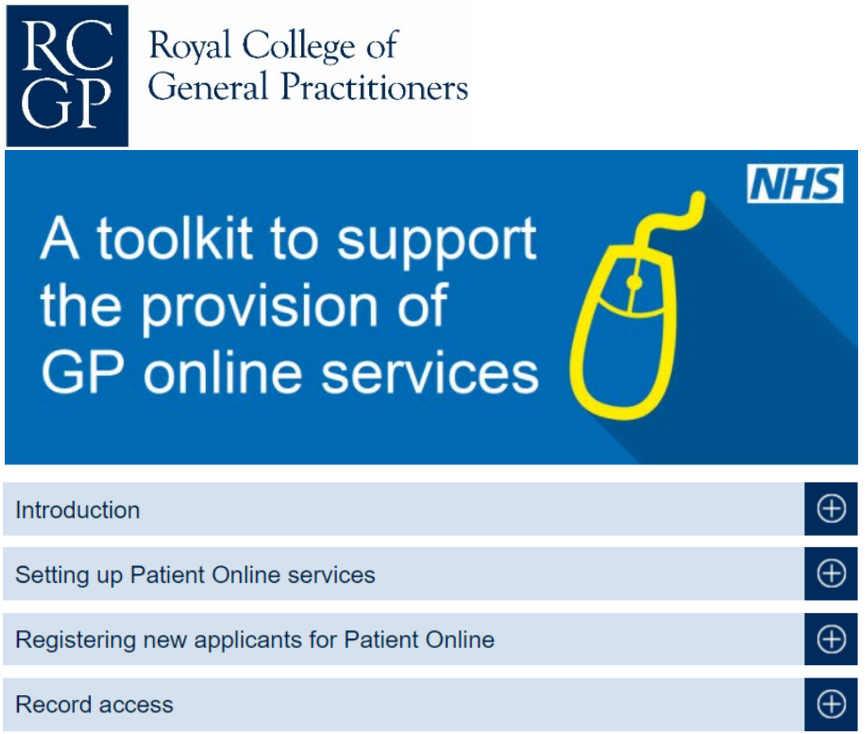
Clinical and patient safety

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.

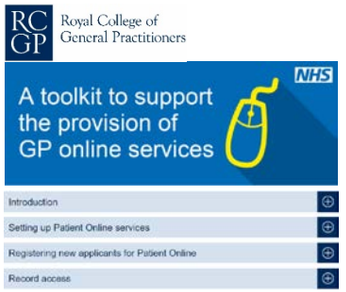


Extract from the RCGP guidance on sensitive information

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

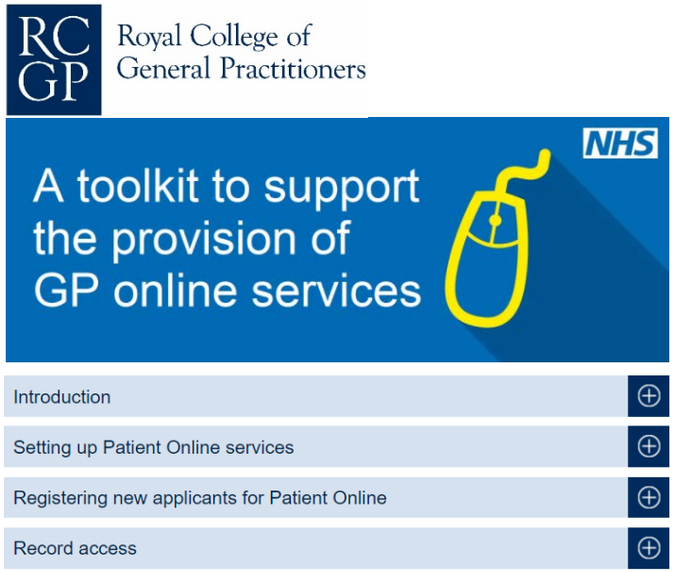
Patients perceived to be at risk of coercion

