Humber Teaching
NHS Foundation Trust

STANDARD OPERATING PROCEDURE
PATIENT ONLINE ACCESS FOR GP PRACTICES

Document Reference	SOP20-037
Version Number	2.1
Author/Lead **Job Title**	Karen Robinson Information Governance Officer
Instigated by: **Date Instigated:**	
Date Last Reviewed:	31 October 2023
Date of Next Review:	October 2026
Consultation:	Clinical Systems, GP Practices, Clinical Safety Officer, Safeguarding.
Ratified and Quality Checked by: **Date Ratified:**	Information Governance Group (virtually) 31 October 2023
Name of Trust Strategy / Policy / Guidelines this SOP refers to:	Access to Health Records Policy

VALIDITY – All local SOPS should be accessed via the Trust intranet

CHANGE RECORD

Version	Date	Change details
1.0	*Sept 20*	*New SOP. Approved at Information Governance Group (22 September 2020).*
2.0	*October 22*	*SOP updated to reflect the Accelerated Patient Access to prospective records from 30/11/2022.Implementation and publication did not go ahead following BMA concerns.*
2.1	*31 October 2023*	*SOP updated to reflect the new contractual implmentation date of 31/10/2023. SOP updated in line with the latest guidance. Section 3.5 updated to minimise full record exemptions and focus on harmful entries. 3.17 added to record any incident in relation to the online process. Appendix A and B applications form updated in line with RCGP templates. Appendix D on redaction simplified and screen shots removed. Appendix E removed and reference to the TPP guide included in 3.16. Appendix E updated. Flow chart added in Appendix G for incoming documents needing a review by a health professional. Approved by Information Governance Group (virtually) – 31 October 2023.*

Contents

1. INTRODUCTION

The GMS and PMS contracts in England require practices to provide Patient online services. Initially this included the ability for the patient to:

- Book/cancel appointment online
- Order repeat prescription online
- View summary information (allergies, adverse reactions and medications online)
- View the detailed coded record

The GP contract in 2023/24 requires new health information to be available to all patients online by 31 October 2023 unless they have individually decided to opt out or any exceptions apply.

- Existing online services users will be provided with access to all data entered onto the system from the date of conversion (31/10/2023). If previously granted, historical coded access and full record access will continue.

- New online services users, once registered, will have access to all data entered onto the system from the later of their registration date or the date of conversion (31/10/2023).

- Patient's under 16 will gain automatic access to future consultations from their 16th birthday.

- In exceptional circumstances – GP practices can identify patients to exclude prior to the change, or update user access settings after the change has been made.

This procedure describes how the Trust will meet these requirements.

2. SCOPE

The procedure covers all Trust employees, including all staff who are seconded to the Trust, contract, voluntary, temporary and agency staff and other people working on Trust premises. This includes members of staff with an honorary contract or paid an honorarium.

Automated access to future consultations will include coded information, free text and documents. It will not include administrative tasks and instant messages between practice staff. Patients will only be able see information that is held in their GP record and not information shared by third-parties that is viewable in the GP system.

Health records will continue to be reviewed before providing retrospective access to historical consultations.

Automated access only applies to people aged 16 years or older.

The patient continues to have the right to submit a Subject Access Request under the UK General Data Protection Regulation and Data Protection Act 2018. The Trust's Access to Health Records Policy will be followed.

3. PROCEDURES

3.1. Online services available

There are different levels of access available to patients. All requests to the practice for online access will be dealt with on a patient-by-patient basis. Patients are able to select the following services:

- Book/cancel appointment online
- Order repeat prescription online
- View their full record from date of access (coded record will be available prior to this date). This will be automatic from 31/10/2023 unless the record is excluded by the practice or the patient opts-out.

Patients may request online access to their full retrospective record as this may help to manage long term conditions. This will be at the discretion of the GP and will only be provided once the record has been reviewed for any exemptions outlined in Section 3.5.

3.2. Registration for online services

Applications for online access will be accepted from the patient as well as their proxy. Proxy access refers to access to online services by somebody acting on behalf of the patient with the patient's consent. Proxy access will not be accepted from any third-party commercial company i.e. Insurance company or solicitors.

The appropriate application form must be completed prior to any online access being enabled, see Appendix A (patient access) and Appendix B (proxy access). Application forms include:

- Advice on password confidentiality being the responsibility of the patient.
- Advice on unexpected bad news and/or abnormal results.
- Guidance on incorrect information/errors, noting that the patient has responsibility for informing the practice.

New patients will be asked if they would like to register for Patient Online as part their New Patient Questionnaire. Patient can also obtain access via the Log in - NHS App Online (service.nhs.uk).

Existing patients with online access enabled can update their access to full retrospective access by completing the form in Appendix C. Identity checks do not need to be re-completed. However, the exemptions (Section 3.5) and the risk of coercion (Section 3.9) will need to be reviewed by the health professional prior to providing access.

The GP within the practice can review and remove access at any point in the future if it is thought that it is in the best interests of the patient or if the services are being misused. GP practices should not enable record access for individual patients if there are any safeguarding/safety concerns.

3.3. Identity Verification

It is essential that identity is verified to ensure that access is granted to patients/proxy users that have a legitimate reason to access a record. This will prevent access being

granted to the wrong person and support the practice to adhere to information security guidelines.

For patient accessing online services through an NHS Login, identity verification is carried out online when they apply for the login. For patients applying direct to the practice, identity will be verified by either of the following:

- **Documentation**
  Two forms of documentation must be provided as evidence of identity, confirming the personal data on the application form. One document must contain a photograph that clearly matches the patient and the other must confirm that the applicants address matches the address record on the electronic health record.

