



Royal College of
General Practitioners

Patient Online

Mental Health

RCGP Webinar, 29th January 2018



Royal College of
General Practitioners

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Person-Centred Care

“Two years ago I was at a stage in my understanding ... that was so limited it placed the entire weight of responsibility for my care on the doctors treating my condition. **I was a passenger, along for the ride.**

Access to my medical data ... in short I am no longer a passenger, I am now very much **part of the management team** for the effective treatment of my condition.”

O.C. Manchester Oct 2017



Mental Health Learning Objectives

1. Use Patient Online safely and effectively
2. Health literacy and digital inclusion
3. Coded records for mental health conditions
4. Managing test results for online access
5. Patient Online in care and support planning



Webinar Programme

1. Introduction to Patient Online and the new toolkit
2. Supports mental health conditions.
3. Role in comorbid long term conditions
4. Special precautions for patient with serious mental illness
5. Scenario
6. Questions

GP Contractual Requirement in England

Book and cancel appointments

Order repeat medication

Detailed care record

**Contractual requirement
for GPs in England**

To offer and provide ...

... unless it could cause
harm to the patient



Demographics



Immunisations



Procedure codes
(medical or surgical)
and codes in consultation
(signs, symptoms)



Allergies/adverse
reactions



Results
(numerical values
and normal range)



Codes showing referral
made or letters received
(no attachments)



Medication
(dose, quantity and
last issued date)



Values (BP, PEFR)



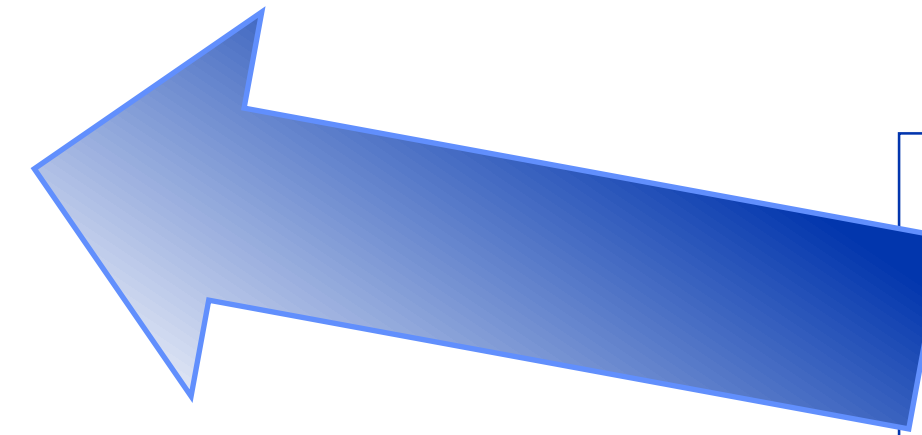
Problems/diagnoses



Other codes
(ethnicity, QOF)

GP Contractual Requirement in England











- Book and cancel appointments
- Order repeat medication
- Detailed care record
- Extended record access (all or part)



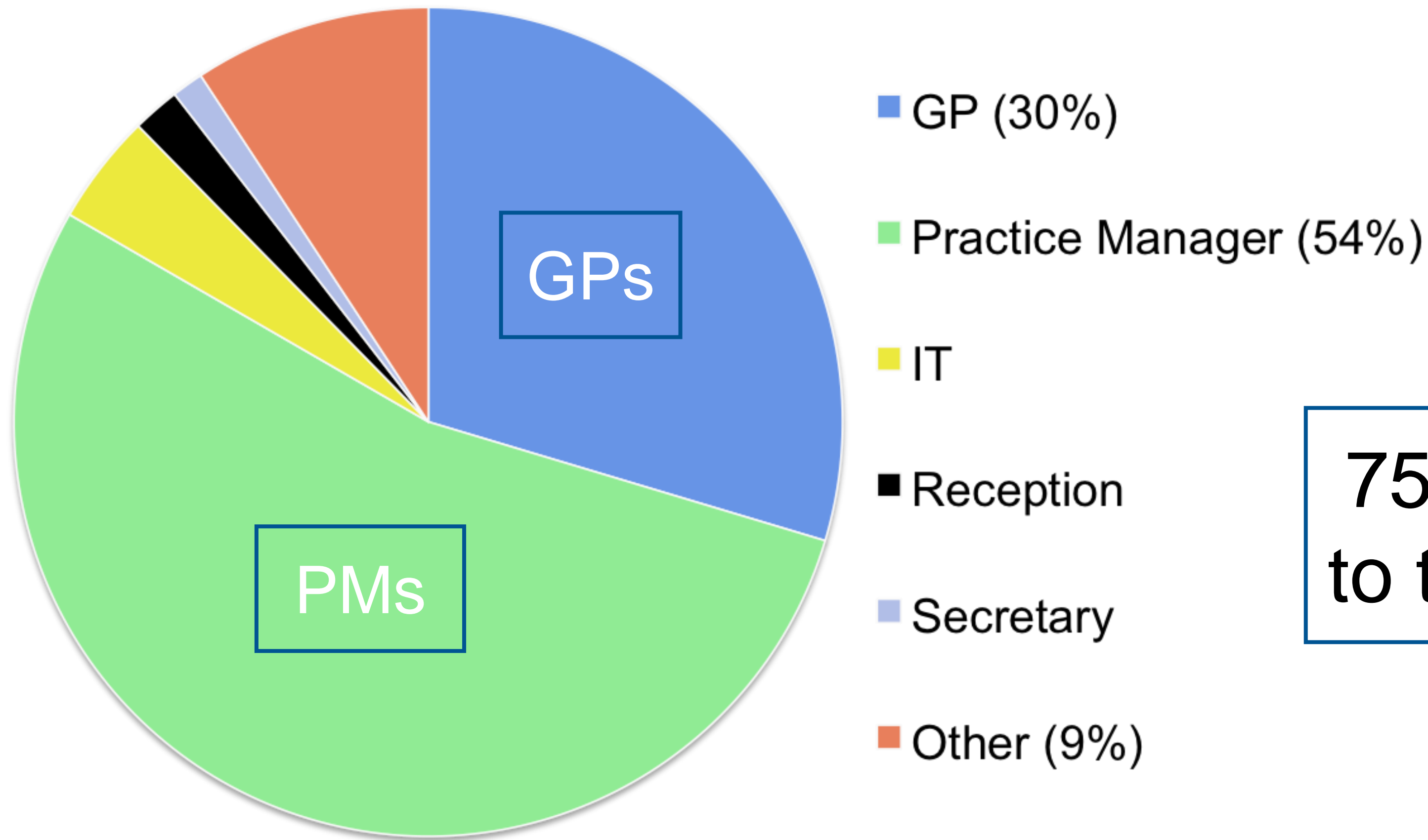
Contractual requirement for GPs in England

To offer and provide ...

