Accelerating access to GP records

Frequently Asked Questions (FAQs)

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1. Accessibility

What access to medical records are GPs required to offer?
Since 2014, patients have had the right to view limited parts of their medical record as part of General Medical Services (GMS) contractual requirements. In 2019, this was updated and the GMS contract set out requirements for general practice to promote and offer online access to coded and prospective information in the medical record, or when requested in writing, access to the ensure historic record.

The NHS England and Improvement Board on 20 May 2021 mandated that 'Enabling access to full prospective GP records for all patients via the NHS App. GP practices would screen data as it is entered onto their IT system.' This was set to be from September 2021 but the date has been extended to November 2022. From this date the GMS contractual commitment places a requirement on general practice to promote and offer online access to all coded and future prospective information in the medical record (clause 16.5ZA.1), or when requested in writing access to the entire historic medical record (clause 16.5ZB).

What access do patients currently have to their GP medical record online?
There are different levels of access that a patient may have as granted by their GP practice. These permissions will remain the same for historic access, although prospective record access will automatically be available to patients from November 2022.

- **Summary/Core information** includes demographics (for example, contact details, NHS number) allergies, adverse reactions and medications.
- **Detailed coded access (DCR)** includes test results, values, coded problems and diagnoses, procedure codes, codes showing referrals made or letters received and other codes (for example ethnicity or Quality Outcomes Framework). Third-party and sensitive content excluded.
- **Full record access** is all coded information and also includes: free text, consultations and documents (Third-party and sensitive content excluded).

Who can get access to their medical record?
Only people aged 16 years or older and registered with a GP in England will automatically have access to their full GP record via the NHS App or any other approved patient facing service apps. People with online accounts set up before their 16th birthday will receive access to records entered after their 16th birthday when they turn 16. If you judge a particular young person to be sufficiently competent to have access to their own records before they reach the age of 16, you can manually allow them to access information on the NHS App or any other approved patient facing service apps. Please see the RCGP GP Online Services toolkit for more information

https://elearning.rcgp.org.uk/pluginfile.php/179161/mod_book/chapter/770/Children%20and%20young%20people%20records%20access%20v3.0.pdf

How do patients get access to their online medical record?
Patients can download the NHS App and will automatically get access to their future full record from November 2022. If a patient wishes to use third-party apps these may require the login details that are provided by their GP practice (pin or linkage key) or they may be able to register using NHS Login if the product is integrated. Information on how to download the NHS App, or open the NHS website to access their NHS account in a web browser can be found here: https://www.nhs.uk/nhs-app/

Can online record access be denied or removed?
Access can be denied or removed if a patient is at risk of serious harm to themselves or another person. It might also be reasonable to temporarily suspend access pending investigation into the suitability of a patient having access. An exclusion SNOMED clinical term can also be applied to prompt a review should access be requested in future. Healthcare workers should remain vigilant and consider ongoing reviews. It may be reasonable/required to meet with a patient to discuss online access, and to determine with the patient what's the right thing for them. For further information, please see supplier guides below

EMIS
https://www.emisnow.com/csm?sys_kb_id=72e713111b2f89543e24ed32b24bcb27&id=kb_article_view&sysparm_rank=1&sysparm_tsqueryId=f56196021bc091183e24ed32b24bcb0a

TPP - https://tpp-uk.com/resources/

2. What will patients see?

What changes are being made to online record access?
From 1 November 2022, patients with an online account will automatically get access to their full prospective GP health record, including free text, letters and documents. Patients will see new information once it is entered, or filed, onto their record in the clinical system. Patients will not see their historic, or past, health record information unless they have already been given access to it by their GP practice. Patients whose GP practices use the TPP or EMIS system will see new GP records entered from November 2022. Arrangements with practices which use Vision Cegedim as the clinical system are under discussion.

Will patients see test results online before a GP has had the chance to review?
Patients should not see personal information such as positive test results until they have been checked and filed to the clinical IT system, giving clinicians the chance to contact and speak to patients first. Please use your test patient to review what a patient will see.