  Acceptable documents include passports, photo driving licences and bank statements, credit card statement, Council Tax statement, mortgage statement. If none of the above are available household bills may be accepted at the discretion of the Practice Manager or named senior administration staff.

- **Self-Vouching**
  A member of the practice staff who knows the patient well enough to verify that they are who they say they are and that no deception is taking place can vouch for the patient's identity.

If neither of these two methods of verification are possible, a trained member of staff may be able to satisfy themselves of the applicant's identity by obtaining response to questions from information held in the medical records. This should take place discreetly and ideally in a planned appointment. It is extremely important that the questions posed do not incidentally disclose confidential information to the applicant before their identity is verified.

For example, the following would not be an appropriate question: "Please can you confirm when you were referred to the Improving Access to Psychological Therapies service?" Instead, an appropriate question might be: "Please can you confirm when you last attended the practice and for what reason", followed by further non-disclosive questions about further details until the staff member is satisfied.

Practice staff will document confirmation of identification on the application form for existing patients and on patient registration for new patients. Copies of identification will not be retained by the practice.

Further information is on identity checking is available at NHS England - Patient Online Services in Primary Care - Good Practice Guidance on Identity Verification

3.4. Timescales

Once identity is verified, the practice staff can grant patient access to appointments, repeat prescriptions and the future health record (unless an exemption applies).

If a patient requests access to their retrospective medical record they will be notified that it may take the practice up to 14-21 working days to review their application and grant access if appropriate. This is a guide only and, in some circumstances, may take longer. This will be at the discretion of the GP and will only be provided once the record has been reviewed for any exemptions outlined in Section 3.5.

3.5. Exemptions

Every discussion and decision relating to records access and safeguarding should be coded appropriately, documented in the GP record and the online user access settings updated accordingly.

3.5.1. Patient declines online access to their record.

If a patient requests for their online access to be withdrawn, the following code should be added to the record along with any reason provided and the online user access settings disabled.

1290331000000103 – Online access to own health record declined by the patient.

3.5.2. Full record Exemption

For future (prospective access) Trust practices will operate an information management policy rather than an access management policy. Harmful entries will be redacted at the point of entry rather than denying patient access to their online record. This will be automatically switched on for existing patients with online access from 31/10/2023 and when a patient reaches their 16th birthday or a patient applies for an online account.
In exceptional circumstances, the practice will not approve online access to detailed coded records or historical consultations (retrospective) and full clinical records (prospective) if it is deemed that it may cause serious physical and/or mental harm to the patient/others or they are unable to keep online access to their records secure. This will be done in consultation with the practice Safeguarding Lead. The GP will clearly document the decision and rationale and the patient online user settings will be updated. The code 1290301000000109 – "online access to own health record withheld following enhanced health record review" should be added to the record.

Prior to implementation, practices will run a report to identify patients who have had online access denied. It will be necessary to apply the SNOMED Enhanced review code: 1364731000000104 to prevent the patient automatically receiving access to future information. These records will be reviewed by the practice to ensure the access denial is still appropriate. Patients can also challenge this decision.

When an application for retrospective online access is received, patient records will be checked by a health professional within the practice prior to granting access. The health professional will check if patients are on certain registers for example, learning difficulties register, child protection register, mental health or have been identified as a possible victim/perpetrator of domestic abuse. The health professional will consult with the patient's usual GP if required before access is granted /denied.
If a risk is identified, the practice Safeguarding Lead will be consulted. In exceptional circumstances, access to the record will be denied. The GP will clearly document the decision and rationale and the patient online user settings will be updated. The code 1290301000000109 – "online access to own health record withheld following enhanced health record review" should be added to the record.

The review may indicate that limited access may be appropriate if the patient is at risk, the access settings should be set accordingly.

Patient circumstances change and these codes should be updated and their record access settings reviewed when a risk is identified or when vulnerable person is no longer vulnerable.

Practices should disable all online access (including proxy access) if they become aware a patient has gone into prison. This will be done by deducting the patient from the system.

3.5.3. Individual entry exemptions

The health professional recording in the clinical record or reviewing the historical clinical record will consider redacting the following exemptions. These exemptions must also be applied at the time information is documented in the record, regardless of whether the patient currently has online access.

A home screen reminder will alert primary care staff if a safeguarding exists in the patient record.

To minimise the information being withheld, consider making two separate entries. One containing information for inclusion in the online record and a separate entry with exempt information to be withheld from the online record.

Redactions may be reversed after a discussion with the patient. For example, an abnormal test result that might upset a patient if unexplained may be redacted until there is an opportunity to explain what it means to the patient.

The process for redacting personal data is in Appendix D. Health professionals should document the reason for the redaction in the note section.

Third Party Information

Information that is deemed third party will not be shared online. For example, an entry in the patient record about a relative and this information is unknown to the patient should be redacted from the online record. Information does not need to be withheld if the information is already known to the patient e.g. the patient provided this information.

Before recording information about or provided by a third-party, clinicians should seek and record their consent to the patient having access to the information they have provided. If the third-party withholds consent, it may be possible to redact the information.

Serious Harm

Information that may be confusing for a patient or may cause harm e.g. safeguarding information, a diagnosis, abnormal result or opinion that the patient is not aware of or records of a past traumatic event that might re-traumatise the patient. An entry about substance misuse; or suspected or actual abuse, violence or coercive behaviour towards the patient or a third-party or an opinion that they may perceive to be stigmatising.

Sensitive consultations/Confidential Information

All information regarding domestic abuse will be highlighted as confidential and will therefore be removed from online viewing. It must be made clear to patients that anything they say in relation to this during a consultation will not be viewable online.

Consider other records where domestic abuse needs to be recorded e.g. children's record and ensure it is hidden from online access. Parental access should be reviewed to consider whether it is still appropriate.