... unless it could cause harm to the patient

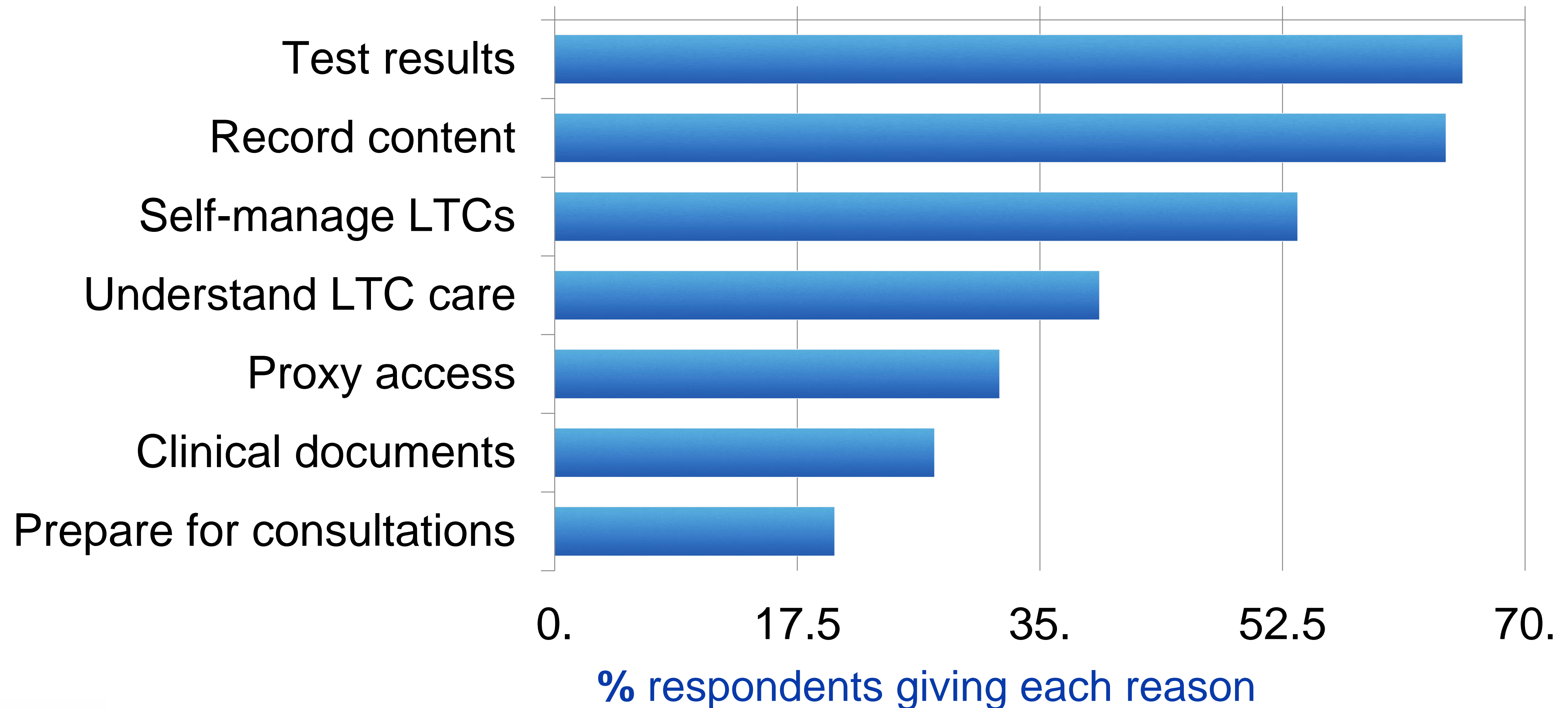
 Demographics	 Immunisations	 Procedure codes (medical or surgical) and codes in consultation (signs, symptoms)
 Allergies/adverse reactions	 Results (numerical values and normal range)	 Codes showing referral made or letters received (no attachments)
 Medication (dose, quantity and last issued date)	 Values (BP, PEFR)	 Other codes (ethnicity, QOF)
	 Problems/diagnoses	

RCGP Survey, August-Sept 2016 (n=211)