Will documents, letters or attachments be viewable by the patient before a clinician has been able to review and approve?
Some systems may allow the automatic upload of items from other care settings into the GP record, such as discharge summaries, test results and letters. You must check with your supplier whether this applies to your system. If this is the case, you should review your options accordingly so that you check the information prior to disclosure to patients.

Will patients be able to see administrative tasks?
Patients will not be able to see tasks, administrative items, alerts, screen messaging, internal email or patient warnings. The only time this might occur is if you have added information directly into the patient record, as part of a consultation or appointment, in which case it would be visible as it forms part of the electronic patient record.

Will patients be able to see information from other health services or third-party organisations?
Patients can only see information that is held in their GP record and not information from third-parties that is viewable in the GP system by health professionals. Communication has been shared with the wider health system and partnership organisations to ensure that staff are aware that patients will see their general practice health records. Staff should be aware that:

- Information sent into general practice will be visible by default as correspondence shared between clinicians should be shared with the patient (NHS Constitution).
- Organisations should continue to share important information with general practice, as this can be made invisible from the patient view when necessary.
- To reduce the risk of inappropriate disclosure, organisations should clearly identify when correspondence should not be patient-visible due to a risk of serious harm.

Will a patient see healthcare workers' names in their records?
Information that may identify staff who have viewed or contributed to a health or care record is not generally exempt from disclosure should an individual request it, irrespective of the

staff member's role within your organisation. However, there may be circumstances in which withholding the identity of a staff member would be justified. Usually this will apply to non-clinical staff and there should be reason to believe that disclosing their details might result in them suffering serious harm. For more information, please visit https://transform.england.nhs.uk/information-governance/subject-access-requests-faqs/

What will a new patient see if moving from another practice?
When a patient registers at a new GP practice from 1 November 2022, they will lose any access they had to historical information but will automatically get access to their future record in full from the date they join that practice. If a patient would like to access their historical information (detailed coded record or full), they will have to request this and the new practice will need to review and redact if necessary.

Can patients request historical record access?
Practices should have been promoting and offering access to the detailed coded record since 2016. When patients receive full access by default from 1 November 2022 they may request historical access. We are encouraging and supporting practices that haven't offered this as a matter of course to start offering detailed coded record access in a controlled manner before the November switch on to ensure they understand the process and can ensure all staff receive the relevant training. Patients have a right to view their information and may request full historic access through a Subject Access Request. Enabling online access to detailed coded records (or full access to the record) empowers patients and will ultimately result in fewer requests for information from the practice in the long term.

What action should be taken if a patient disagrees with an entry in their record?
Health and care professionals have a legal duty and professional responsibility to keep health and care records accurate and up to date. However, mistakes in record keeping can occasionally happen. Patients and service users have the right to request for their records to be rectified if they feel inaccurate information is held about them. If you believe that an amendment request concerns health or care information that is factually accurate, you should not amend the record. However, it is good practice to give patients and service users the opportunity to have an entry put into the record to say they do not agree with a particular part and why. For more information please visit https://transform.england.nhs.uk/information-governance/guidance/amending-patient-and-service-user-records/

Will patients who have online access to their records be able to amend or edit their patient information?
Patients will only have viewable access to their online record. If a patient requires any changes to be made, eg name address, this should be requested at their GP practice,

3. Safeguarding

How can GP practices identify and safeguard vulnerable patients?
The vast majority of individual patients who are at risk of serious harm will belong to known high risk groups. Many of these patients will already have safeguarding plans in place and should already be known to general practice, however this list of high risk groups is not exhaustive and the practice may have concerns about patients who do not fall within these groups.You should consider turning off access for any individual considered to be vulnerable to coercion, whose recorded information may be harmful to them, or to individuals who are unable to keep their record secure.