Confidential information that is not intended to be shared with the patient, for example case conference minutes, MARAC information. This should include any codes, free text, references within consultations and any document including referrals.

Any consultations of a sensitive nature may be highlighted as confidential.

Some data may be more sensitive if there is still a risk that someone is still abusing a patient. If they gain access to it, it could lead to serious harm to the patient. Coded family planning data, including medication or any indication that the abuse is suspected by the practice is particularly sensitive. Communication from domestic violence agencies and Multi-Agency Risk Assessment Conferences (MARACs) may be highly sensitive.

Mental Health Problems

Patients within the Practice with a mental illness have as much right as any patient to have access to their records, however, if there is a likelihood that access to their record may cause an individual physical or mental harm then it may be necessary to redact some of the information within their record, or

In extreme circumstances, refuse access to the whole record, in this circumstance the named GP responsible for the care of the patient will have a conversation with the patient to explain the reasons for refusal of access. This will be documented in the patient record.

For further guidance please see RCGP GP Online Services Guidance – Managing potentially harmful information.

3.5.4. Staff names in records

Staff names detailed in patient records are not considered third party information. If a member of staff believes that they are likely to suffer serious harm as a result of their name being released, they are entitled to raise an objection in writing to the Practice Manager, detailing why the disclosure would be harmful. Each request will be considered on a case-by-case basis in consultation with the Trust's Data Protection Officer and Caldicott Guardian. It is not technically possible to redact staff names from online access, however in exceptional circumstances, removal of the patient's online access will be considered.

3.6. Granting Access

Once the necessary checks and reviews have been carried out, the patient's Online Services tab will be updated to

"Enable full clinical record access" this should be from the data access is granted unless specified by the reviewer **and**

"Enable detailed coded record access" this should be to "all consultations" once a review has been completed.

Once access is authorised, the patient will be provided with their username and password. These credentials can be given to the patient by:

- SMS, using a verified mobile number recorded in the clinical system.
- Email, using a verified email address recorded in the clinical system.
- Printout, staff will confirm the patient's personal data to ensure the correct log-in details are provided. If the details are provided by post, the username and password must be sent separately.

For security, the system requires patients to change their password at first log on.

The same options are available for patients requesting password to be re-set. Patients can also re-set their own password via the "I've forgotten my password" on the SystmOnline Login page.

3.7. Childrens records

At age 11 young people may request access to their online services. The practice must decide whether having access to online services is in their best interests. Access by the young person may be refused if:

- there are concerns about the patient's best interests
- the young person lacks the capacity to consent
- there is a risk that the young person may not keep their access secure
- there is a risk of coercion

For children under 11 who are not deemed competent, someone with parental responsibility for the child can apply for access to their child's record and online services as a Proxy User, where it is in the child's best interest. Please see the Access to Health Records Policy for guidance on Parental Responsibility.

Proxy access to a child's record will automatically be disabled when a child reaches the age of 11.

For children aged 11-16, a parent/guardian/carer will need to re-apply using the Proxy Access Registration Process and a competency assessment must be carried out. If the child is not deemed competent, proxy access may be authorised if it is felt to be in the child's best interests. This will be reviewed by the practice when the child attends a further appointment and on an annual basis or on request by the patient or proxies.

If the child is competent, the child must authorise the request for proxy access. Access will be granted providing that it is the child's best interests. The competent young person has the following options:

- Stop their parent's proxy access to their online services, where the parents still have access after their 11th birthday.
- Allow their parents to have access to their online services or to specific services only e.g. appointment booking or repeat prescriptions but not to the medical record.
- Request access to their online services where nobody currently has access.
- Switch off all online access until such time as the young person chooses to request access.

A child deemed competent and **coded** with the Gillick competency code may have access to their online record or authorise a parent/carer to have Proxy Access.

People aged 16 or above are assumed under the Mental Capacity Act 2005 to have the mental capacity to make a decision about whether to give someone proxy access to their GP online services and record. It may be helpful to offer the 16-year-old their own online access, following this procedure. If they already have an account or set up an account, they will automatically have record access to future information entered after their 16th birthday and all entries will be considered by the health professional before making available online

If the young person lacks the capacity to make a decision about access at this age, it may be in their best interests for someone else to retain access to the record. For example, if the young person has a severe learning disability and it would be in their best interest for the parents to retain access, they may do so.

Best interest decisions should usually be taken by the GP who knows the child and family best. It may be helpful to consult practice team members and other health and care professionals who know the family well. The Trust's Mental Capacity Act and Best Interest Decision Making Policy should be followed.

3.8. Proxy Access

A competent patient can choose and consent to allow proxy access to relatives and/or carers in order to help them book appointments, order repeat prescriptions or help them manage their healthcare with access to their clinical record.

The form included in Appendix B must be completed. Proxy access will not be accepted directly from any third-party commercial company i.e. Insurance company or solicitors.

Proxy access will be authorised in the following circumstances:

- A patient who has been deemed as competent has authorised and consented to online access.
- The patient lacks capacity to give consent but there is another legal justification to provide access, e.g. registered power of attorney for health and welfare, a court appointed deputy, or if the GP decides it is in the patient's best interests in line with Mental Capacity Act 2005 or if there is an advance decision recorded for the patient about proxy access.
- For children under 16, please see Section 3.6.

The practice must ensure that the level of access granted to the Proxy is appropriate and does not exceed what has been agreed by the patient.

The practice can redact any information that the patient does not want visible to them, however it will need to be explained this will not be visible to both patient and proxy.

Where an adult patient has been assessed as lacking capacity, the authorising health professional must ensure that the level of access permitted is the minimum necessary for the performance of the applicant's duties. Proof of authority must be obtained and a copy uploaded onto the patient's record.