75% offering online access to the detailed coded record

Reasons to recommended record access



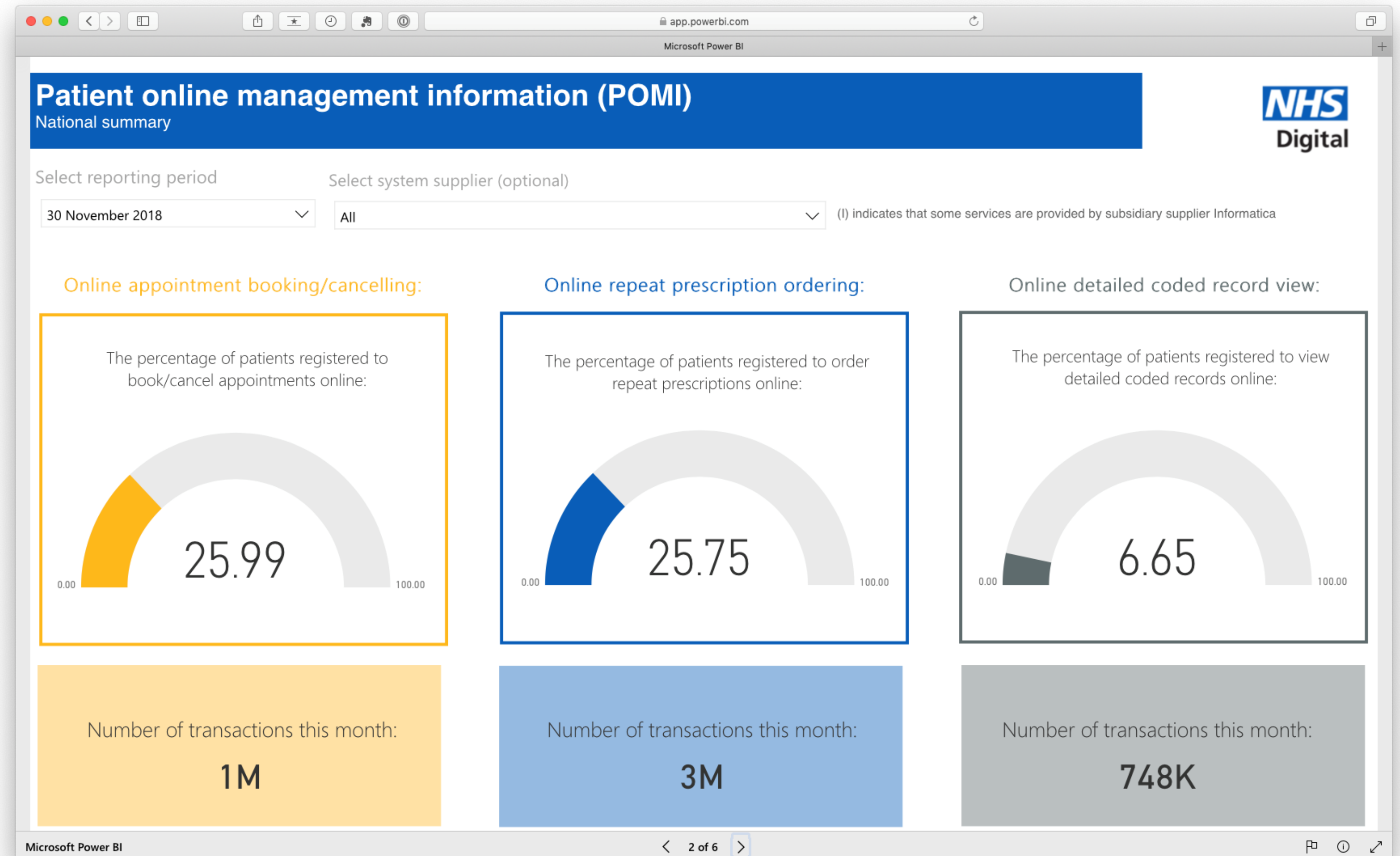
Patients Registered for Patient Online

NHS Digital

GP Data Hub

POMI

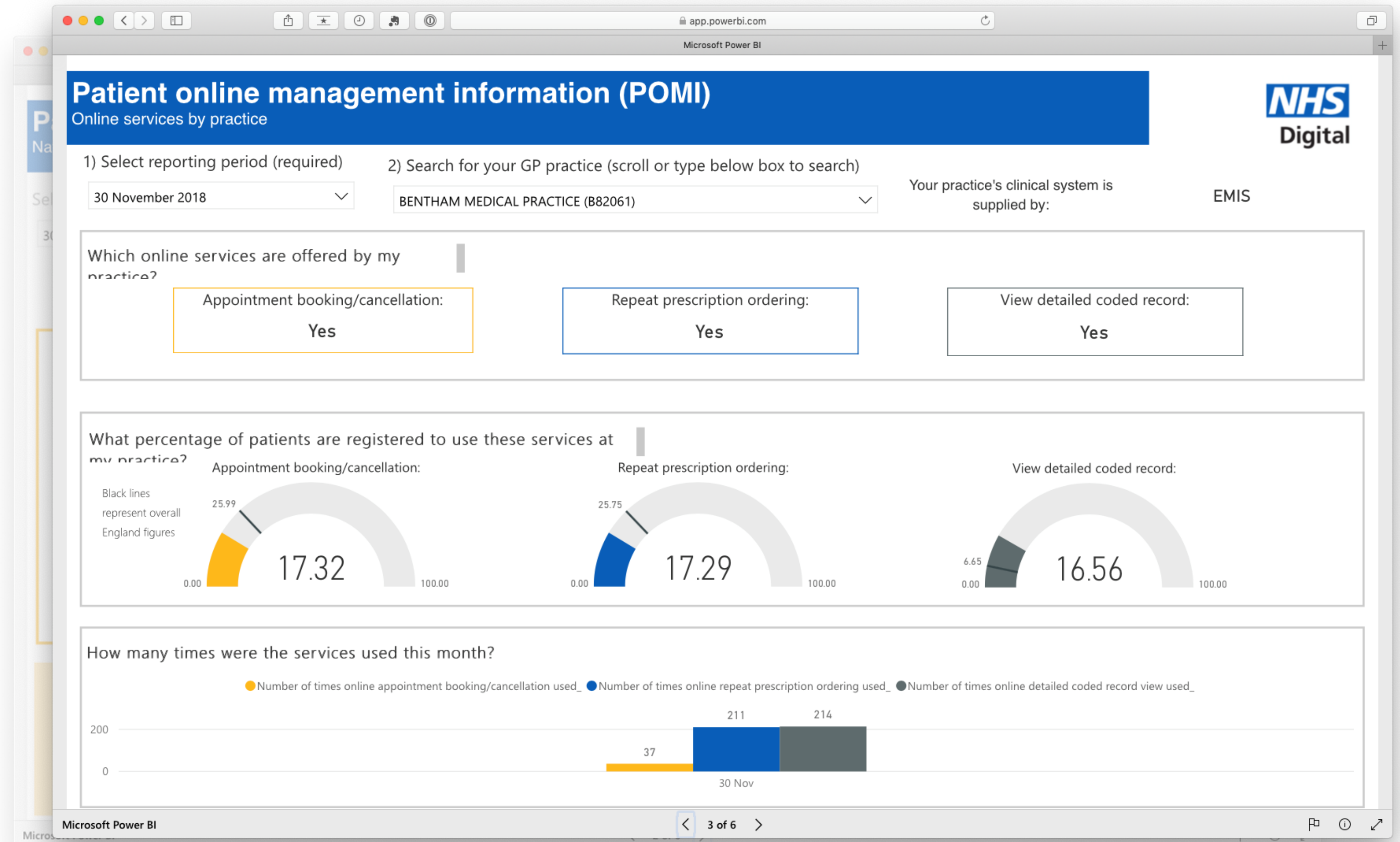
<https://bit.ly/2oeevmq>



Patients Registered for Patient Online

NHS Digital
GP Data Hub
POMI

<https://bit.ly/2oeevmq>

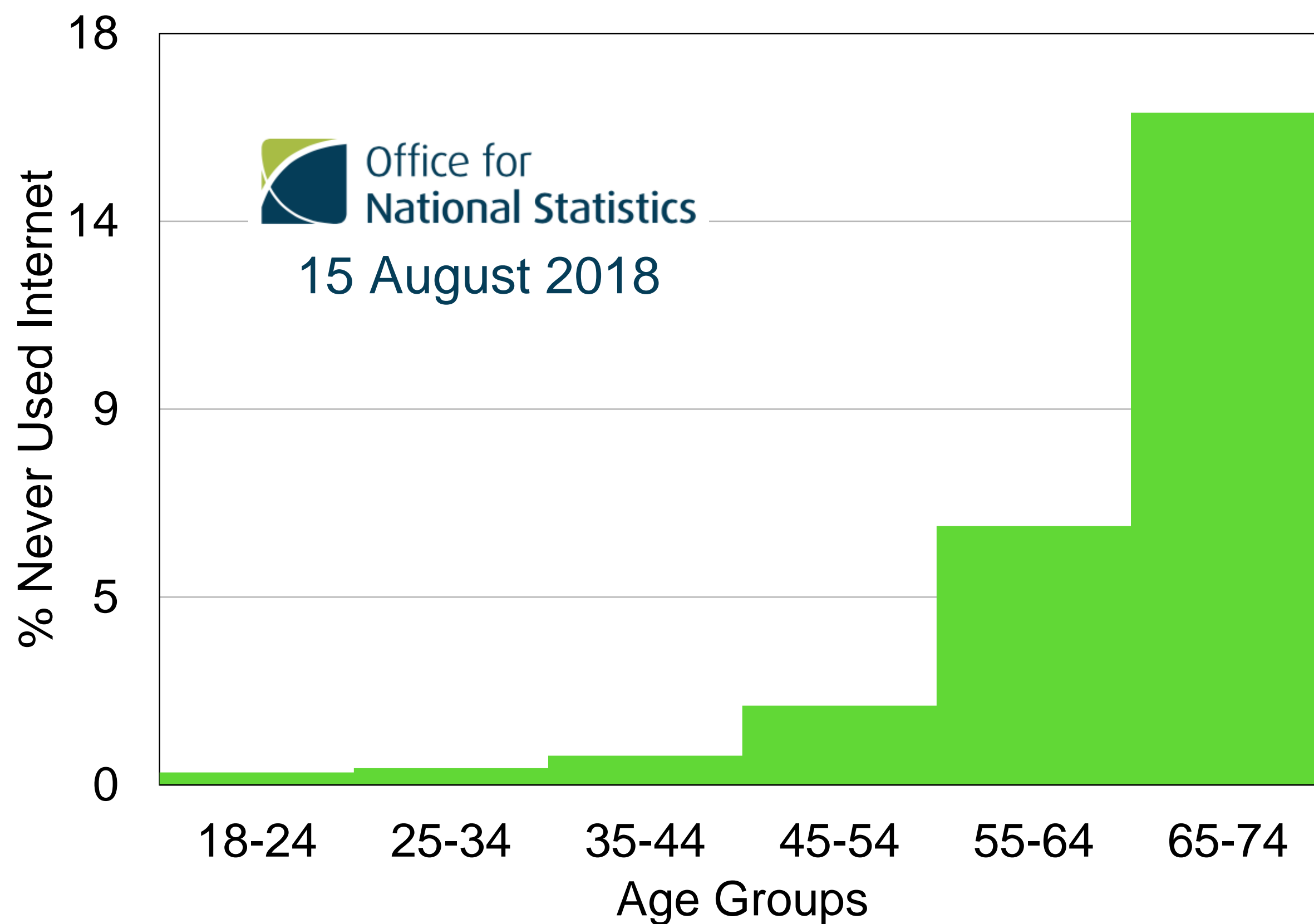


Health Literacy

- 59% women, 50% men use internet for health information (ONS 2018)
- 43% of working-age adults in England have low health literacy
 - ability to read and write
 - computer and numerical literacy
 - ability to interpret graphs and visual information
- Teach back - chunk and check