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

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 SystmOne	✓	✓	✓
Vision	✓	✗	✗

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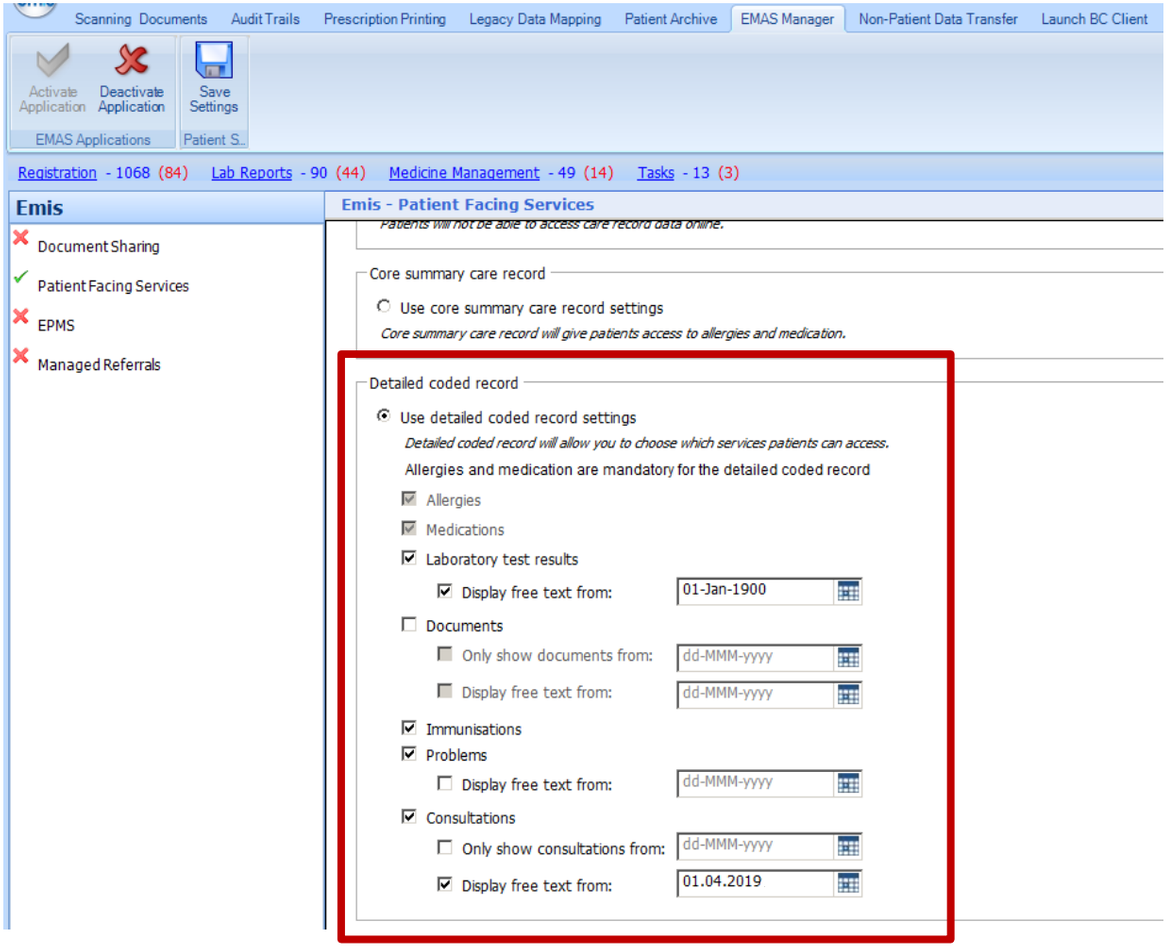
Prospective full record only

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.