Findings and recommendations from early adopter sites can be found here:
https://digital.nhs.uk/services/nhs-app/nhs-app-guidance-for-gp-practices/guidance-on-nhs-app-features/accelerating-patient-access-to-their-record/learning-from-early-adopter-sites

For more information about safeguarding vulnerable adults, please visit there RCGP GP Online Service toolkit here
https://elearning.rcgp.org.uk/mod/book/view.php?id=13455&_ga=2.26797245.1841274166.1658599026-49673857.1658504029

What will a patient see if there are already safeguarding alerts, flags, codes, notes, documents recorded on the GP clinical system?
Patients will be able to see coded information, free text, letters and documents including safeguarding information unless redacted or hidden. It is important to review and redact where there is a risk to the patient. It is recommended that practices use their test patient to see what is visible to a patient. For instructions on how to set up a test patient, please visit
https://digital.nhs.uk/services/nhs-app/nhs-app-guidance-for-gp-practices/set-up-a-test-patient

Redaction guidance for:

TPP SystmOne
https://tpp-uk.com/resources/

EMIS
https://www.emisnow.com/csm?sys_kb_id=72e713111b2f89543e24ed32b24bcb27&id=kb_article_view&sysparm_rank=1&sysparm_tsqueryId=f56196021bc091183e24ed32b24bcb0a

For information and guidance on coding safeguarding information, please visit the RCGP toolkit link
https://elearning.rcgp.org.uk/pluginfile.php/170658/mod_book/chapter/349/RCGP-Safeguarding-Coding-Information-June-2017.pdf

Are safeguarding entries by other professionals, for example, school nursing/health visiting team and midwives viewable to the patient?

It is important that the wider health system and partnership organisations are aware that patients will see their general practice health records. The letter notifying general practice has also been shared with wider system leaders to inform them of the upcoming changes.

They should be aware that:

- Information sent into general practice will be visible by default as correspondence shared between clinicians should be shared with the patient (NHS Constitution).
- Organisations should continue to share important information with general practice, as this can be made invisible from the patient view when necessary.
- To reduce the risk of inappropriate disclosure, organisations should clearly identify when correspondence should not be patient-visible due to a risk of serious harm.

Can a GP surgery hide safeguarding information entries not made by staff in general practice?

Information entered into the GP medical record is viewable unless redacted/hidden or record access is not enabled for the patient. As the data controller, the GP practice is responsible for ensuring that any potentially harmful or confidential third-party information in the patient's record is not visible to the patient online. All GP systems have a method of preventing information in the record being visible via GP online services. For further guidance, please visit
https://transform.england.nhs.uk/information-governance/guidance/subject-access-requests/

Will patients be able to see safeguarding codes, for example, at risk of domestic violence?

No, the aim of the code is to protect and is not visible. Where there may be safeguarding concerns, healthcare workers can prevent patients from having automatic access to new information by adding a Systematised Nomenclature of Medicine Clinical Term (SNOMED CT) code to their record. Please refer to your clinical system supplier for more information on how to apply these codes. Additional guidance can be found here
https://digital.nhs.uk/services/nhs-app/nhs-app-guidance-for-gp-practices/using-enhanced-review-snomed-codes-when-giving-a-patient-access-to-their-health-record

How can it be ensured that information made available online is safe for the patient and practice?

Prospective access to full records from November 2022 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 GP Online Services toolkit available at https://elearning.rcgp.org.uk/mod/book/view.php?id=13455

Can online access be restricted in bulk, for example, if patients are identified as being high risk, for example, from a safeguarding list?

Codes can be applied in bulk, however caution should be applied if cohorts of patients are excluded to prevent potential discrimination. Effort should be made to ensure at risk individuals are reviewed to assess if record access can be provided. For more information and guidance please visit https://digital.nhs.uk/services/nhs-app/nhs-app-guidance-for-gp-practices/guidance-on-nhs-app-features/accelerating-patient-access-to-their-record/learning-from-early-adopter-sites#safeguarding-patients-who-should-not-have-access

4. Redacting or hiding information in a patient record

When should a practice redact or hide information?

While enabling patients to view their medical records will be beneficial to the majority of patients, there may be challenges for a minority. This is especially true in relation to safeguarding vulnerable people as the record may contain third-party/confidential/sensitive information which the patient must not see or could be harmful to the patient. It may be beneficial to temporarily withhold data in some cases so the patient can be informed or to assess risk of harm, for example, sensitive test results. In some cases it may be required that specific information entered into the GP medical record is redacted/hidden or that record access is not enabled. All GP systems have a method of preventing information in the record being visible via GP online services. Hiding information (sensitive or third-party) from the patient view (either future or historic) does not hide information from other healthcare professionals.