Digital Exclusion

People Who Have Never Used Internet (%)



NHS Widening Digital Participation

<https://bit.ly/2LtjqZR>

Future Digital Inclusion

<https://bit.ly/2f4nTaR>

Online Centres Network

<https://bit.ly/2vSeAOw>

Practice barriers to record access

- Training
- Workload
 - clinical assurance of the record
 - patients' response
- Record quality
- Safeguarding
- Motivation

RCGP Patient Online Programme

Aim - to increase awareness and confidence in using Patient Online in patient care

Intended for the whole practice team

Toolkit of guidance documents and templates

Webinars

Podcasts

Input from other Royal Colleges, academia and the voluntary sector, and individual health professionals and patients

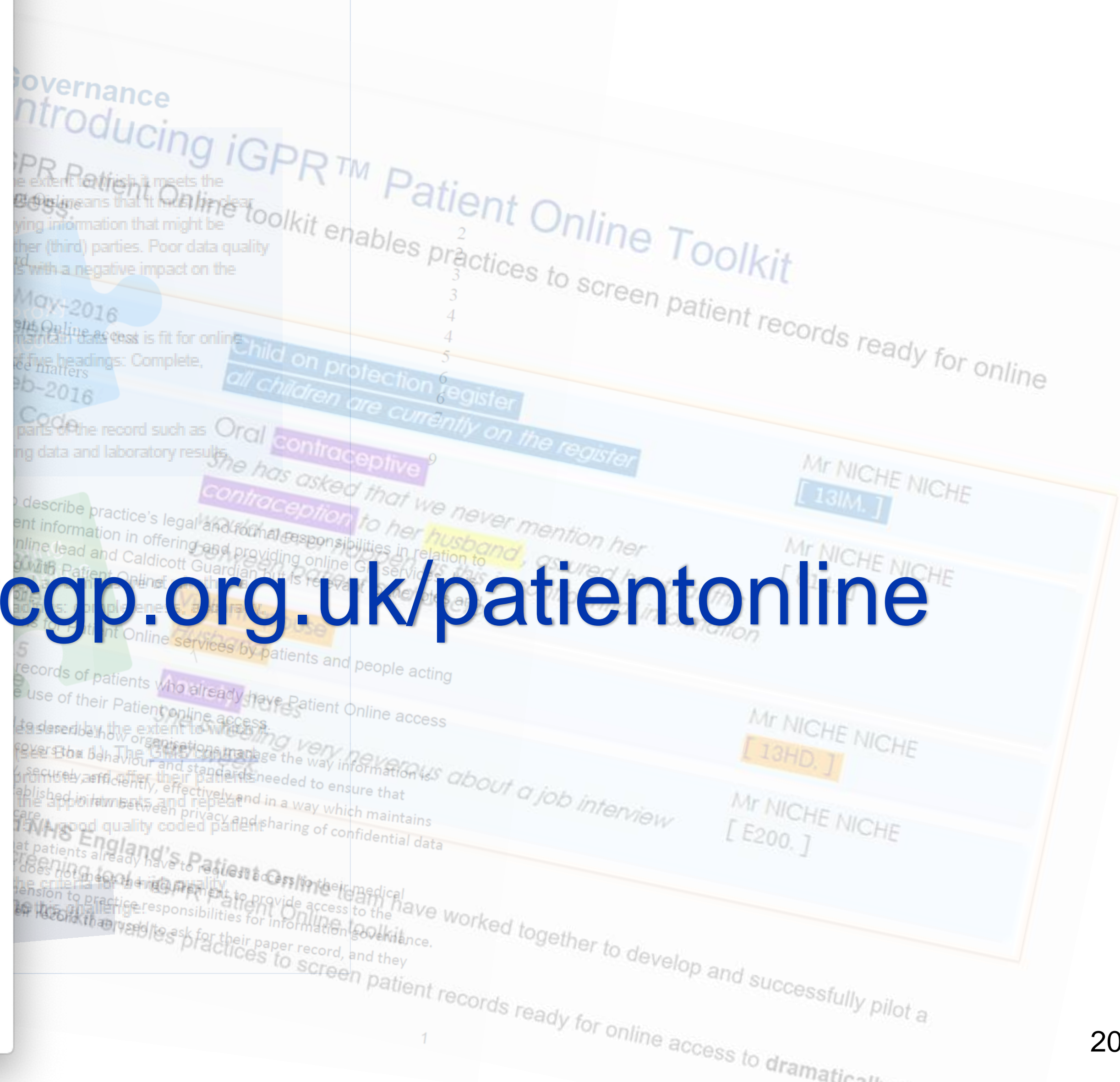
Patient Online Toolkit

Book and cancel appointments
Order repeat medication
Detailed care record
Extended record access (all or part)

Managing new applications
Safeguarding
Information Governance
Patient Information
Clinical benefit

Patient Online Toolkit

www.rcgp.org.uk/patientonline



Patient Online Toolkit

rcgp.org.uk

POL Toolkit

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About us

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Patient Online Toolkit

A toolkit to support the provision of GP online services

The Patient Online toolkit has been written by the RCGP, in collaboration with NHS England, for GPs, nurses and practice staff to offer Patient Online to patients effectively, efficiently, safely and securely. The toolkit also includes clinical exemplars which demonstrate how Patient Online can empower patients to take greater control of the management of their health conditions as part of a person-centred approach to care.