Proxy access should not be granted or should be withdrawn if:

- Practice staff have good grounds for suspicion that the patient consenting to proxy access not doing so willingly.
- Authorised practice staff believe a patient aged under 16 is competent to make a decision on access and does not give consent for proxy access by the person who is seeking it.
- If there is a suspicion that proxy access will create a risk to the security and privacy of the patient.
- The patient, having previously expressed the wish not to grant proxy access to specific individuals loses capacity, either permanently or temporarily and such a person requests proxy access, the advance decision should always be recorded in the patient's record.
- The patient's GP assesses that the proxy access being requested is not in the best interests of the patient.

The decision to withhold/withdraw access should be clearly documented on the application form.

Proxy access should be reviewed when:

- Requested by the patient.
- If access had been given based on consent and patient loses capacity, unless the patient specifically consented before they lost capacity to an enduring proxy access that would continue after they lost capacity.

Access was enabled on behalf of an adult lacking capacity and they regained capacity. Proxy access should then only continue with the patient's consent.

3.9. 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.

Vulnerable groups who are likely to be at increased risk include, but not restricted to:-

- 16 to 17 year olds including Looked After Children, Care Leavers and children on Child Protection Plans
- Victims of any type of abuse, but especially Domestic Abuse, Modern Slavery, Trafficking and exploitation of any kind
- Adults with safeguarding information coded on their record such as 'Adult Safeguarding Concern'
- Known perpetrators of abuse
- Those with learning disabilities
- Those with autism
- Those with dementia
- Asylum Seekers and those whose immigration status is uncertain
- Those with serious mental health conditions

- Those with post-traumatic stress disorder
- Other vulnerable groups including those who are homeless and those with substance misuse issues
- Prisoners, including those who are about to/have just gone into prison, and those who have come out of prison.
- Patients who are blind/visually impaired, who have poor literacy, who use different languages other than English, who communicate in different ways, who have other accessibility issues such as dyslexia and attention deficit hyperactivity disorder

The practice will include the implications of coercion during the patient application process for online services by way of issuing them with a patient leaflet detailing the implications.

The practice will consider the risk of coercion on a case-by-case basis as requests for access are received, and if necessary, will decline access. The patient's named GP will discuss with the applicant the reasons for refusal of access.

Practitioners must remain vigilant to the risk as patients may fall into a coercive relationship at any time. If coercion is identified as a risk with regard to a patient previously registered for online services, then access will be immediately removed, unless there is a significant risk that it could alert a perpetrator that there has been a disclosure of abuse.

The practice will **NOT** accept any proxy application **directly** from a proxy, except in exceptional circumstances. The practice will have additional security steps in place to check the authenticity of the application, for example, contact the patient where possible using contact information held in their medical record.

Prior to automated access switch on, practices will add a SNOMED code for patients who may be vulnerable to coercion due to reasons of safeguarding, domestic abuse, a patient with a learning disability, severe mental health or substance misuse issues. This will prevent automated access until a review has been carried out. See 3.5 for further information.

The RCGP – GP Online Services Guidance – Safeguarding vulnerable groups of patients should be followed when reviewing online access and recording sensitive information in the records of such patients.

3.10. New patients registering with the practice

From the date of implementation, when a new patient registers at the practice they will lose any access they had to historical information from their previous practice but will automatically get access to their future full record from the date they join the practice, providing they have an NHS login.

If a patient would like to access their historical information (detailed coded record or full), they will have to request this and the practice will need to review and redact record if necessary. Please note that currently redactions made to patient record at the previous practice are not transferred to the new practice.

The functionality of the "Enhanced review indicated before granting access to your own health record" will be transferred with the patient record via GP2GP and the same logic will apply at the receiving practice once the record has been received and accepted.

Should GP2GP fail, or an online account be created before the transfer, the practice will need to manually update record access settings once the previous record has been received to ensure it is appropriate. Prospective access will recommence from the date the patient is registered at the new practice.

Practices will review online access for all newly registered patients at the point of registration to ensure the access level is appropriate. The record should be checked for the presence of a 104 code and any subsequent review codes. Full record exclusion will only be in exceptional circumstances as described in 3.5.2

The patient online access registration form will be included in new-patient registration packs.

3.11. Appointments

This practice will allow a patient to pre book up to 2 appointments in advance (regardless of how these appointments are made online appointments cannot be made if the patient has reached 2 appointments in advance), this is inclusive of all Nurse type appointments and GP appointments.

There is a process in place for any patient abusing the online appointment booking services, as follows:

- Practice will issue an initial warning letter
- If the action continues the Practice will suspend access for two calendar months
- The practice will then reinstate the functionality to the patient
- If the abuse continues the Practice will inform the patient that their ability to book/cancel online appointments will be removed on a permanent basis.

The number and type of appointments made available via online services are as follows:

- GP appointment - 2 appointments per GP morning session and 2 appointments per GP afternoon session.
- Nurse appointments – Not yet allocated
- Healthcare Assistants- Not yet allocated

The practice will review these on a monthly basis.

3.12. Record Keeping

Trust GP Practice staff

All staff entering information into the record must have an awareness that the patient may be able to see it. All records should be clear and accurate and legible and follow the requirements set out in professional body guidance. All documentation must be filed in the correct record.

Health professionals should ensure that information is recorded in a way which makes it easy for the patients to understand it.

Access to the full clinical record for patient brings further record keeping responsibilities. Health professionals should be mindful about whether the entry they have created is sensitive, as outlined in Section 3.5. Sensitive information should be redacted from the online record at the time it is recorded regardless of whether online access is currently enabled by unticking “Visible in the online record” box in the “Event Details” template. A home screen reminder will alert primary care staff if a safeguarding exists in the patient record.

Consider making two separate entries, one containing information for inclusion in the online record and a separate entry with exempt information to be withheld from the online record.