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

EMIS redaction

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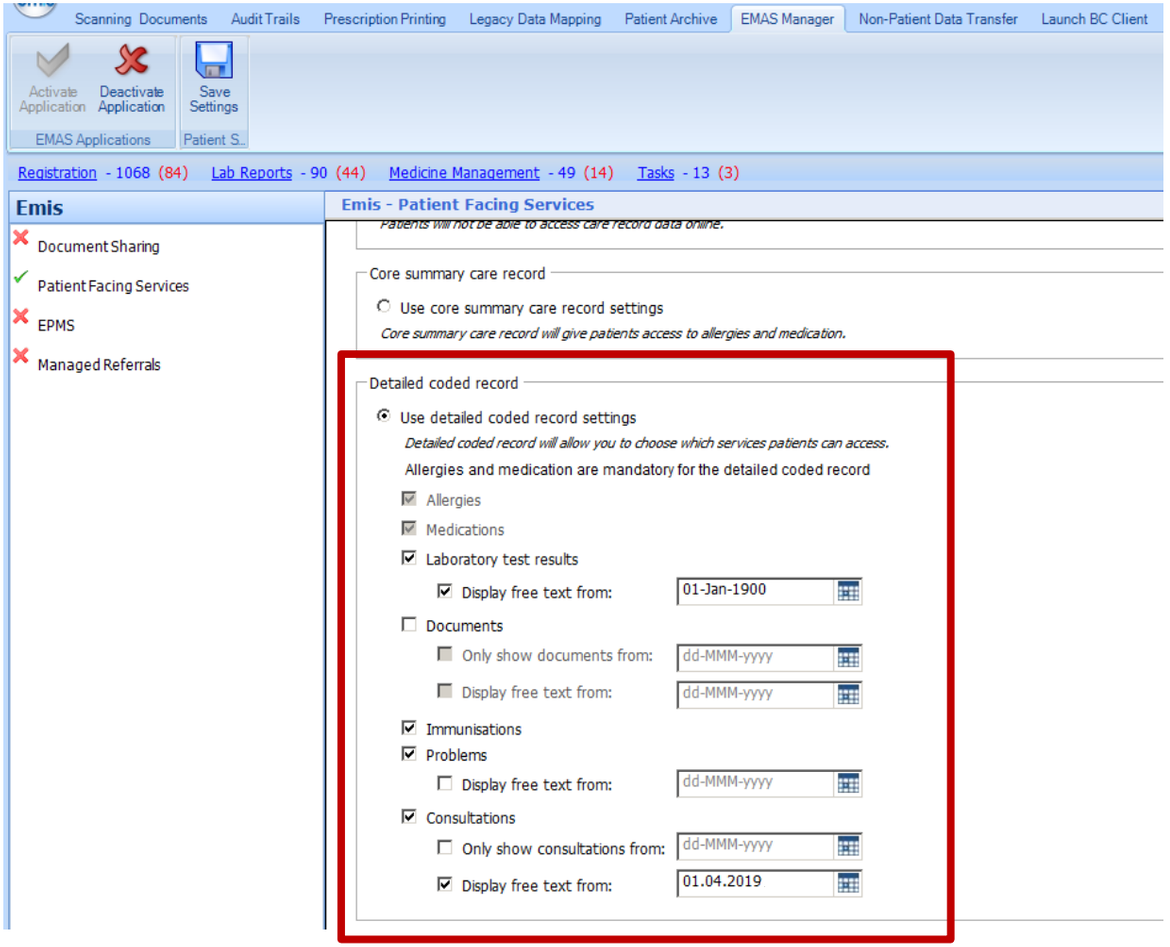
Prospective full record and retrospective detailed coded record

Patients will see their detailed coded record (DCR), plus
- Laboratory test results
- Immunisations
- Problems
- Consultations

from the date entered.



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.

