From 1st November (2022), all patients aged 16+ will have the ability to *automatically* view information *subsequently added* to their electronic GP record – that is, information added on or after 1st November.

*What does that mean?*

* For patients who already have *full online records access (i.e. access to their entire, historic electronic GP record),* it means nothing
* For patients who have “basic” online access – that is, the ability to just request repeat medication, make appointments (where enabled), and update demographic information – they will automatically, and suddenly, be able to view new information added to their GP record – consultations, results, documents, free text etc
They will not require our permission, nor will we need to do anything to enable this
They automatically get *prospective, detailed, care record access*
* For patients who do not currently have online access, it means that whenever they do sign up to the NHS App they will then, suddenly, and *automatically*, be able to view new information added to their GP record
They will not require our permission, nor will we need to do anything to enable this
They automatically get *prospective, detailed, care record access*
* For children aged <16, and who have an NHS App login, they automatically get *prospective, detailed, care record access* once they turn 16

*What doesn’t that mean?*

It doesn’t mean that patients will suddenly be able to view their entire, historic, GP record – information dated on or before 31st October 2022. They will still need to request that level of “full access” from us, their GP will still need to check that it would be safe for such access to be granted, and I/we will still need to check the record to redact any information that should not be visible.

It will have no effect on the process of a patient making a data subject access request, as is their right under Article 15 of the UK GDPR. We will deal with SARs in exactly the same way as we do now.

*What are the implications of prospective records access?*

1. We should assume thatevery single patient aged 16+ has prospective access (whether they actually do or not)
We should do that *now*
2. That means that – unless you take steps – everything filed into the EMIS Web record will be visible to the patient – every consultation, result, EMIS document, Docman document, free text comment
So be careful what you put in your consultations

1. If you don’t want the patient to be able to see a particular piece of information:

*permanently ­–* such as a safeguarding report
*temporarily* – such as a result that you want to discuss with the patient first

then it needs to be made not visible online (as per the attached guidance)

1. That might mean creating *two* consultations, one hidden, one not hidden, *if you feel that is needed*
2. We need to be vigilant to hide stuff (make non-visible) *as we file it.*Pitfalls - remember to hide where appropriate:
* Results downloaded from pathlinks
* Discharge summaries with distressing information or diagnosis, until you have discussed it with the patient
* Correspondence which clearly shows a colleague’s email address, or mobile phone number
* Everything safeguarding
* Results that you don’t want the patient to see before you have discussed it with them
* Letters provided in confidence from family member/neighbours etc
* Documents containing personal data about another person (3rd party information)

*How can we stop this for an individual patient?*

If you genuinely believe that a patient absolutely must not have automatic prospective (not historic) records access, then you can add a code, before 1st November, to their notes to prevent that switch-on for them (or when they sign up to the NHS App).

Adding the SnoMed Code “*enhanced review indicated before granting access to own health record*” will prevent automatic ‘switch-on’ of online access to prospective records.

This code does not affect proxy access but when applied to those under 16 years old it will prevent them from automatically having access after their 16th birthday.

That code being added should be the exception. You might genuinely feel that a patient would be put in mortal danger if automatic records access happened, perhaps because you have strong suspicions that they are in a controlling and coercive relationship and that it is highly likely that their partner would have access to the patient’s app.

You may then wish to discuss records access with the patient first, and then remove the code if you are satisfied that prospective access would be safe.

Just because a patient has a history of depression or psychosis, or that you anticipate safeguarding information will be incoming to their record, it is not a reason to *automatically* exempt them from prospective access. Think about the patient and their circumstances, and discuss it with your Caldicott Guardian if needs be.