



Kent Local Medical Committee

Supporting list based personalised care, the partnership model and meaningful collaboration

FAQ Prospective Access to Records

What is prospective share of GP notes to patients and what will it mean from patients?

Once activated for your practice it will mean all eligible patients e.g. all of those **without** a 104 redaction code applied to their notes, aged over the age of 16, will automatically be able to read free text in their GP record, but only from that day forwards with nothing historical visible at all.

How will patients view their notes?

This will be facilitated by NHS app or similar, so if patients have access to the NHSapp (about 50% of patients currently do), from the date your practice goes live, they will simply be able to click on a button on the app and see their notes.

What components of the GP (EMIS/DOCMAN) patient record are included in the patient view of their records?

The patient view will include all **prospective** free text from consultations, all problems (once activated in a current consultation), medications, investigations, Docman documents and all generated referral letters. The only thing not included are tasks and warning alerts added to their notes. Documents / results are not shared until they have been filed into the EMIS record e.g. **not** provisional results / documents.

PLEASE NOTE: It is not yet clear if documents filed after the switch no date, but filed with a historical date prior to the practice switching on access, will be visible to the patient. This is being clarified by the CSU.

How does that differ from what happens now?

Most patients with the NHS app can view their active medications and repeats, many can already view their investigation results (depending on individual practice settings). Currently patients can request to have access to their notes, but the process request is processed by the practice and a decision is made. In addition, current access via this route tends to be both historic and prospective.

What are the main concerns that GPs have?

1. *Increase in workload for practices* - Some GPs are worried about the impact of reading their notes which are not currently written for patients to read which could cause confusion and increase workload when asked to clarify entries.
2. *Early arrival of information on patient record* - There is concern that information arriving at the patient record, particularly letters highlighting important diagnoses could be available in the patient view prior to the patient being told by a hospital specialist team e.g. finding out a cancer diagnosis from a cancer MDM summary.
3. *Coercive relationships* Data indicates that 1 in 20 relationships are coercive and there is a worry that the current safety and confidentiality of a GP and patient consultation could be breached if a coercive and controlling partner asks to look at their GP records.

4. *Accidental sharing of 3rd party information* for instance if a safeguarding letter or MARAC form contains 3rd party information that the patient is not aware of e.g. address of an ex-partner, the ex-partner who may not have wanted their address sharing could have their confidentiality breached.

What are my contractual responsibilities for enabling prospective access to GP records?

The current contract that was imposed on the profession requires that by the 1st of November, practices enable prospective access to notes for all suitable patients. GP partners are the data controllers and must be sure that there are safe and reliable processes in place to ensure information can be shared safely. Partners should be sure all their staff have had adequate training. Partners must endeavour to ensure that activating prospective sharing will not jeopardise safety.

What do practices need to do prior to enabling prospective access to GP records?

EMAS settings need to be configured correctly and then for patients to have automatic access, EMIS need to run a special program called a script. This identifies the patients suitable and activates them. We are aware the CSU and EMIS have been contacting practices to book for this to happen prior to October 31st. The CSU can be contacted at training.scwcsu@nhs.net if they wish support with enabling bulk record switch on.

Can I stop a patient viewing their records?

This can be done by entering the SNOMED '104' code onto a patients record which will prevent the patient having automated access to their records following your practices activation date. There is guidance for practices to follow produced by NHSE suggesting which patients are may not be suitable i.e. because of safeguarding concerns. There are two searches that have been developed to help identify those patients and these are available from the CSU at training.scwcsu@nhs.net.

Can I stop all my patients automatically viewing their records?

Yes, this is possible if you bulk entered a 104 code for every patient. However, NHSE and ICB have data on % of patients with 104 codes and have indicated this could be deemed to be a breach of contract if there is no justifiable clinical reason for a patient being restricted from seeing their record.

Can I tell if a 104 code has been applied to a patient's notes when adding a consultation?

It is not immediately obvious if a 104 code has been applied to a patient's notes. However, the CSU has written a protocol which can be added into EMIS which will then show in the prompt box that the 104 code is in place.

Can I override the 104 code?

Yes, by adding a 106 code.

Can I stop specific items in the patient record to be visible?

Yes, if the patient has automatic access, but a clinician decides the information in the consultation is not suitable for patients to view, clinicians /admins staff can click on the 'online visibility' icon on the blue banner in EMIS, near the top of the screen when entering the consultation and select 'do not display on the patients online care record'. Similarly, there

is an option to manage online visibility as documents are scanned on to DOCMAN. Clinicians who file results in EMIS will have probably noticed that at the time of filing you can select if the result is suitable of the patient online record or not. Training can be provided by the CSU on how to manage these restrictions by contacting them at training.scwcsu@nhs.net

Resources

There are resources available to assist practices prepare for the switch on at:

BMA - [Updated guidance on accelerated access to GP-held patient records \(bma.org.uk\)](http://bma.org.uk)

- latest contractual guidance & links to resources

RCGP toolkit - [GP online services toolkit: Record Access \(rcgp.org.uk\)](http://rcgp.org.uk)

- How to prepare
- Flow charts
- Consent forms
- Communication guidance and leaflets
- IG & Safeguarding considerations & guidance
- Clinical exemplars ie LTC condition management

NHS digital - [NHS App access to GP health records - patient communications for practices - NHS Digital](#)

CSU Training and go live support

Webinar to be held on Tuesday 3rd October at 12noon: [Click here to join the 3rd October EMIS PRA webinar at 12noon](#)

Contact - training.scwcsu@nhs.net