EMIS redaction

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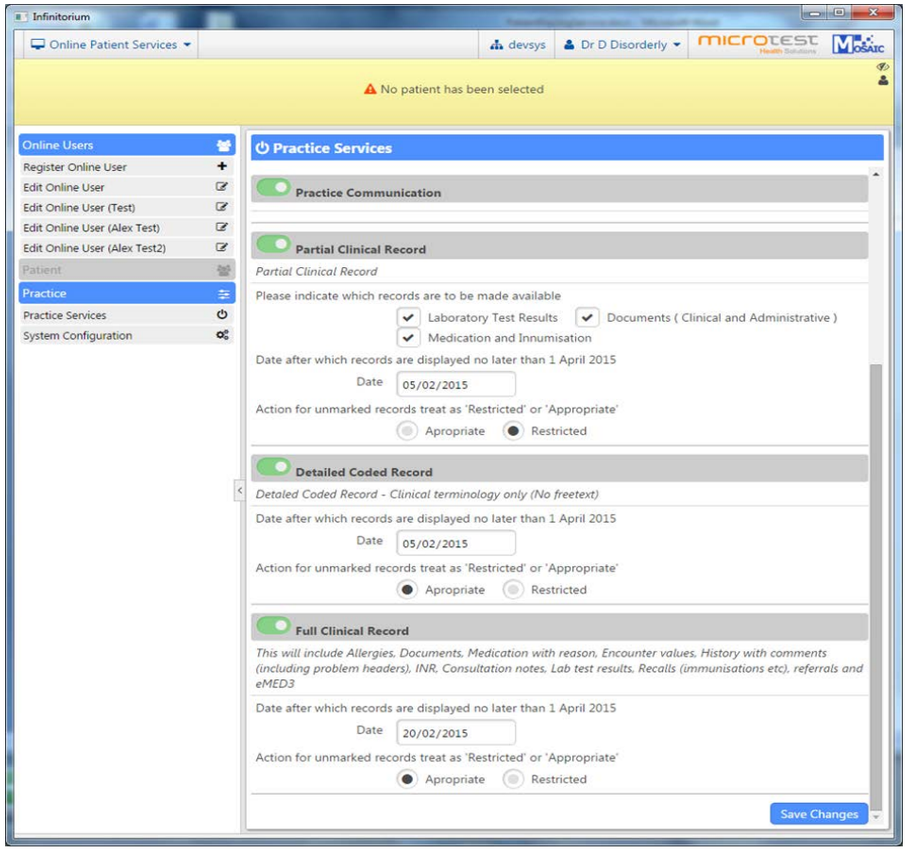
Microtest Evolution



