

GP Online Services Guidance

*Working with automatic record access*

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Introduction

This guidance document supports practices with ways of working with automatic record access. The Toolkit guidance “Practice Preparations for Automatic Record Access” covers the actions the practice is recommended to take before the access is enabled. This guidance is on patient and clinical safety and information governance. The clinical value of online record access is covered thoroughly in the “Clinical Benefits” section of the Toolkit with relevant clinical scenarios to illustrate how to achieve the clinical benefits of record access to patients.

1. Prioritise safe, high quality records

At the start of automatic record access, approximately 45% of patients in England aged 16 years and over will have access to everything added to their records in the future as soon as they are filed. Anyone else may obtain online access to their GP record automatically if they use an NHS Login or patient facing services apps or web portals such as the NHS App, Airmid or Evergreen.

It is important to bear in mind the impact of record access when creating or amending patient records. Avoid ambiguous information, abbreviations, and euphemisms whenever possible and code data accurately.

General practice must consider whether disclosure would be likely to cause serious harm to the physical or mental health of the data subject or another individual (Paragraph 2(1) of Schedule 3, Part 2 of the DPA 2018). British Medical Association (BMA) guidance on the Serious Harm Test states circumstances in which information may be withheld on the grounds of serious harm are extremely rare. Not every patient who has safeguarding concerns is at risk of serious harm from access to their record information.

If potentially harmful information cannot be redacted safely, it may be necessary to switch off record access (see below). Remember that the absence of expected entries in the record or the withdrawal of access can be a strong signal that something harmful has been redacted. This may be particularly challenging for patients being challenged to share their online record access.

Safe, high-quality records are a standard that applies to everyone creating records in the practice and it should be the norm for service delivery.

Ref: There is more information on these topics in the guidance on “Data Quality for Record Access” and “Managing Potentially Harmful Information” in the Toolkit.

1. Consider patients’ literacy and numerical skills and digital poverty

Be aware of patients’ literacy and numerical skills. There is an existing professional responsibility to ensure that records are legible and patients understand and are informed about the care that is being provided. Clinicians will, therefore, need to write notes bearing in mind that patients may see them. People receiving health information often benefit from receiving spoken information in the consultation rather than relying on written information in the online record.

Ref: Good Things Foundation’s Learn My Way website. - https://www.learnmyway.com/courses/gp-services-online-a-how-to-guide/ (accessed 22 August 2022)

Ref: Digital Poverty Alliance, UK Digital Poverty - https://digitalpovertyalliance.org/wp-content/uploads/2021/11/UK-Digital-Poverty-Evidence-Interim-Review-v1.016182.pdf (accessed 22 August 2022)

1. Minimise the information needing redaction from online view

You can minimise the amount of information that needs to be redacted from online view by explaining what is in their records and what it means to them personally. This will help to alleviate their concerns about their health record and is most helpful for people with complex multi-morbidity or a poor understanding of their health.

Patients should feel confident that they can report questions to the practice about omissions, mistakes, or entries that they find upsetting or with which they disagree. The practice is under no obligation to change the record unless they think that the change is correct. If the practice declines to make a change at the request of a patient, it is reasonable to add a note that the patient asked for the entry to be changed or added.

Patients may react strongly to something in their notes that they find challenging or stigmatizing.

Ref: NICE offers guidance on how to manage violence and aggressive patients (Guideline NG10) - https://www.nice.org.uk/guidance/ng10 (accessed 22 August 2022)

Ref: <https://transform.england.nhs.uk/information-governance/guidance/amending-patient-and-service-user-records/>

Ref: There is more information about the right of patients under the General Data Protection Regulation 2018 to have personal data rectified at https://ico.org.uk/for-organisations/guide-to-the-general-data-protection-regulation-gdpr/individual-rights/right-to-rectification/ (accessed 22 August 2022)

1. Always redact potentially harmful information

It is important to redact potentially harmful or confidential third-party information from online view as it is entered in the record and before the information is filed. Do not save the task for later as it could be immediately visible as soon as it is entered into the record. Any patient may acquire online access at any time, so the safety of the record has to be considered in every consultation and every time information is entered in anyone’s record. Remember redaction systems cannot redact all potentially harmful information, and even the absence of redacted information such as a consultation note may imply that information has been redacted from online view.

Ref: There is more information on these topics in the guidance on “Managing Potentially Harmful Information” in the Toolkit.

1. Always redact confidential third-party information

Information received from a third-party may include important information about safeguarding risks that must be recorded in the notes but may cause harm or distress if it is viewed online. Recording confidential information received from a third-party or about a third-partymay also result in harm or breach the confidentiality to the third-party. Third-party information may be information recorded by mistake in the wrong patient’s record or family history information provided by a relative.

There are four steps that you can take to record the information:

* Check if the third-party is willing to have their identity explicitly recorded.
* Ensure that the third-party understands and accepts that the patient may be able to infer the source of the information and the third-party referred to.
* Obtain and record the consent of the third-party for the patient to have access to the information before recording the information.
* If necessary, redact confidential information so that the information is not visible to the patient accessing their health record.

The third-party may decide to withhold the information or make it clear that they do not wish it to appear on the patient’s record.

Ref: The Caldicott Review, *Information to Share or Not to Share*, 2013. section 3.9 has information on managing third party data - https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment\_data/file/192572/2900774\_InfoGovernance\_accv2.pdf (accessed 22 August 2022)

Ref: Medical Defence Union, Redacting Third-Party Information from Notes - https://www.themdu.com/guidance-and-advice/guides/redacting-third-party-information-from-notes (accessed 22 August 2022)

1. Temporarily redact adverse information

Some informationsuch as unexpected results in a laboratory report or a letter, can be temporarily redacted until there has been an opportunity to explain it to the patient. It may be possible to avoid completely redacting a document by asking whoever sent the document to send a safe version. A safe version may simply be a version that can be addressed to the patient without the harmful or upsetting information, clearly the original will have to be maintained.