If a young person with proxy access has a consultation that may contain sensitive information e.g. contraceptive advice, discuss with the patient whether they are happy for this to be part of their online record and whether the contraception should be put on repeat prescription.

Before recording third party information, you should discuss the possibility that the patient will see the information if they have access to their record. There are four steps that you can take:

- Ensure that the third-party understands that the patient may be able to infer the source of the information.
- Ensure that the third-party is prepared to bear that risk or to have their identity explicitly recorded.
- Obtain and record the consent of the third-party for the patient to have access to the information before recording the information.
- Redact the information so that the patient cannot see it online but it may still be available to the patient through a subject access request.

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

It is essential that incoming documents and letters are reviewed to ensure that patients do not see information online that they are not yet aware of e.g. a diagnosis or a test result that has not been discussed with the patient or information that would fall into an exemption outlined in 3.5. All incoming documents and letters will be reviewed initially by the practice Data Quality Team.

<u>Documents requiring clinical action</u>
The reviewer will forward the document to a clinician for review. The clinician will redact any document that must <u>not</u> be part of the online record.

<u>Documents not requiring clinical action</u>
The reviewer will review the document and make available for the patient to view online any that:

- have already been seen by the patient e.g. correspondence copied to the patient, documents provided by the patient.

- are within the knowledge of the patient e.g. referral letters, referral forms, clinic letters, appointment letters, OOH/111/urgent care attendance. See Appendix F for further information.

If the document contains information about a third party that is not known by the patient, the reviewer will redact the document from the online record, following the process in Appendix D.

The reviewer will request a health professional's review of any documents containing: -

- Further information/opinions that the patient may not be aware of e.g. test results.
- Sensitive information such as safeguarding, domestic abuse, offender information, mental health.
- Information about children under 16 and vulnerable adults.
- Any document that reviewer is uncertain about or would like to check.

If there are concerns, the Data Quality Team will electronically stamp the letter with "Possible safeguarding issue". They will add a red flag and note so that it is clear to the health professional. The flow chart in Appendix G will be followed.

This must not be made available to the patient online prior to the review. The document should remain "unfiled" until the review takes place

Non-GP Trust staff

When sending letters and documents to GP practices, all staff should be aware that patients may be able to see it through online patient access. Staff should make sure:

- all information should be clear and accurate and legible and follow the record keeping guidance set out by their professional body.
- information is written in a way which makes it easy for the patients to understand.
- they tell the practices if the document contains third party or serious harm information that should be withheld from the patient's online access.

  This should be done by printing and posting the document manually rather than sending electronically. The document should clearly state:

  THIS DOCUMENT CONTAINS THIRD PARTY/SERIOUS HARM INFORMATION (specify as appropriate) AND SHOULD BE EXCLUDED FROM ONLINE PATIENT ACCESS

  The final decision to withhold information from the patient will be made by the practice. All other documentation to GP practices should continue to be sent electronically.

3.13. Amending information

Widening access to health records makes it more likely that patients will read the entries being made. Sometimes, an individual may believe that inaccurate information has been added to their record. In such circumstances, the author of the entry will review the entries in line with the Access to Health Records Policy.pdf (humber.nhs.uk)

3.14. NHS App

Patients are also able to access online services via the NHS App. This will allow patients to:

- check their symptoms using the health A-Z from the NHS website
- find out what to do when they need help urgently, using NHS 111 online
- book and manage appointments at your GP practice
- order repeat prescriptions for collection at your practice or a pharmacy they have already nominated
- securely view their GP medical record
- register to be an organ donor
- choose how the NHS uses their data

All Trust practices are connected to the NHS App and this links into the practice clinical system. Patient online access to records using the app is set in the practice's clinical system and not by the app itself.

Practices will ensure that there is clear appointment naming for online bookable appointments available to patients.

From 31/10/2023 patients will be able to see their prospective records (including coded information, free text and documents) via the NHS App.

3.15. Promoting Patient Online Access

This practice will promote the Patient Online service to all patients using a number of methods to raise awareness to our patients. Methods of promotion to be used are as follows:

- Displaying NHS App GP health records access poster within patient waiting areas
- Advertising on the Online Services page of the practice Website (see appendix E)
- Informing patients using SMS text messaging.
- Notifying the Patient Participation Group and reviewing feedback
- Verbally with the patient
- Ensuring online access registration forms are included as part of the new patient registration packs.
- Highlighting in the practice answer phone message
- Advertising on repeat prescriptions forms

Practices will promote the NHS App using the posters and leaflets provided by NHS Digital - Tell your patients about the NHS App. Further materials are also available from NHS England Patient Information Guides and Digital materials

3.16. Implementation

Patient online access has been in place for a number of years. This is an enhancement to provide prospective access to their full clinical record from 31/10/2023. To facilitate this enhancement, Practice Managers will:-

System changes

- Prior to implementation, ensure access to full clinical records is enabled within the clinical system for all new patients and bulk online access is enabled for existing patients following the TPP guide Accelerating Citizen Access to GP Data. “
- Run a report to identify patients who have had online access denied. It will be necessary to apply the SNOMED Enhanced review code to prevent the patient automatically receiving access to future information.
- Ensure a home screen reminder is set up to notify staff that there is a safeguarding code in the patient record.
- Reviews are undertaken by clinicians when a patient is identified as “at risk” and that the Safeguarding Lead is consulted before access is denied.
- All records are reviewed prior to providing retrospective access to the historical record.

