DPS10 Online Access Protocol

Upwell Health Centre and Welle Ltd (Pharmacy)

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Online Access

From a currently unknown date in 2022 NHS England / NHS Digital will be turning on **full** online access to prospective data for all patients through the NHSApp (and other approved Apps) for SystmOne / TPP users and EMIS users. It is important for all to start considering now how this will affect uploads to patient records and considerations.

What is Online Access?

This is a feature that allows patients to view their health record online, either through the NHSapp or a web portal.

There are different levels of access:

* **Coded Access:** Basic coded information from the record
* **Detailed Coded Access:** All coded information plus the ability to order repeat prescriptions and book appointments
* **Full Online Access (Contemporaneous):** Instant access to prospective data as soon as it is saved to the patient record.
* **Full Online Access (Retrospective):** Plus, from next year, access to all historic information uploaded to the core GP record

What is the current standpoint?

The current contractual requirement of GP practices is to provide detailed coded online access for patients.

The 2020/2021 GP contract, found [HERE](https://www.legislation.gov.uk/uksi/2020/226/schedule/1/made), also includes a requirement to provide **full** online access to patients (section5(71Z)) on the condition that appropriate redaction software is available. We have historically advised that it is not necessary to provide full online access since there is no appropriate redaction software available within the clinical system.

Regardless, the recent notification suggests that the initiative will proceed despite the lack of redaction software and many professionals (IG, LMC, RCGP, BMA etc) across the Country are raising concerns. Furthermore NHS England / NHSX confirmed that they consider the current “hide from view” functionality to be suitable redaction software, however we disagree.

What is our DPO current advice?

Our current position is that providing full online access is an infringement of data protection legislation and there are a number of risk areas that we have particular concerns about:

**Confidentiality Breach**

It is not uncommon for patient referrals / prescriptions / letters or consultations to be uploaded to the wrong record in error.

Under the previous process, there was time to correct this. Under the new process, the patient will have sight of this information instantaneously and potentially even receiving push notifications that a new upload has been made to their record.

We have already seen an upward trend of patients seeing other patients’ information for practices that have online access enabled.

**Infringement of the Law Related to Subject Access Requests**

Patients may perceive online access as a way of fulfilling their access rights as it enables an individual to review the information held about them by the GP Practice. NHS England are also advertising this as a way to uphold of the right of access for individuals and reduce the burden on GPs.

Under UK GDPR / DPA 2018 a Controller (the practice) is required to ensure that all information is provided and that any that is withheld, must meet the thresholds for specific exemptions set out in the legislation.

It is a criminal offence to withhold information for the purposes of Access Requests unless it legitimately meets an exemption. Hidden from view has the potential to withhold information that does not meet an exemption simply because it cannot isolate and redact certain information from a consultation, it’s either all or nothing.

This means that all staff will require specialised subject access request and exemption training (as confirmed by the ICO) and be required to review all information before uploading with the exemptions in mind. Where they are unsure, or an exemption is applied, that letter / referral / consultation will require being “hidden from view”

**Patient Seeing Test Results Too Soon**

Under the new process, it is possible that blood test results / cancer diagnosis / other updates requiring delicacy or support might be seen prior to discussion with the clinician.

The clinical system apparently does allow the practice to delay the uploading of certain tests to a certain date so that the clinician has time to contact the patient.

However, if the patient appointment gets cancelled / rescheduled, the information will still be released to patient unless the date of release is also amended.

**Increased patient calls / complaints / rectifications about consultations**

We have seen an upward trend of patients raising complaints on concerns about information held in their record. Whilst we advocate for patients to exercise this control over their information, we are concerned that practices do not have the resources to respond effectively. Similarly, practices are expected to allocate the resource to review historic records of all patients prior to the full switch on in 2023.