- Introduction
- Setting up Patient Online services
- Registering new applicants for Patient Online
- Record access
- Clinical care
- Clinical exemplar 1: diabetes mellitus
- Clinical exemplar 2: end of life care
- Clinical exemplar 3: dementia
- Clinical exemplar 4: inflammatory arthritis
- Acknowledgements

www.rcgp.org.uk/patientonline

Clinical care

Clinical exemplar 1: diabetes mellitus

Clinical exemplar 2: end of life care

Clinical exemplar 3: dementia

Clinical exemplar 4: inflammatory arthritis

Acknowledgements




Record Access Clinical Exemplars

Webinars
Podcasts
Guidance documents
Resources

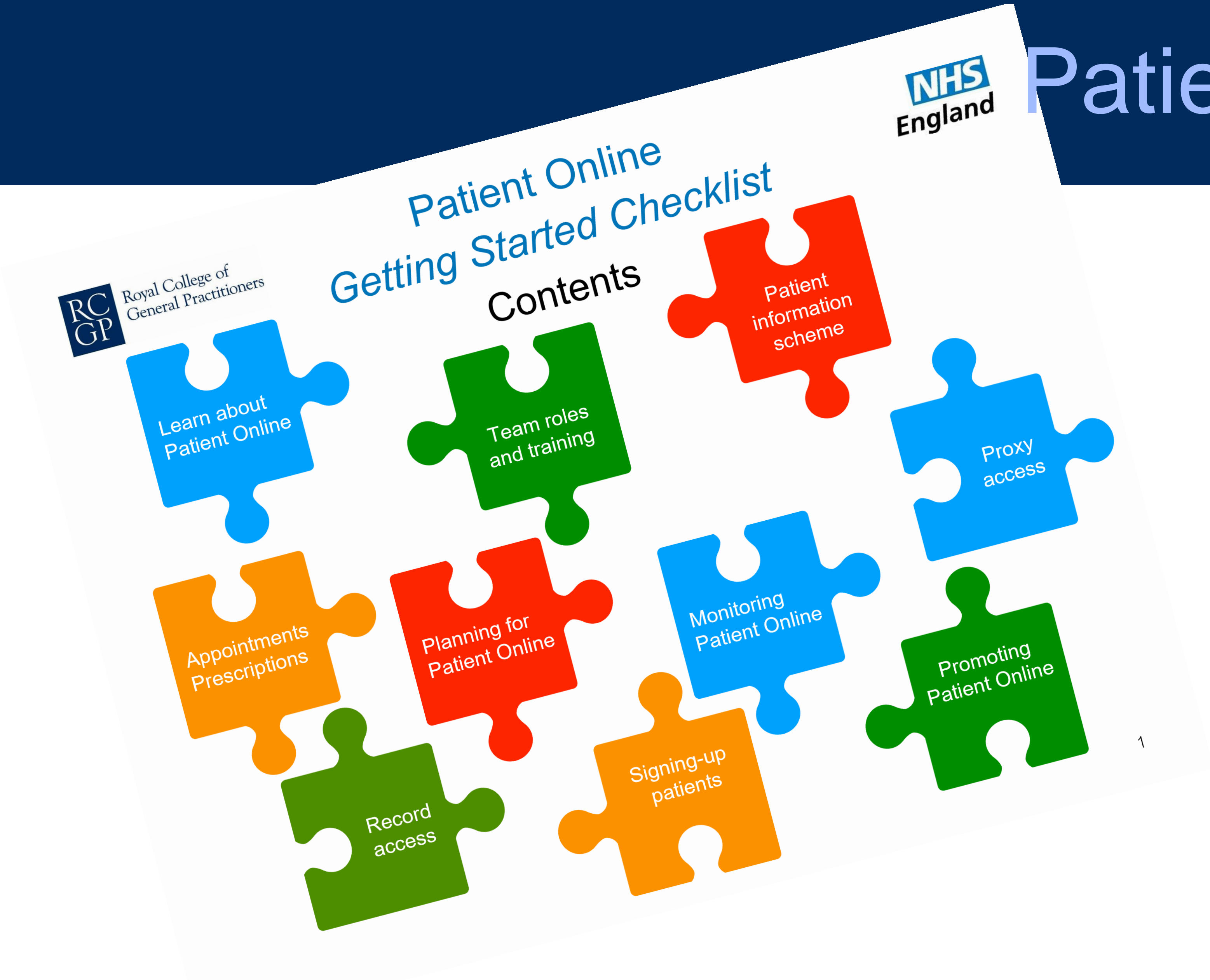
/patientonline

- Record access (+)
- Clinical care (+)
- Clinical exemplar 1: diabetes mellitus (-)



The resources in this section are for GPs and practice nurses who help patients make decisions about their diabetes, especially practice nurses working in diabetes clinics, but the principles can be applied to many long-term conditions. It covers the use of Patient Online record access to enable patients to:

- ▶ use laboratory results and other coded data that is relevant to their diabetes to monitor the impact of their self-care and adherence to treatment
- ▶ use the information to help decide what matters most to them and prepare for consultations
- ▶ review and contribute to their diabetes care plan.



GETTING STARTED WITH ONLINE RECORD ACCESS

Online access is helpful to both patients and GP practices. Record access can help patients manage their long-term conditions and be more engaged with their care. It can play a central role in providing person-centred care. Access by family members and carers will help them to care for the patient. Record access can present risks to patients and the practice related to privacy breaches and misuse of the data by other people. This guidance describes how to get started with offering and promoting online record access in a way that minimises the risks.

Why offer online record access?

Online Record Access is an essential part of collaborative person-centred care. It can help patients manage their long-term conditions and feel more engaged with their care. Access by family members and carers will help them to care for the patient.

Since March 2016 it has been a contractual requirement for English GP practices to promote and offer online access to 'all information from the patient's medical record which is held in coded form' as well as the usual transactional services (see Box 1). The requirement has remained unchanged since then. By March 2017 over half a million patients in England had online record access.

An RCGP survey of practice members in August 2016 showed that common reasons for recommending online record access to patients were:

- See their test results
- See what is in their record
- Help self manage long term conditions
- Support family and carers
- View correspondence
- Prepare for consultations

The same survey showed that there are some common perceived risks to online record access. Over 33% of respondents were concerned about at least one of the following:

- Coercion to share online access
- Access to data that may be harmful to the patient
- The wrong person may be given access
- Patients will not keep their records secure
- Patient will disagree with the data in their record

Getting started with online record access

- Parents will demand access to their teenagers' records

This guidance describes how to manage new applications for online access to minimise these risks and enable patients to use the system safely and get the full benefit of using record access. There is more information about some specific areas in other documents on the Patient Online toolkit.

There are a number of processes that practices should undertake to register new applicants for online record access safely. They can be time consuming but should not be omitted. It may be helpful to start to offer access to the coded record slowly, beginning with a test patient, then rolling it out to a small number of selected patients, involving the patient participation group. Once comfortable with how it all works, the next step is to promote record access more widely. Information leaflets and promotional materials are available from system suppliers and NHS England.

Suppliers may vary in the data that they display online but generally it includes the coded data listed in the graphic from NHS England. GP system suppliers also vary in how they will provide online access to the rest of the record, including free text and scanned documents (see Full medical record access, below). Providing a patient with online record access will not meet the requirements of a Subject Access Request under the Data Protection Act 1998.



Patient Online Toolkit



Application form for online access to the practice online services

Surname		Date of birth	
First name			
Address			
Postcode			
Email address		Mobile number	
Telephone number			
I wish to have access to the following online services (please tick all that apply):			
1. Booking appointments		<input type="checkbox"/>	
2. Requesting repeat prescriptions		<input type="checkbox"/>	
3. Accessing my medical record		<input type="checkbox"/>	
I wish to access my medical record online and understand and agree with each statement (tick)			
1. I have read and understood the information leaflet provided by the practice		<input type="checkbox"/>	
2. I will be responsible for the security of the information that I see or download		<input type="checkbox"/>	
3. If I choose to share my information with anyone else, this is at my own risk		<input type="checkbox"/>	
4. If I suspect that my account has been accessed by someone without my agreement, I will contact the practice as soon as possible		<input type="checkbox"/>	
5. If I see information in my record that is not about me or is inaccurate, I will contact the practice as soon as possible		<input type="checkbox"/>	
6. If I think that I may come under pressure to give access to someone else unwillingly I will contact the practice as soon as possible.		<input type="checkbox"/>	
Signature			Date
For practice use only		Practice computer ID number	
Patient NHS number	Method used	Vouching <input type="checkbox"/>	
Identity verified by (initials)		Vouching with information in record <input type="checkbox"/>	
Documentary evidence provided			Date
Authorised by			
Date account created			
Date login credentials emailed/given			
Level of record access enabled		Notes / explanation	
Detailed coded record <input type="checkbox"/>			
All prospective <input type="checkbox"/>			
All retrospective <input type="checkbox"/>			
Other limited parts <input type="checkbox"/>			
Date clinical assurance completed			Assured by (initials)
Reason for refusal if record access is refused after clinical assurance.			