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

Microtest redaction

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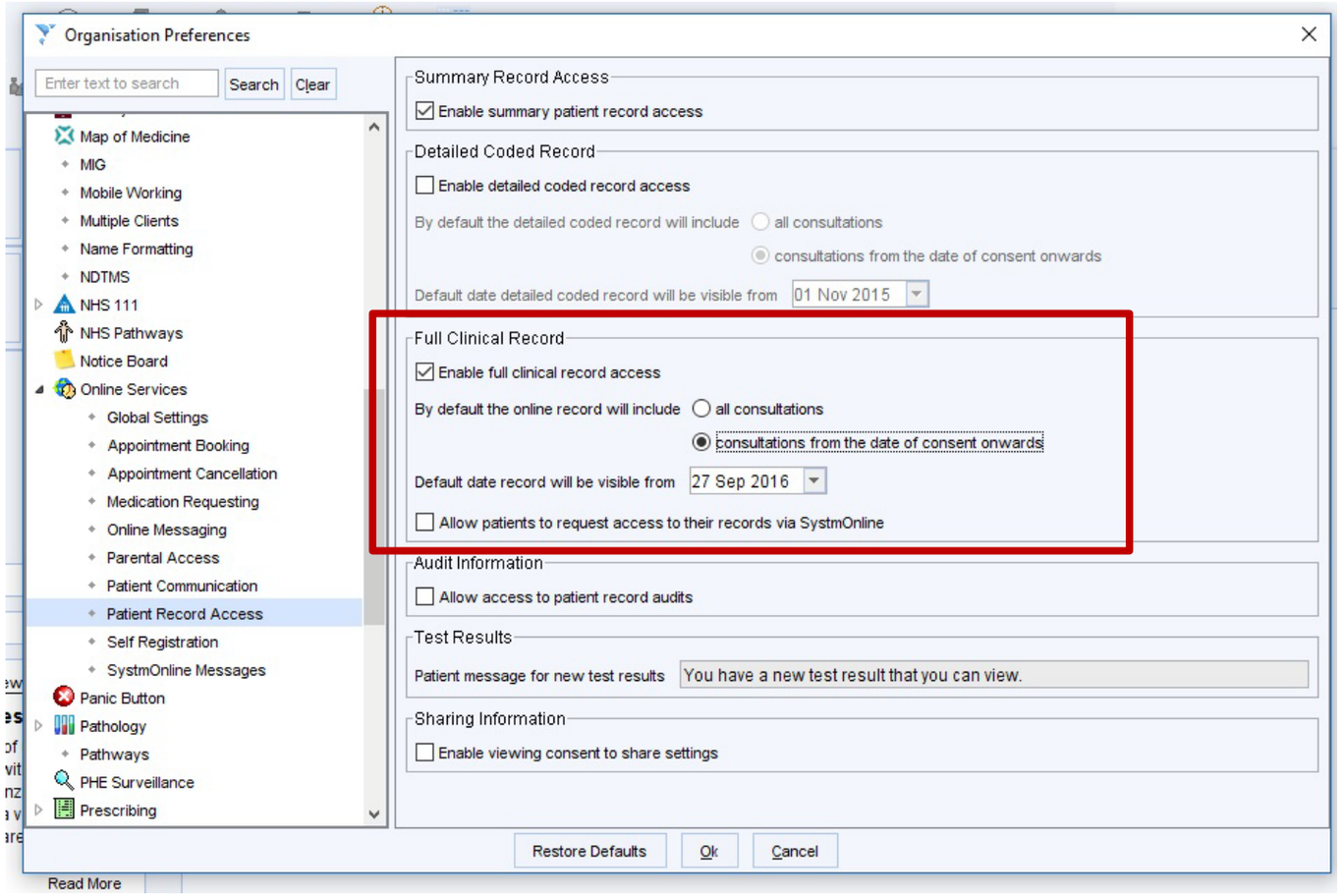
Enabling prospective access in your clinical system

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.



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.

TPP redaction

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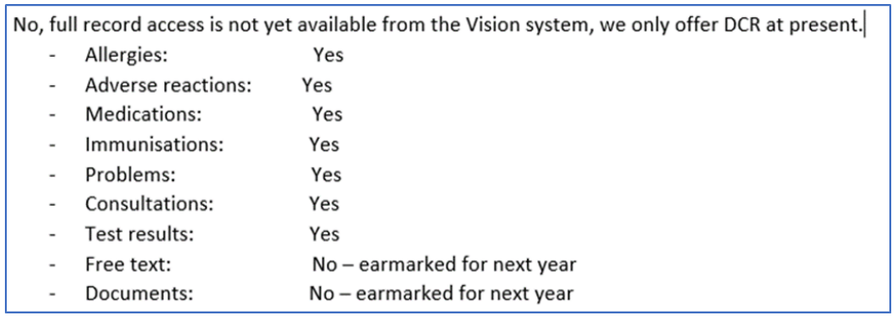
At present, Vision does not provide the functionality to offer prospective record access

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.