Staff training

- Staff are briefed on this procedure including new starters, locums/temporary staff when they join the practice.
- Staff attend the online awareness sessions provided by NHS England or watch GP webinar recording 4th May 2023 - Implementation Team - FutureNHS Collaboration Platform
- All staff to watch the video: Giving patients access to future general practice records - YouTube (2:41 minutes).
- Staff understand that, when appropriate, information must be redacted from online view at the time it is entered into the patient’s record regardless of whether online access is currently enabled. The process in Appendix D should be followed. There are useful videos to support this Why and when to make information not visible in patient records - YouTube and How to redact on TPP SystmOne - YouTube
- Relevant staff watch the Medical record keeping - Accelerating patient online access-20230510_125928-Meeting Recording - Implementation Team - FutureNHS Collaboration Platform

Applications

- Ensure updated applications in Appendix A, B and C are available to patients.
- Online access is actively promoted to newly registering patients.

3.17. Incident reporting

Any significant or learning events that happen following launch of this programme should be reported. Any safeguarding issues identified should be shared with the Trust Safeguarding Team via Datix, who can then escalate to the safeguarding team within NHSE to ensure national oversight of any evolving issues. Additional support can be accessed by emailing: england.nhsximplementation@nhs.net.

4. REFERENCES AND USEFUL DOCUMENTS

- Patient Online Toolkit, Royal College of General Practitioners: Patient Online Toolkit GP online services toolkit: Introduction (rcgp.org.uk)
- Online Access to Records Guide, The Medical Defence Union, https://www.themdu.com/guidance-and-advice/guides/online-access-to-records
- Practice Guidance – Offering Patients Prospective Online Access, NHS England and BMA General Practitioners Committee (GPC), https://www.england.nhs.uk/publication/patient-access-to-records-online-prospective-record-access/
- GP online services: Good Practice Support and Resources Guide, 2018, NHS England, https://www.england.nhs.uk/wp-content/uploads/2018/10/gp-online-services-communications-toolkit-3.pdf
- Guidance for GP Practices on the NHS App, https://digital.nhs.uk/services/nhs-app/prepare-your-practice-for-connection-to-the-nhs-app
- Access to patient records through the NHS App - NHS Transformation Directorate (england.nhs.uk)
- Accelerating Citizen Access to GP Data – SystmOne User Guide
- NHS England Patient Online Services in Primary Care - Good Practice Guidance on Identity Verification
- GP Online Services Guidance – Safeguarding vulnerable groups of patients (RCGP)
- GP Online Services Guidance – Managing potentially harmful information (RCGP)

5. RELEVANT TRUST POLICIES

Access to Health Records Policy.pdf (humber.nhs.uk)

Humber Teaching NHS Foundation Trust

Patient Online Access Registration Form

Surname			
First name			
Date of birth			
Address			
Postcode			
Email address			
Telephone number		Mobile number	

I wish to have access to the following online services (please tick all that apply):

1. Booking appointments.	☐
2. Requesting repeat prescriptions.	☐
3. Access to my (future) medical record	☐

Application for online access to my medical record

I wish to access my medical record online and understand and agree with each statement (please tick)

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

Signature		Date	

For practice use only

Patient NHS Number:			
Identity verified by:	Method used (tick all that apply): Vouching ☐ Vouching with information in record ☐ Photo ID and Proof of residence ☐	Details of documentary evidence	Date:
Clinical assurance completed by.		Date:	
Reason for refusal if record access is refused after clinical assurance.			
Level of record access enabled: Summary record ☐ Detailed coded record ☐ Full record (prospective only) ☐ Detailed coded record from date: _____ ☐		Notes/explanations	
Authorised by:		Date:	
Date account created:	Date login credentials given to patient:	Method: Email ☐ Text ☐ Printout in person ☐ Printout by post ☐	

Humber Teaching
NHS Foundation Trust

Patient Online Access

Important Information - Please read before returning this form

If you wish to, you can now use the internet to book appointments with a GP, request repeat prescriptions for any medications you take regularly and look at your medical record online. You can also still use the telephone or call in to the surgery for any of these services as well. It's your choice. **If you wish to register for online access as a third member or on behalf of a child please request a different form.**

It will be your responsibility to keep your login details and password safe and secure. If you know or suspect that your record has been accessed by someone that you have not agreed should see it, then you should change your password immediately.

If you can't do this for some reason, we recommend that you contact the practice so that they can remove online access until you are able to reset your password.

If you print out any information from your record, it is also your responsibility to keep this secure. If you are at all worried about keeping printed copies safe, we recommend that you do not make copies at all.

The practice may not be able to offer online access due to a number of reasons such as concerns that it could cause harm to physical or mental health or where there is a reference to third parties. The practice has the right to remove online access to services for anyone that doesn't use them responsibly.

Before you apply for online access to your record, there are some other things to consider.

Although the chances of any of these things happening are very small, you will be asked that you have read and understood the following before you are given login details.

Forgotten history There may be something you have forgotten about in your record that you might find upsetting.
Abnormal results or bad news If your GP has given you access to test results or letters, you may see something that you find upsetting to you. This may occur before you have spoken to your doctor or while the surgery is closed and you cannot contact them.
Choosing to share your information with someone It's up to you whether or not you share your information with others – perhaps family members or carers. It's your choice, but also your responsibility to keep the information safe and secure.
Coercion If you think you may be pressured into revealing details from your patient record to someone else against your will, it is best that you do not register for access at this time .

Misunderstood information Your medical record is designed to be used by clinical professionals to ensure that you receive the best possible care. Some of the information within your medical record may be highly technical, written by specialists and not easily understood. If you require further clarification, please contact the surgery for a clearer explanation
Information about someone else If you spot something in the record that is not about you or notice any other errors, please log out of the system immediately and contact the practice as soon as possible.
Incorrect information If you find something you think is not correct, you should contact us. The staff will be able to answer your questions and set things right when needed. Please bear in mind that you cannot change the record yourself.
Proxy Access: Parents may request a proxy access to their children's records; this will cease automatically when the child reaches the age of 11. Any subsequent proxy access will need to authorised by the patient subject to a competency test being completed.