Application form for online access

Getting started with online record access



DATA QUALITY

Since 31 March 2016 English practices have been contractually required to promote and offer online access to "all information from the patient's medical record which is held in coded form" as well as the usual transactional services. The requirement has not changed since then. By June 2018 almost 6% of patients in England had online record access.

There is also a non-contractual requirement for practices "to provide patients with online access to clinical correspondence such as discharge summaries, outpatient appointment letters, and referral letters [from a chosen prospective date] unless it may cause harm to the patient or contains references to third parties." There is no requirement to offer access to consultation free text and word-processed care plans but all GP systems are capable of this.

A good quality patient record must be fit for these new purposes. It is not always clear which patients have online record access and it is impossible to know who might have access next month. It makes sense for everyone in the practice who is recording information in the patient record to bear this in mind at all times. This guidance is intended to offer guidance to clinicians about how they should respond to this challenge.

Box 1: Good data quality is data fit for purpose
The electronic patient record is created for many purposes, which include to:

- record what happened in consultations, the opinion of the clinician and the plan agreed with the patient
- summarise important elements of the patient's health
- enable computerised decision support
- call and recall patients
- provide evidence for medico-legal purposes
- support practice administration
- demonstrate performance for payment purposes
- communicate with other clinicians, through shared record views
- enable clinical audit and research
- act as a resource for all secondary uses of the patient record.

Characteristics of good records for online access

Clinical records that are accurate, unambiguous and well organised work for patients and clinicians alike. It is clear that inaccurate, ambiguous and badly curated data can be confusing and may mislead both patients and clinicians with a negative impact on the patient's health and safety.

GP systems differ in how they organise patient records, especially the coded data, and particularly problem codes. This guidance does not offer advice on how to use specific systems. Training materials provided by your practice system supplier or the National User Group are the best source of advice for that, but there are principles of what constitutes

a good quality record that apply to all systems.

Data quality in the electronic patient record has long been described by the acronym CARAT, standing for Complete, Accurate, Relevant, Accessible and Timely.

Complete - In a high quality record, all the key data about a patient's health will be coded (see the Good practice guidelines for general practice electronic patient records: guidance for GPs. 2011). Patients with record access may offer diagnoses, allergies, vaccinations, operations or events that they see are missing.

Accurate - A patient's record changes with time as problems occur and become inactive and as working symptom-based problems acquire a formal diagnosis. GP records must represent clinical uncertainty; coding an uncertain diagnosis may be misleading. Text qualifiers that record uncertainty may not be visible to the patient, or other clinicians using shared records. When different codes are used for one condition it may appear as though there have been several episodes of, for example, stroke or cholecystectomy. Some diagnosis codes are ambiguous and are best avoided. Patients should be warned when they apply that they may not understand all the medical terms in their record (see Health Literacy below).

Relevant - There may be data that you would normally not code, that would be of particular interest to the patient if they could see it in the

Patient Online Tools

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 Patient Online, 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 Patient Online creates new and additional opportunities for coercive behaviour that must be addressed by practices.

Domestic violence and abuse statistics (England and Wales)

"For the year ending March 2017 CSEW, an estimated 1.9 million adults aged 16 to 59 years experienced domestic abuse in the last year, equating to a prevalence rate of approximately 6 in 100 adults. Women were more likely to have experienced domestic abuse than men (7.5% compared with 4.3%). This equates to an estimated 1.2 million female victims and 713,000 male victims."
 - Office of National Statistics - Domestic Abuse in England and Wales

"We estimate that at least one child in every reception school class has been living with abuse for their whole life."
 - Safelives (2017). Insights National Briefing

The challenges of coercion for practices
 GPs, practice managers and staff involved in new applications by patients for Patient Online must be aware of the potential impact of coercion and the indications to look out for in order to help patients who might be subject to coercion. RCGP, CAADA (Co-ordinated Action Against Domestic Abuse) and IRIS (Identification & Referral to Improve Safety) have published guidance for practices to help effective response to patients experiencing domestic abuse (see Resources below).

Practice staff must be aware of the potential for coercion and be vigilant in its detection. Coercion to share or misuse access to Patient Online is most likely to happen if the patient is a child, an adult in an abusive relationship, or an elderly or otherwise vulnerable adult.

As part of patient enrolment, it is important that practice staff discuss the issue of coercion with patients, and ensure that they understand and accept the risks. Every new applicant should be asked a question to raise the issue of coercion such as "Is it possible that you may come under pressure to give someone access to your personal information in Patient Online against your will".

These considerations should be included in a registration form for online services for patients (a template for a new application form is available in the toolkit). Patients need to understand and tick

all six statements in the template application form before access is granted.

Recommended statements for Patient Online application forms

1. I have read and understood the information leaflet provided by the practice.
2. I will be responsible for the security of the information that I see or download.
3. If I choose to share my information with anyone else, this is at my own risk.
4. If I suspect that my account has been accessed by someone without my agreement, I will contact the practice as soon as possible.
5. If I see information in my record that is not about me or is inaccurate, I will contact the practice as soon as possible.
6. If I think that I may come under pressure to give access to someone else unwillingly I will contact the practice as soon as possible.

Proxy Access

Patients may choose to share their Patient Online login details with family, friends and carers (including staff in a care home) but as part of their access application they must be advised of the risks of doing this. It is preferable for anyone who is going to access to the patient's Patient Online account, to have their own personal log in details, if the practice clinical system has this facility. This is called proxy access. It makes it easier for the practice to switch off the other person's access if

Patient Online Toolkit



The iGPR Patient Online Toolkit screens patient records for third party and sensitive entries across codes, free-text and attachments.

Introducing iGPR™ Patient Online Toolkit

iGPR Patient Online toolkit enables practices to screen patient records ready for online access.

11-May-2016 Problem	Child on protection register <i>all children are currently on the register</i>	Mr NICHE NICHE [13IM.]
09-Feb-2016 Read Code	Oral contraceptive <i>She has asked that we never mention her contraception to her husband, assured her that this would never happen as this is confidential information between patient and doctor.</i>	Mr NICHE NICHE [614..]
05-Jan-2016 Read Code	Violent spouse <i>Husband</i>	Mr NICHE NICHE [13HD.]
15-Jul-2015 Read Code	Anxiety states <i>She is feeling very nervous about a job interview next week.</i>	Mr NICHE NICHE [E200.]

Niche Health and NHS England's Patient Online team have worked together to develop and successfully pilot a medical record screening tool - iGPR Patient Online toolkit.
iGPR Patient Online toolkit enables practices to screen patient records ready for online access to dramatically reduce this workload.