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)

Vision redaction

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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

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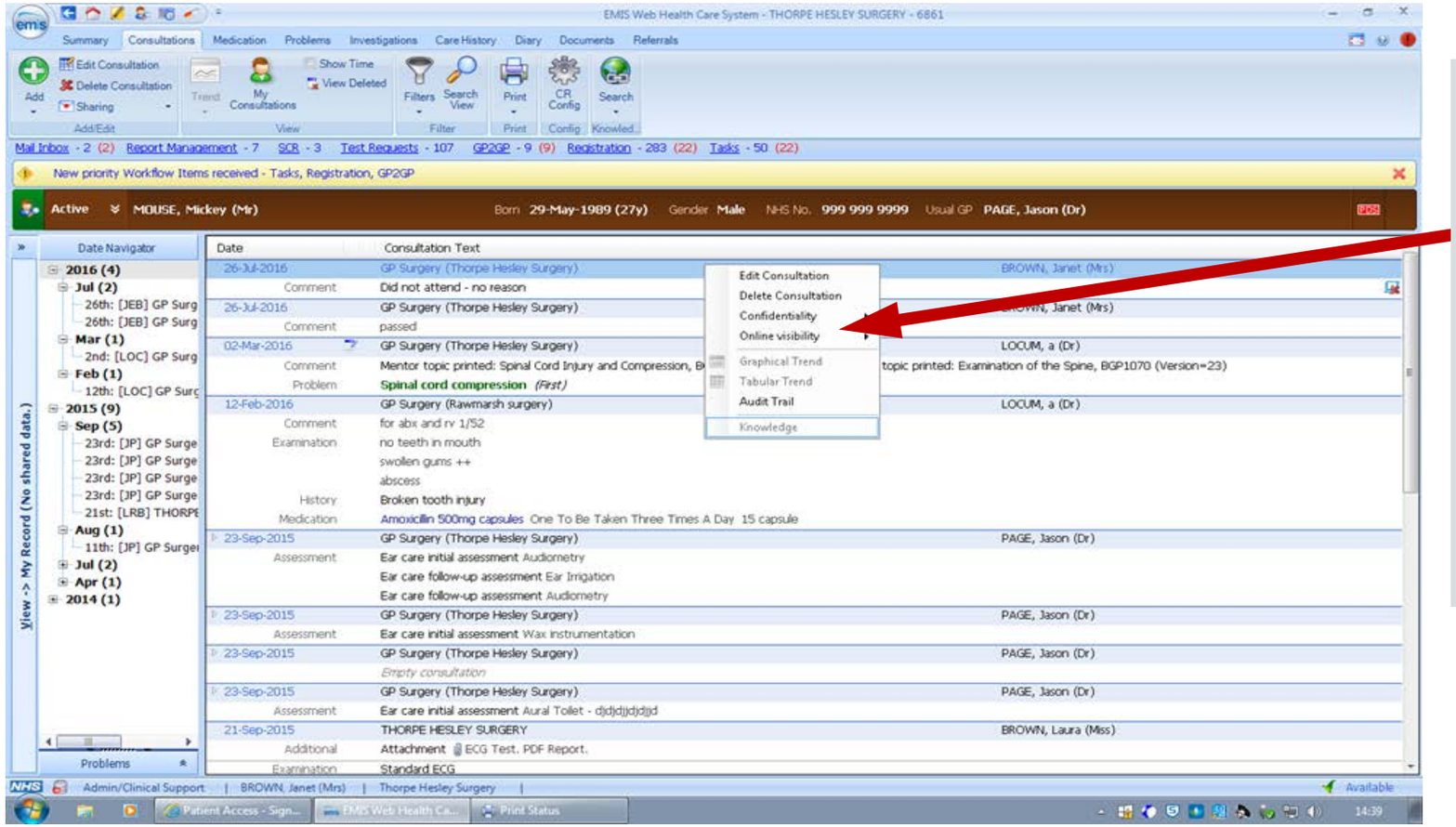
Redacting Sensitive Information from Online View



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

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

EMIS setup

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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