**Safeguarding Risk to Children and Vulnerable Adults**

We have liaised with the ICO earlier this year regarding an incident for one of our practices where child abuse information was released to a parent by mistake through full online access. The ICO concluded that:

*This incident therefore appears to have occurred primarily due to NHS England’s*

*requirement to provide mandatory online access to patient records when*

*requested to do so and an absence of any specific guidance regarding this*

*process, particularly in relation to the management of and online access to*

*information created after the initial review of a patient’s record has taken place*

*and online access has been granted. This issue can therefore be considered a*

*national level concern rather than a specific processing failure by X practice*

Currently, there has been no resolution to the national concern and no further guidance from NHS England on how to manage this process.

We recognise that proxy access (such as parental access to record) will not become full online access, however, this risk remains as safeguarding information is added to all family members records. This means a parent with full online access to their own record may see an upload that talks about the safeguarding concerns about the family as a whole.

**Language Used in Consultation Notes May Cause Upset / Distress**

Some legacy records may include notes or comments that require what we called “supported disclosure”. This might be because they were written in a way that could be deemed inappropriate or personal. We have seen this happen, for example, notes about aggressive behaviour of patients.

We have also seen some staff recently uploading information about difficult encounters into the patient record and the patient raising objections to the use of language. For example, recording in the patient record that they were “rude” or “argumentative.”

Historically, the practice would have had an opportunity to disclose these in a way that is supportive and gives the patient an opportunity to make changes or obtain an apology.

**Are practices still indemnified or will insurers find practices liable for incidents arising.**

We are currently unaware of whether insurance companies will consider this covered. The NW LMC are asking these questions of the NHS and other stakeholders and we will keep you informed as they obtain answers.

What does the upcoming change mean?

Despite our grave concerns, it appears as though the national mandate will be imposed.

The change will start with just new added data being available to patients and then next year all retrospective data will be available to patients. NHS England are currently working with the clinical system providers to provide a software update that allows the clinical system provider to turn on online access at a national level.

At a local level, the practice is able to turn the online access back off, however, NHS England have confirmed they would see this as a breach of contractual requirements and would take necessary action against any NHS provider who does so.

There is the further risk that even if the practice turns it on at a local level that NHS England will override this at a later date and the patient data will become available without due preparation.

For SystmOne users this means from a currently unknown date in 2022 all patients who are or will sign up to online access / download the NHSapp (or other authorised app) will have access to all data added to their record from the moment it is saved to their record.

For EMIS users this means from mid-2022 all patients who are or will sign up to online access / download the NHSapp (or other authorised app) will have access to all data added to their record from the moment it is saved to their record.

We are unclear on whether this will mean that at the date of turn on for all practices patients will still see information from the 1st of April 2022 or from the date the functionality is switched on.

Other practices have managed this change, why can’t we?

Whilst other peers or providers may assert that they have fixed the issue or found a workaround, this does not mean that their approach is lawful or mitigates the risks we discuss above.

Having reviewed their approaches, we are not satisfied that any of these workarounds mitigate the high risk to rights and freedoms of individuals. At a recent webinar given by a practice who claimed to have found a solution, it became clear they have done so under the misapprehension that Data Protection legislation does not apply to any individual seeking access to their own information. This approach disregards Chapter 3 UK GDPR which specifically deals with the rights of an individual to their information.

In light of this, we have raised this to the UK Information Commissioner and are aware of a number of other organisations such as the Norfolk and Waveney LMC, the National Information Governance Network and RCGP who share these concerns and are lobbying for a delay in roll out.

In case this is not successful we have produced the following guidance to attempt to reduce the risk for our practice customers as much as possible.