1. Avoid failure to record potentially harmful information

Do not be afraid to record potentially harmful entries in the record when they are appropriate. A record of suspicions of a serious diagnosis or a safeguarding risk may be very useful in the future care of a patient. Failure to record these thoughts can lead to serious harm to the patient. Use words carefully, explain opinions and redact information, which may include a whole consultation note, if necessary.

1. Discuss information risks with patients

Communicate pro-actively with individual patients about information risks and safeguarding concerns. This does not just apply to consultations with obviously vulnerable patients. Make use of opportunities in consultations to find out if the patient is vulnerable to safeguarding risks and to being coerced to share their access. Discuss what you will record in the notes to avoid unexpected information or misunderstanding for the patient when information is seen online, or harm from third-parties who gain access to the record.

Especially when documenting any disclosures from a patient about abuse or other sensitive information, agree with the patient whether it is appropriate and/or safe for the information to be visible online.

This is not just about safeguarding risk. Discuss the possible implications of suspected diagnoses and the reasons for referrals and investigations so that patients are prepared for what they may see online.

Explain about data redaction and reasons for blocking or switching off record access if it is relevant. It may be possible to avoid redacting information if discussion with the patient shows that there is no risk.

Ref: Advice for GPs on asking about and discussing safeguarding risk from SafeLives - https://safelives.org.uk/sites/default/files/resources/Pathfinder%20GP%20practice%20briefing.pdf (accessed 22 August 2022)

1. Discuss online record security and coercion

Consider if patients can keep their online access secure. Ask timely questions to test their understanding of the importance and their ability to understand how to keep their access safe:

* Have you read and understood the information leaflet provided by the practice?
* Do you know how to secure your online access to your GP practice and record?
* Do you need any help to keep the record that you see or download secure?
* If you choose to share your information with anyone else, do you know that it is at your own risk?
* If you suspect that your account has been accessed by someone without your agreement, are you able to change your access login credentials and do you know to contact the practice as soon as possible?
* If you see information in your record that is not about you or is inaccurate, do you know to contact the practice as soon as possible?
* If you think that you may come under pressure to give access to someone else unwillingly, do you know to contact the practice as soon as possible?

Ref: *“*RCGP Online Record Access Application Form” in the Toolkit

1. Use inbox auto-file functions with care

Consider switching off the inbox auto-file functions for reports and documents if they make information available to the patient before it has been reviewed by a clinician who knows the patient.

1. Switch off online record access if the risk is high

Consider switching off online record accesswhen potentially harmful information cannot be redacted and/or the patient may be being coerced into access to their record. When possible, discuss this with the patient first to see if switching off the record can be avoided. Switching off access may indicate to an abuser that there is data in the record that is being redacted from them. Current online record access must be switched off in the IT/clinical system’s GP Online Services controls.

Remember that switching off record access will not affect the patient’s ability to use online repeat prescription or appointment services. It may be important to also consider disabling these services if they create a risk of serious harm.

Ref: The use of SNOMED CT terms for record access is considered in more detail in the “SNOMED Terms that Control Automatic Record Access” guidance in the Toolkit

1. When patients move to a new practice

Patients moving to a new practice will lose the record access they had at their last practice, and it will re-start from the date they registered with their new practice. Registration is an opportunity to ensure they know how to keep their record access secure and to check if they are at risk of coercion to share their record. Consider whether to restrict automatic record access until the new patients’ historic records have been reviewed and the practice is satisfied with their decision to allow or restrict access.

Ref: Registering new practice patients and automatic record access is discussed in the “SNOMED Terms that Control Automatic Record Access” and summarized in the “Flowchart - New Patient Registration and Auto Access” in the Toolkit.

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| Checklist of ways of working with automatic record access to help ensure patient safety |
|  | Almost 50% of patients can see their record.  This is a list of ways of working to support patient safety in the context of record access. | Check |
| 1 | **Prioritise safety, always creating high-quality records with the impact of online access in mind**.  Establish a data quality policy.  |   |
| 2 | **Be aware of patients’ literacy and numerical skills.**  Create easy records for patients to understand, at an appropriate level for most people, using language chosen for patients to read.  |   |
| 3 | **Minimise the information that needs to be redacted and alleviate their concerns about their health record** by explaining what is in their records and what it means to them personally. |   |
| 4 | **Redact potentially harmful pieces of information** from online view before they are filed in the record.  The safety of the record must be considered in every consultation and every time information is filed.  |   |
| 5 | **Redact confidential information received from a third-party or about a third-party,** including family history or information recorded by mistake in the wrong patient’s record.   |   |
| 6 | **Some information can be temporarily redacted** until there has been an opportunity to explain it to the patient.    |   |
| 7 | **Do not avoid recording important entries in the record**, especially suspicions of a serious diagnosis or a safeguarding risk.  |   |
| 8 | **Communicate pro-actively with individual patients about information risks**, e.g.suspected diagnoses, the reasons for referrals and investigations and consultations with vulnerable patients.    |   |
| 9 | **Consider if patients can keep their online access secure.**  Ask timely questions to test their understanding of the importance and their ability to understand how to keep their access safe.  |   |
| 10 | **Consider avoid using auto-file functionality** for laboratory results or documents in your inbox if the patient may see harmful information.  |   |
| 11 | **Consider switching off online record access if the risk to the patient is high,** and potentially harmful information harm cannot be completely redacted.  |   |
| 12 | **New patient** registration is an opportunity to ensure patients know how to keep their record access secure and to check if they are at risk of coercion to share their record.  |   |