More information

For more information about keeping your healthcare records safe and secure please visit the below website:
https://www.nhs.uk/nhsengland/thenhs/records/healthrecords/documents/patientguidancebooklet.pdf

Consent to proxy access to GP online services

Note: If the patient does not have capacity to consent to grant proxy access and proxy access is considered by the practice to be in the patient's best interest section 1 of this form may be omitted.

Section 1

I,…….. (name of patient), give permission to my GP practice

to give the following people ……..……..

proxy access to the online services as indicated below in section 2.

I reserve the right to reverse any decision I make in granting proxy access at any time.
I understand the risks of allowing someone else to have access to my health records.
I have read and understand the information leaflet provided by the practice.

Signature of patient	Date

Section 2

Online appointments booking	☐
Online prescription management	☐
Accessing the (future) medical record for (name of patient)	☐

Section 3

I/we…….. (names of representatives) wish to have online access to the services ticked in the box above in section 2

for ……..…… (name of patient).

I/we understand my/our responsibility for safeguarding sensitive medical information and I/we understand and agree with each of the following statements:

I/we have read and understood the information leaflet provided by the practice and agree that I will treat the patient information as confidential	☐
I/we will be responsible for the security of the information that I/we see or download	☐
I/we will contact the practice as soon as possible if I/we suspect that the account has been accessed by someone without my/our agreement	☐
If I/we see information in the record that is not about the patient, or is inaccurate, I/we will contact the practice as soon as possible. I will treat any information which is not about the patient as being strictly confidential	☐
If I/we think that I/we may come under pressure to give access to someone else unwillingly, I will contact the practice as soon as possible.	☐

Signature/s of representative/s	Date/s

Section 4

The patient (This is the person whose records are being accessed)

Surname	Date of birth
First name	
Address Post Code	
Email address:	
Telephone number:	Mobile number:

The representatives

(These are the people seeking proxy access to the patient's online records, appointments or repeat prescription.)

Surname	Surname
First name	First name
Date of birth	Date of birth
Address Postcode:	Address (tick if both same address ☐) Postcode:
Email	Email
Telephone	Telephone
Mobile	Mobile

For practice use only

Patient NHS No:			
Identity verified by:	Method used (tick all that apply): Vouching ☐ Vouching with information in record ☐ Photo ID and Proof of residence ☐	Details of documentary evidence	Date:
Clinical assurance completed by:		Date:	
Reason for refusal if record access is refused after clinical assurance.			
Level of record access enabled: Summary record ☐ Detailed coded record ☐ Full prospective record ☐ Full (retrospective) record from date:_____ ☐		Notes/explanations on proxy access	
Authorised by:	Date:		

Date account created:	Date login credentials given to patient:	Method Email ☐ Text ☐ Printout in person ☐ Printout by post ☐

Important Information – Please read before returning this form

It will be your responsibility to keep your login details and password safe and secure. If you know or suspect that your login details have been compromised, then you should change your password immediately.

If you can't do this for some reason, we recommend that you contact the practice so that they can remove online access until you are able to reset your password.

If you print out any information from the record, it is also your responsibility to keep this secure. If you are at all worried about keeping printed copies safe, we recommend that you do not make copies at all.

More information

For more information about keeping healthcare records safe and secure please visit the below website:

https://www.nhs.uk/nhsengland/thenhs/records/healthrecords/documents/patientguidancebooklet.pdf

Humber Teaching NHS Foundation Trust

Online Patient Access - Update to Full Clinical Record

Surname			
First name			
Date of birth			
Address			
Postcode			
Email address			
Telephone number		Mobile number	

I wish to update my current online access to be able to view my full clinical record. I understand that this only include information added to my record after access is granted.

I wish to access my medical record online and understand and agree with each statement (please tick)

I have read and understood the information on the reverse of this form.	☐
I will be responsible for the security of the information that I see or download.	☐
If I choose to share my information with anyone else, this is at my own risk.	☐
If I suspect that my account has been accessed by someone without my agreement, I will contact the practice as soon as possible	☐
If I see information in my record that it not about me, or is inaccurate I will log out immediately and contact the practice as soon as possible.	☐
If I think I may come under pressure to give access to someone else unwillingly I will contact the practice as soon as possible.	☐

Signature		Date	

For practice use only

Patient NHS Number:			
Clinical assurance completed by:		Date:	
Reason for refusal if record access is refused after clinical assurance.			
Authorised by:		Date	
Date account updated			

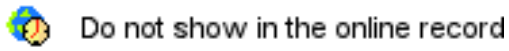
Appendix D - Redact information from the Patient New Journal View

There is a useful video from NHS Digital: [How to redact on TPP SystmOne - YouTube]

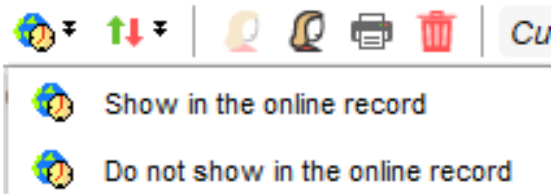
Data recorded in SystmOne can be hidden from the patient's online record. This will apply to the entire consultation and not individual items. If an attachment needs to be redacted, the full entry will need to be marked for redaction.