Risk Mitigation

**It is always possible to take off the “hide from view” and show to the patient at a later date, therefore, should you ever be in doubt you must hide from view in the first instance and consult with Caldicott Guardian / DPO / SIRO or other appropriate member of the practice.**

1. All staff must read the Kafico provided subject access request protocol
2. All staff adding to the clinical system must attend (or watch the recorded session of) the Kafico SAR training
3. All staff must ensure they understand how to hide consultations from online access view (<https://www.england.nhs.uk/wp-content/uploads/2019/12/Prospective-records-access-practice-guide-v1.2-accessible-1.pdf> Page 11 and 12)
4. All staff must read any information before they upload to the clinical system and hide from view where they suspect it will meet an exemption.
5. All staff must take extra steps to ensure they are in the correct patient record before saving anything into the record.
6. It is best practice to only have one patient record open at any one time, to assist in preventing saving information to the wrong record.
7. For subject access requests, staff must not rely on something being “hidden from view” as confirmation that it meets an exemption.

**Consultations**:

Clinical staff must consider the following before saving to a patient record:

* Is the information factual?
* Was this a consultation with a family member instead of the patient?
* Is the language appropriate?
  + Think “patient advised that partner has gonorrhoea” as opposed to “patient’s partner has gonorrhoea”
* Is there any third-party information in the consultation?
* Is there any safeguarding information in the consultation?
* Is this information likely to cause serious harm to any individual?
  + I.E. Significant mental health concerns
* Is there social work information in the addition?

**Test Results:**

All staff should ensure that test results of any kind that may cause distress to the patient do not go live until after the patient has met with a clinician.

Where it is possible to schedule the test results to go live at a certain date after the patient has seen a clinician this must be updated where that appointment is rescheduled to ensure the test results do not go live in the meantime.

**Letters / Correspondence from other health and social care providers:**

All staff must read the correspondence before saving to a patient record and consider:

1. Is there any third-party information in the letter?
   1. For example, is it a social services letter about the family as a unit and therefore has information about each child and both parents in it?
2. Is there any safeguarding information in the correspondence?
3. Is any of the information likely to cause serious harm to any individual?
   1. I.E. Is there any significant mental health concerns?
4. Is it a confidential letter from the police / social services?

Actions:

* If yes to the above, hide from view
* If no, save to the patient record
* If unsure, hide from view and raise to relevant staff member to undertake review.
* If upon review, staff are still unsure, this should be raised to CG / DPO

**Safeguarding / Child Abuse Data:**

It is important when uploading data to a record to ensure that no child abuse / safeguarding information is revealed without due consideration. This is taking into account that safeguarding information may be added directly to the alleged abuser records and not just the potential victims.

The child abuse exemption slightly differs from other exemptions in that it is necessary to ensure that you neither confirm nor deny that the information exists. For standard SARs this usually means removing the information rather than blacking out so that the parent / legal guardian is not aware something is hidden from their view.

This is more difficult for online access as there is no ability to hide just a part of a consultation. You either hide all or none. There is a risk that hiding all, particularly when the parent / legal guardian was present at the consultation, would reveal that something in the consultation is hidden from them. This applies to adult safeguarding and domestic violence concerns as well.

For example, let’s say a vulnerable patient attends for an ear infection but clinician notices shadowed bruising and is aware patient is a victim of coercion and control.

In the consultation notes it is written

“Patient attended due to ear infection, blood seen in ear canal, 1 week course of antibiotics prescribed and to come back in if not cleared up by end of the week.

Also noted further bruises on arm and given history, will raise to safeguarding lead to review and escalate to adult social services.”

The patient would expect to see this consultation on their online access, or their partner, who is abusive, may have the app so that they can see the consultations. However, this has been hidden from view due to the safeguarding element. This inadvertently reveals there is something hidden from the abuser and the patient creating increased risk to the victim.

We would advise doing the following moving forward:

1. Complete consultation and write up notes on reason for visit and save to the record
2. Create a second consultation with the safeguarding risks and “hide from view” before saving to record.

**Patient Complaint:**

Any complaints should be raised to your DPO in the first instance so that we can support in navigating this new stage of patient access and support in responding appropriately, patients are likely to raise complaints to the ICO more often if they feel their complaint has not been managed appropriately and we have noticed an upward trend in individuals being less patient.