Summary so far

Online record access

- Benefits and barriers
- GP uptake of Patient Online in England

RCGP Patient Online Toolkit

Patient Online and Mental Health

Book and cancel appointments

Order repeat medication

Detailed care record

Extended record access (all or part)

Patient Online and Mental Health

Book and cancel appointments

Order repeat medication

Detailed care record

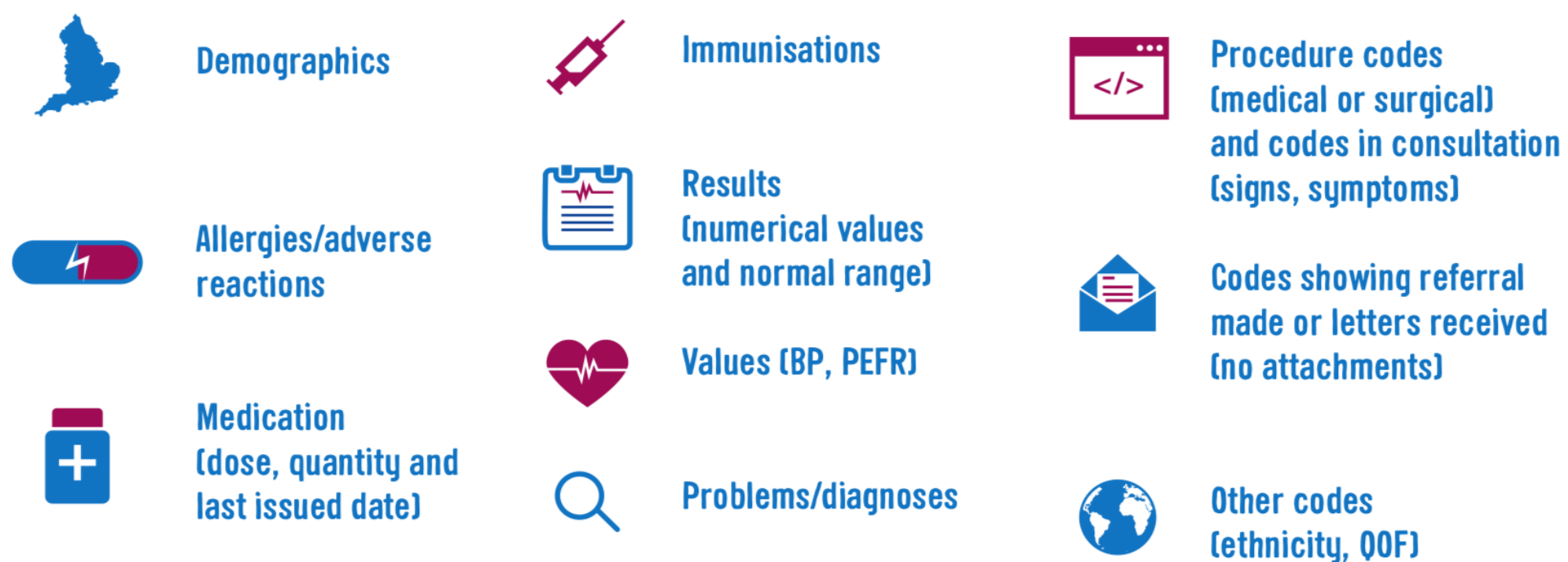
Extended record access (all or part)

- Booking appointments potentially less intimidating

- Avoid confusion with complex prescription regimes.
- Reminds patients when they last ordered.
- Alerts them to medication review dates.

Patient Online and Mental Health

Book and cancel appointments
Order repeat medication
Detailed care record
Extended record access (all or part)



Problem list
Lifestyle and work
Examination results
Test results
Questionnaire scores
Care plan codes
Past medication
Allergies and ADRs
Preventive healthcare

Patient Online and Mental Health

Book and cancel appointments

Order repeat medication

Detailed care record

Office of National Statistics survey 2013

- 43% of the British population used the internet for health related information, 35% of which were mental health related