Redactions can be done in a number of ways:-

Right clicking the header of individual consultations in either the New Journal or Tabbed Journal screens and select **do not show in the online record.**



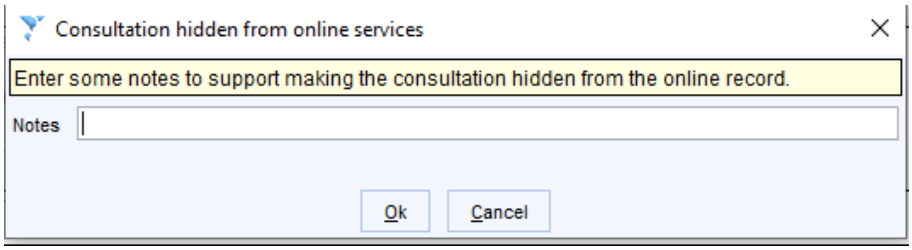
Using the toolbar menu on selected consulations to hide one or more consultations selected.



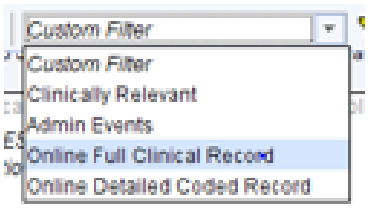
Using the event details dialog - clicking the details toolbar button will let you alter event details for the current consultation. Then unticking **visible in the online record** will hide it.

Please note, marking an event as private will not hide from online view.

You will be prompted to add a note giving a reason for withholding the information.



Use the Custom Filter to review the information seen by the patient.



NB. The filters do not show test results.

Appendix E - Internet Entry for the Online Services Page of the GP Websites

Online services allow you to access a range of services via your computer, mobile or tablet. Once you have signed up, you may be able to:-

- book, check or cancel appointments online
- renew or order repeat prescriptions online
- view your electronic medical record, including information about medication, allergies, vaccinations, previous illnesses and test results.

From 31 October 2023, if you are over 16 and have an online account, such as the NHS App or SystmOnline, you will now be able to see all future notes and health records from your doctor (GP). Some people can already access this feature, this won't change for you.

These changes only apply to people with online accounts. You can create an online NHS account Log in - NHS App Online (service.nhs.uk). Alternatively, you can register for an online account with the practice, please speak to a member of the practice team.

If you do not want to see your health record, or if you would like more information about these changes, please speak to your GP or reception staff.

You can still contact the practice by phone or in person, this is just another option, which other patients have found is more convenient and saves them time. More information including "how to" leaflets and videos of patients and why they are using GP online services are available at www.nhs.uk/gponlineservices.

Appendix F - Documents not Requiring Clinical Action

The below documents will be made available for the patients to view online if they are in the knowledge of the patient.

(Extract from HABIT guide).

- OH/111/ urgent care / pharmacy if seen and treated
- IDLs elective admission requiring no action
- Clinic letter requiring NO INPUT from clinician*
- A&Es (adults)
- GOS18 (to secretary)
- Retinal Screening
- Physiotherapy
- CC's / internal referral letters between consultants
- Newborn hearing screening
- Appointment letters
- Aortic Aneurysm screening
- DNAs
- Correspondence the patient has been copied into.

If the document contains information about a third party that is not known by the patient, the reviewer will redact the document from the online record, following the process in Appendix D.

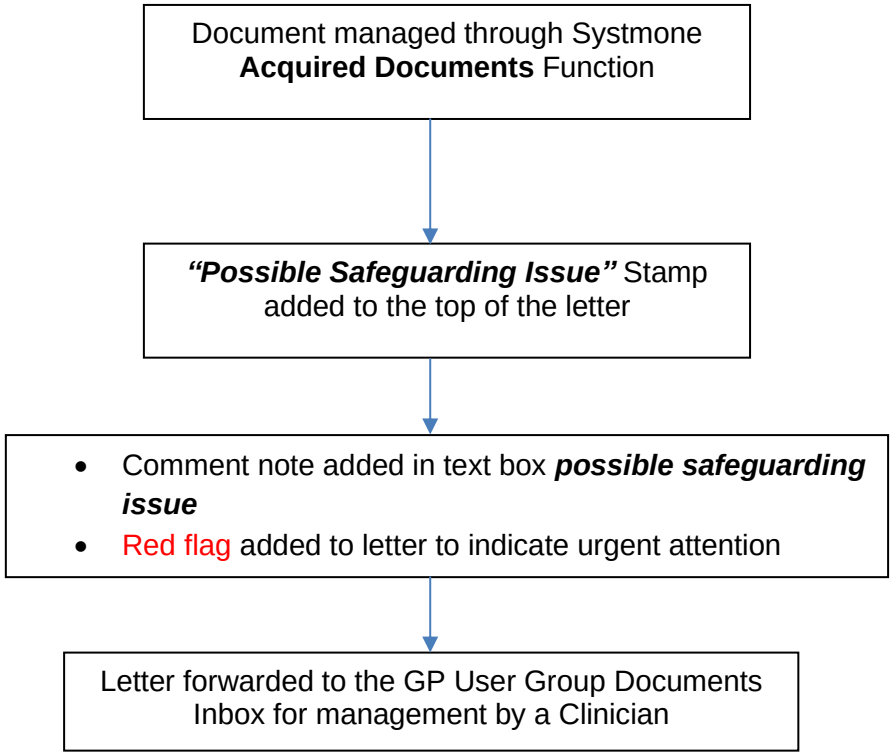
The reviewer will request a health professional's review of any documents containing: -

- Further information/opinions that the patient may not be aware of e.g an urgent result such as a scan or histology result, the outcome from a 2-week wait (rapid access).
- Sensitive information such as safeguarding, domestic abuse, offender information, mental health.
- Information about children under 16 and vulnerable adults.
- A document containing a specific warning that it is not for patient viewing.
- Any document that reviewer is uncertain about or would like to check.

The document must not be made visible in the online record until the health professional has reviewed.

Appendix G - Data Quality Team - Post Processing Flowchart

DATA QUALITY TEAM – POST PROCESSING FLOWCHART
POTENTIAL SAFEGUARDING ISSUE



Screenshot of Letter in the Documents Inbox for processing by the Clinicians