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To:
- ICB:
  - medical directors
  - chief nurses
- Acute, mental health and community trust:
  - medical directors
  - chief nurses
- NHS England regional medical directors

NHS England
Wellington House
133-155 Waterloo Road
London
SE1 8UG

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Dear Colleagues

Offering patients access to their new (prospective) health information

In line with the NHS Long Term Plan and the Data Saves Lives strategy, the NHS is working to make it easier for patients to digitally access their health information in their general practice records.

Starting from next week, GP IT systems at practices across the country are being reconfigured in a phased rollout to allow new health record entries, including appointment details, test results and clinical letters, to be made visible to patients automatically. You can read the latest update on the NHSD website.

It means most patients aged 16 and over with online accounts (such as through the NHS App or other patient online apps) will automatically be able to view new (prospective) entries in their GP clinical record. **This will include information sent into general practice from secondary care and other providers to be added into the patient record, such as outpatient clinic letters, discharge summaries and other correspondence.** GP practices have already been providing this access to over 1.2 million people, and this change will allow all online users, who can safely have this access, to benefit.

The changes support the legal rights of patients to be able to access their health record and, as the NHS Constitution pledges that all clinical correspondence should be shared with the patient, these will be visible by default for most patients. The measures will apply prospectively, so previous correspondence will not automatically be made accessible (patients continue to have the right to make a Subject Access Request for historic data).

In exceptional circumstances, general practice can redact whole items that should not be disclosed, including “where the disclosure of or access to the information is likely to cause serious harm to the physical or mental health of the individual or another person”. If a clinician writing a letter feels a specific piece of correspondence meets this threshold, they should mark the letter clearly and prominently in this way e.g. “not for disclosure to patient”. It is not possible to redact parts of letters or other correspondence, only the whole item can be redacted.

Similarly, if the clinician believes the patient cannot keep their online access to records secure, or the patient expresses concern about being able to view their records online, then the clinician should inform general practice to not disclose the letter and to consider reviewing any access that is being provided.

It is important that all staff who send information into general practice are aware of this change. In summary, when sending any correspondence to a general practice that will be filed into the GP record, staff sending the correspondence should now be considering the following:

- sensitive test results – if you do not wish your patient to view results or diagnosis that you have carried out until you have had the opportunity to speak to them in person, please either wait until you have spoken to the patient or mark your correspondence clearly and prominently that it is not for disclosure to the patient.

- abnormal test results requiring no action - whilst no action may be required from a clinical point of view, seeing ‘abnormal’ results may cause distress to the patients. Therefore, please include an appropriate explanation that the patient will understand.

- safeguarding or third-party information – if a communication being sent to general practice risks causing harm if viewed by the patient, please make this known to primary care colleagues by marking clearly and prominently e.g. not for disclosure to patient, stating the reason why.

- language and medical terminology - please be aware that your communication could be read by your patient, so it is recommended that every care is taken to record clinical correspondence in a way that both conveys the necessary detail to other professionals and considers the impact of receiving such a letter for patients.

- access to GP records does not replace the current practice of communicating and sending letters directly to patients, staff should continue to follow their local processes

Some services do not automatically send correspondence to general practice except when the patient has consented to do so (for example sexual health or HIV clinics). In

cases where there is consent, health professionals should inform patients that it will automatically be available to view by the patient as part of the general practice record.

If you have access to directly enter information into the general practice clinical system, then please familiarise yourself with the information and resources that have been provided for general practice staff.

For any questions or for further guidance, please email england.nhseimplementation@nhs.net

Yours sincerely,

Vin Diwakar
Medical Director for Secondary Care
Medical Director for Transformation
NHS England

Dr Kiren Collison
Deputy Medical Director for Primary Care
NHS England