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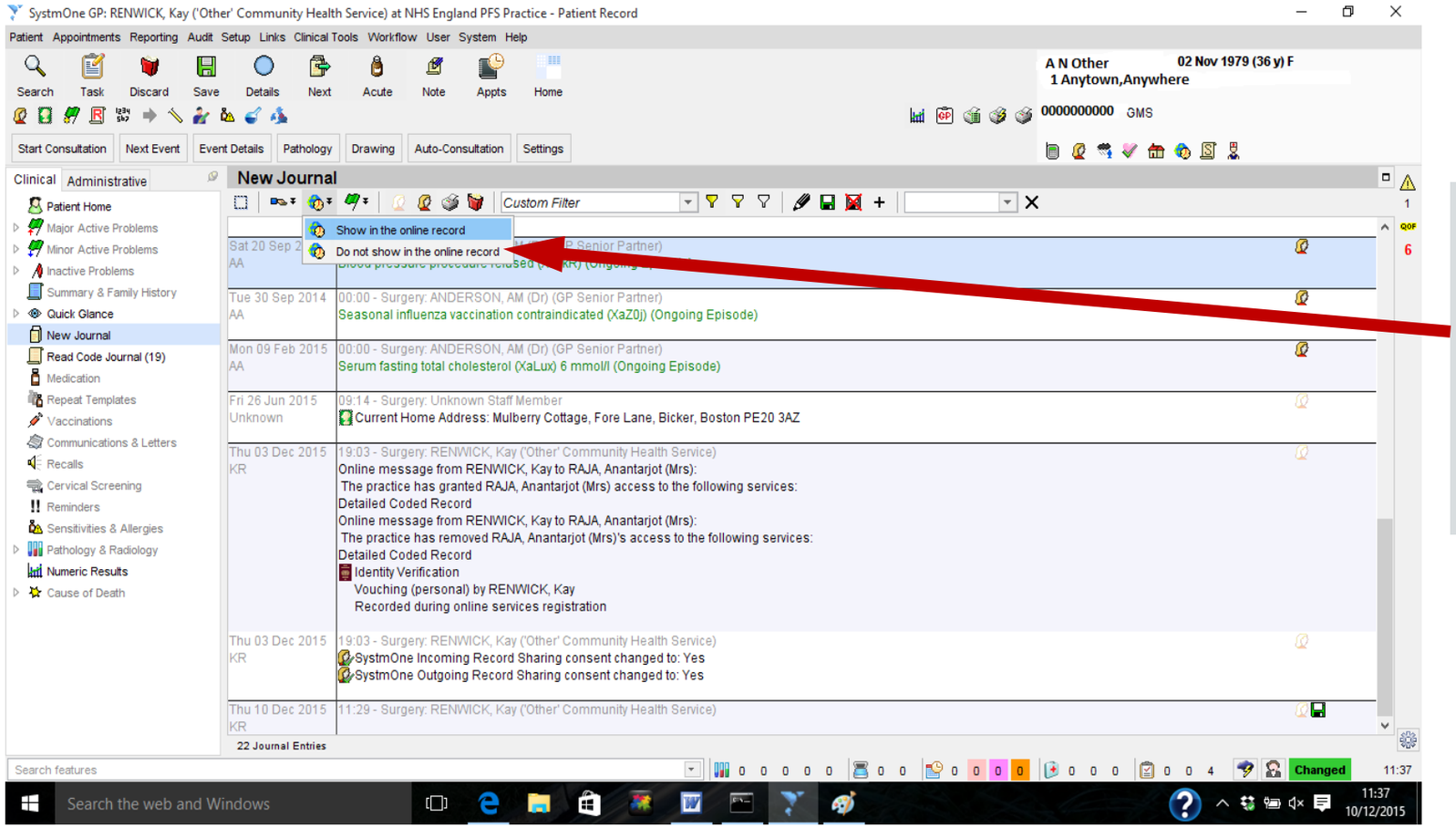
Redact information from the Patient New Journal View – this can be selected and deselected here