For further guidance on exemption, please visit https://transform.england.nhs.uk/information-governance/guidance/subject-access-requests/

What type of information should be reviewed and redacted/hidden?
GP records sometimes contain confidential information that relates to a third-party that the patient must not see. There may also be information that is sensitive or that could be harmful to a patient and is not suitable to share. Where there is concern that information may be confusing for a patient, or may cause harm, access to the record and entries made should be reviewed. All GP systems have a method of preventing information in the record being visible via GP online services. For more information about what may be classed as sensitive information and actions to take, please watch this short video presented by GP Dr Phil Koczan.

"Why and when to make information visible in patient records": https://www.youtube.com/watch?v=e9K32Vbf5zM

Are there exemptions to what information should be made available?
There may be instances where access should be limited or not provided to a patient. The Data Protection Act 2018 highlights exceptions which apply both to subject access requests and online records access. For more information please review guidance here

https://transform.england.nhs.uk/information-governance/guidance/subject-access-requests/

For more information about the types of scenarios where access might be denied, please listen to Deputy Director for NHS Safeguarding Kenny Gibson and Dr James Higgins detail circumstances that may cause harm, changes in circumstances, vulnerability and coercion. Additionally, they discuss "when to consider not providing record access to a patient". https://www.youtube.com/watch?v=51QcqkYG7VM

Who is responsible for redacting or hiding information?
As the data controller, the GP practice is responsible for ensuring that any potentially harmful or confidential third party information in the patient's record is not visible to the patient online. Such information should be redacted/hidden. This prevents it being visible through GP online services but does not affect the visibility of the information in the practice and when shared for direct patient care or used for decision support software and clinical audit.

5. Proxy access and settings

How do the planned changes to record access affect proxy access and settings?
The new changes do not apply to proxy. For more information including clinical system user guidance, please visit
https://digital.nhs.uk/services/nhs-app/nhs-app-guidance-for-gp-practices/guidance-on-nhs-app-features/linked-profiles-and-proxy-access

Who should proxy access be given to?
Some patients find it helpful for a second person to have access to their online health record. This is often a family member, a close friend or a carer who they trust to act as their proxy to access some or all of the services offered by online services. Please review the RCGP guidance for more information that can be found here
https://elearning.rcgp.org.uk/mod/book/view.php?id=13455&chapterid=770

What should be done with information that a patient does not want a person with proxy access to view?
While some patients find it helpful for a second person to have access to their online health record it is reasonable to hide from view any information the patient does not want visible to them; however it will need to be explained that this will not be visible to both patient and proxy. Please see the RCGP guidance for more information that can be found here
https://elearning.rcgp.org.uk/mod/book/view.php?id=13455&chapterid=770

How should safeguarding information be entered into a record if the patient has a proxy user linked, such as a child or young adult?
Any safeguarding information that is entered in the record in consultations, documents or by any other route should be hidden from the online view of the proxy or the patient. All GP clinical systems can do this without restricting access to the information in the practice or when the patient's record is shared for clinical care.

6. Preparing for full prospective record access

How will the planned changes impact practice workload?
Following an initial rise in new enquiries as practices and patients become familiar with routine record access, we expect this change to reduce administrative workload for practice staff by reducing patient phone calls, emails and visits. This should also deliver benefits for staff and practices, including increased patient satisfaction and greater operational efficiencies.

Although GPs, nurses and other clinical staff will be required to consider the potential impact of each entry, and customise or remove access for some individuals in rare cases, we expect that the overall long term benefits will outweigh any increase in workload due to improvements in communications and data quality.

How can a practice prepare for the planned changes to record access?
The GP readiness checklist has been produced to support practices in preparing for the upcoming changes to provide prospective record access to all patients. It signposts to relevant resources that include an updated RCGP GP Online Services toolkit and a series of videos and learning from early adopter sites. A PDF copy of the Checklist can be found on the FutureNHS workspace.

7. Other links and resources

- Future webinar sessions registration page
- Learning from early adopter sites
- Resources for GP practices including examples of patient communication.