Royal College of Psychiatrists

- Patients use internet to improve health literacy

Patient Online and Mental Health

Book and cancel appointments

Order repeat medication

Detailed care record

General information

<https://www.rcpsych.ac.uk/healthadvice/atozindex.aspx>

<https://www.mentalhealth.org.uk/a-to-z>

<https://www.mind.org.uk/information-support/a-z-mental-health/>

<https://www.rethink.org/diagnosis-treatment>

Lab Tests

<https://labtestsonline.org.uk/tests-index>

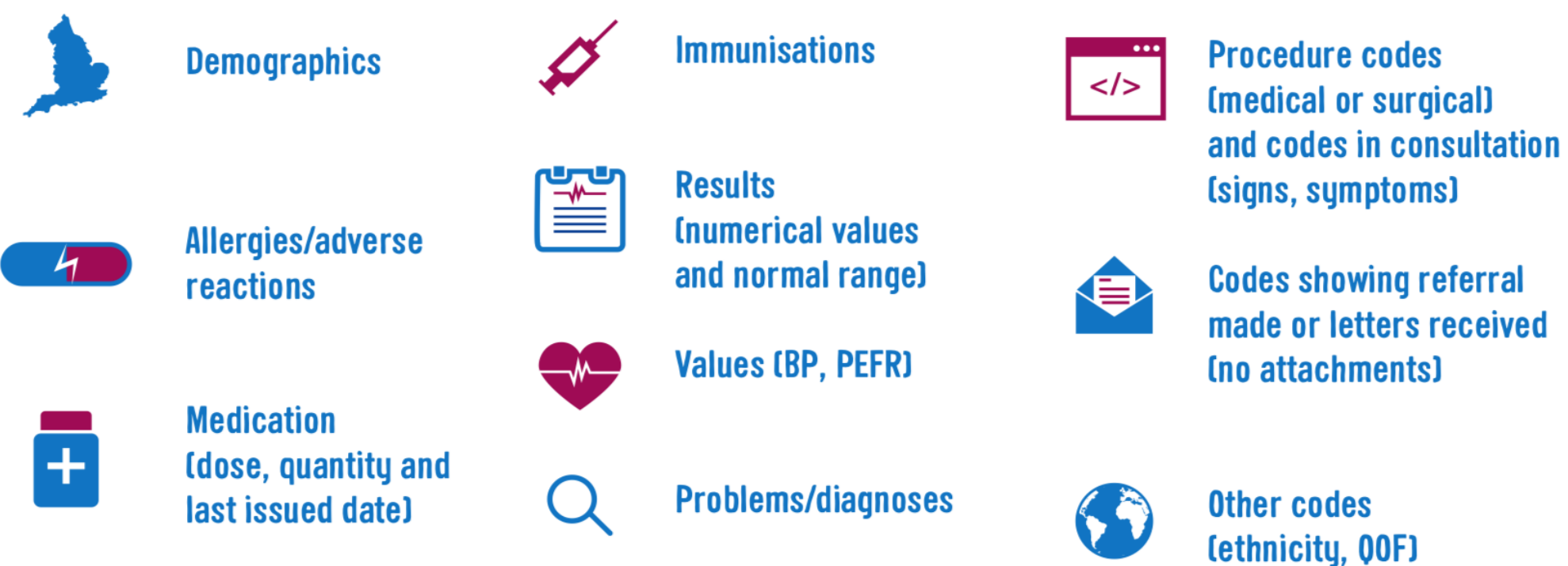
Patient Online and Mental Health

Book and cancel appointments

Order repeat medication

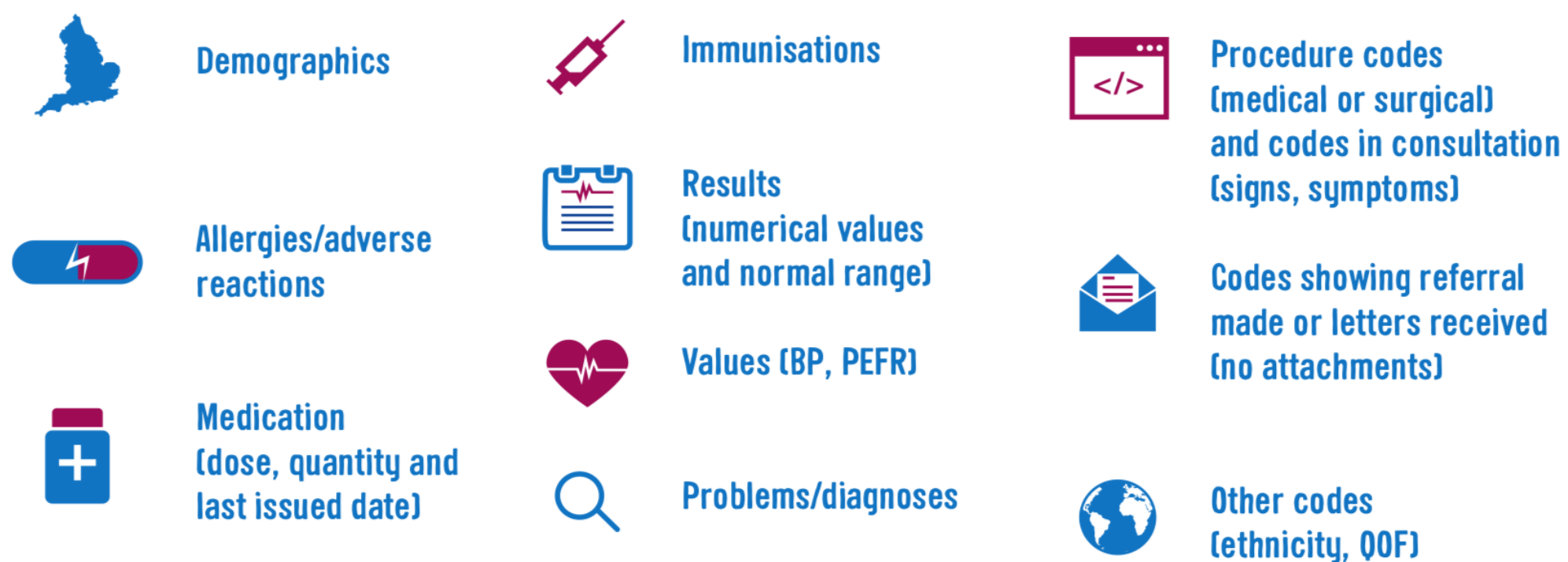
Detailed care record

Extended record access (all or part)



Patient Online and Mental Health

Book and cancel appointments
Order repeat medication
Detailed care record
Extended record access (all or part)



Attached documents
Consultation notes
Free text



Hospital OPD letters
Discharge reports
Radiology reports
Referral letters

...

Patients Using the Detailed Coded Record

- Identify any inaccuracies that might be present

Problem list

Lifestyle and work

Examination results

Test results

Questionnaire scores

Care plan codes

Past medication

Allergies and ADRs

Preventive healthcare

Using the Detailed Coded Record

- Identify any inaccuracies that might be present
- **Generally improve their health literacy though access to their detailed coded record**

Problem list
Lifestyle and work
Examination results
Test results
Questionnaire scores
Care plan codes
Past medication
Allergies and ADRs
Preventive healthcare

Using the Detailed Coded Record

- Identify any inaccuracies that might be present
- Generally improve their health literacy through access to their detailed coded record
- **Check blood test results**

Problem list

Lifestyle and work

Examination results

Test results

Arthritis-relevant codes

Care plan codes

Past medication

Allergies and ADRs

Preventive healthcare

Mental health and comorbid disease

- Patients with long term conditions 2-3 times more likely to experience mental health problems.
- Patient Online can help integrate mental health and physical health more closely
- Can be used for care planning and priority setting and multiple aspects of patient care.

Further detailed guidance on the use of POL in chronic long term conditions such as diabetes, inflammatory arthritis, and dementia are available in the RCGP toolkit.

Summary so far

Patient access to record data relevant to mental illness

Coded information enables person-centred care

Safe Online Record Access

Identity verification

Safeguarding – coercion, proxy access

Clinical assurance of the record

Redaction of potentially harmful data

Good data quality – unambiguous

Continuity of care



Safe Record Access in Mental Illness

Increased vulnerability to coercion

Increased sensitivity to record content

Record intrinsically more unsettling

Refusal and withdrawal of access

Proxy access



Patient Online Toolkit

Detailed guidance can be found in the Toolkit

New Applications for Online Record Access

Safe Online Record Access

Coercion

Patient Online for Mental Health Conditions



Clinical Scenario

- Andrew Mason is a 32-year-old who over the last few months has problems with his mood.
- He has multiple symptoms of depression
- He reports that he drinks 22 units per week and smokes 20 cigarettes day.
- His GP carries out a PHQ-9 and a GAD-7, scores 19 and 11 respectively.
- GP diagnoses depression, refers to local IAPT services, and starts Sertraline 50mg once a day, with a review in 2 weeks.

Clinical Scenario coding

- Andrew Mason is a 32-year-old who over the last few months has problems with his mood.
- He has multiple symptoms of depression
- He reports that he drinks **22 units per week** and smokes **20 cigarettes day**.
- GP carries out a **PHQ-9** and a **GAD-7**, scores **19** and **11** respectively.
- GP diagnoses **Depression**, refers to local IAPT services, and starts **Sertraline 50mg once a day**
- Review in 2 weeks.

Coded information in **Red**

Clinical Scenario use of POL

Andrew can use Patient Online to access his detailed coded record and use transactional services.

He sees his recent diagnosis of depression, his PHQ-9 and GAD-7 scores, his alcohol and cigarette use.

His medication list includes an acute prescription for sertraline 50mg daily, but he cannot order a repeat.

His review date is noted as a diary entry and reminds him to make an appointment for review with his GP, which he does online.

Clinical Scenario review

1. Several weeks later his GP repeats the PHQ-9 and GAD-7, now 9 and 6 respectively and records the results. Andrew agrees to continue the sertraline and return to the GP places it on repeat.
2. Andrew can continue to access POL transactional services and view his detailed coded record.

Clinical Scenario overview

1. Highlights how clinical coding can be used in a more straightforward case of depression to enable POL.
2. Coding encourages best practice and provides information that is accessible to the patient via POL
3. Can be used to encourage patient engagement, safe prescribing and medication review.

Summary

Patient can be useful in mental health conditions ...

for patients and the practice

Access to coded information supports person-centred care

Patient Online

empowers patients,

improves record accuracy and health literacy, and

supports care of co-morbid disease

What's Next

Guidance document that contains all of the relevant information, resources and links to related guidance

Podcast

Further collaborative work

Questions?