Select here to hide or unhide information –

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

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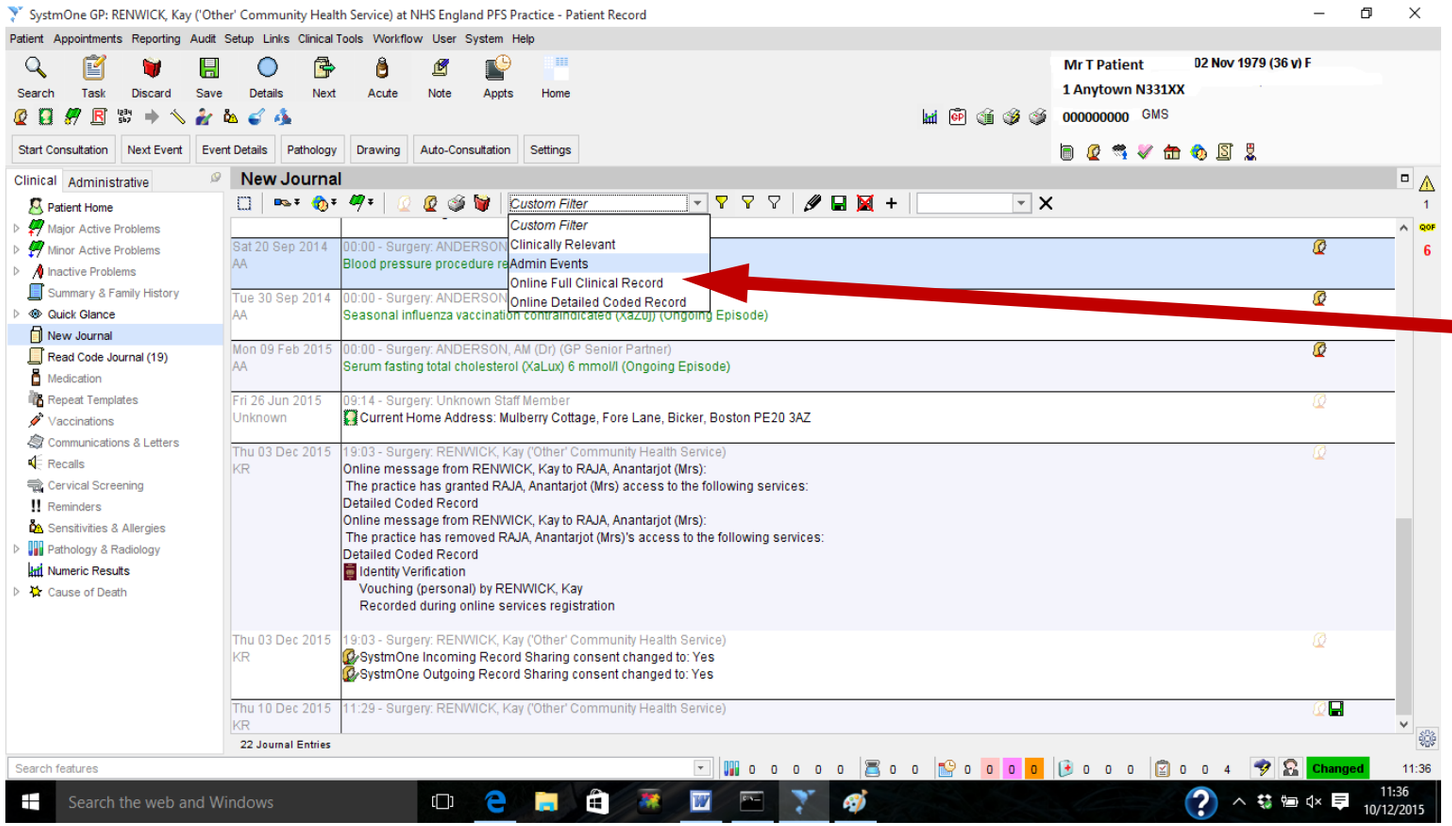
How to review what the patient will see

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



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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- 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