**Particular Patients:**

All practices have cases that are somewhat more difficult to manage in terms of demand, complaints, and concerns but also in terms of level of safeguarding risk.

It may be appropriate to consider your patient list and determine whether there are any patients that you believe it would be inappropriate for them to have online access.

We will need to undertake a small assessment to ensure that this is appropriate as NHS England may look to challenge your decision if a patient complains to them, so please do engage with us if you have any patients that you are considering turning online access off for.

For those who are using the Kafico Managed Disclosure Service, we can happily undertake a full review and exemption application for particular patients, prior to April 1st.

**Other Providers with access to your clinical system module:**

You may have other providers, such as midwives and physios, who have been granted access to the practice clinical system module and so their entries will appear in the core GP record and therefore on online access.

You must share this guidance with them, via email, and ensure they are aware that they must follow this guidance and raise any questions with the practice and your DPO, not their organisation IG lead / DPO.

What about Subject Access Requests Recieved?

Given this access is currently only for future data we advise continuing with access requests in the same way you have been doing. This is because the current redaction for online access requires the entire upload to be hidden from view and so there is a risk of over redaction where only part of the consultation / letter meets an exemption. When handling a manual SAR, you would need to include the information from that upload that does not meet the exemption.

It would be inappropriate to consider the online access function to be completely satisfying the rights of the individual given its limitation and therefore would advise against refusing to provide any data added from the 1st April 2022.

Transparency

If you have Kafico materials published, we will be adding an Online Access section directly and will show this to you in our pre-Go Live Workshop end of March 22.

If you don’t have our materials, we recommend that you add some materials that make it clear to patients that Online Access is not a SAR. This protects you from the offences related to overreaction.

Further Questions

We will continue to push back and raise our concerns at all the relevant forums.

Please do not hesitate to contact Hannah or Emma at [hcalway@kafico.co.uk](mailto:hcalway@kafico.co.uk) or [Emma.Cooper@kafico.co.uk](mailto:Emma.Cooper@kafico.co.uk) with any questions on the changes.

Appendix 1: Preparation Checklist

We have reviewed our patient list to determine if there are any whom we are concerned about giving online access to

All our staff have read the Kafico Disclosure Protocol (issued wc 7th March 2022)

All our staff have read the online access guidance issued by Kafico

All our staff have either attended Kafico Subject Access Request Training or watched the recording

We have provided the online access guidance to any third-party health or social care provider who has been given access to the practice clinical system module

We have considered how our test results are uploaded to the patient record to ensure they are not visible before any necessary consultation has been undertaken

We have ensured all staff are aware of how to “hide from view” within the patient record and the sort of information to look out for (safeguarding, letters from other providers, mental health, crime, confidential information about other family members)

All our staff are up to date on their data protection training

We have added to our onboarding checklist to include this guidance and raising awareness to new staff of this functionality

We have created a list of patients over 16 who lack capacity and will undertake assessments for each to determine whether access it appropriate

Appendix 2: Template Letter to Patient

Dear [insert patient name]

Thank you for your request, we have reviewed in line with our obligations under the Data Protection Act 2018 and with guidance from our Data Protection Officer.

Whilst NHS England have enabled online access for “future data” for patients, there are certain circumstances where it may be inappropriate to provide online access to a specific patient. This could be due to the inability to remove third party information or because of a potential for serious harm caused by the information being added to the record.

In order to remove full online access, the practice undertakes an assessment to determine whether providing access would be detrimental to the patient or an infringement of the Data Protection Act 2018 due to the limitations of the functionality to redact information that meets exemptions.

In this instance, we have reviewed your request to reinstate your online access and our initial assessment to remove your access and have determined;

[remove as appropriate]

* We are able to provide you with online access as the assessment is outdated and we are satisfied the information no longer meets an exemption.
* We are unable to provide you with online access as your record contains third party information that it would be impossible to redact due to your current involvement with social services / adult social care / mental health trusts.
* We are unable to provide you with online access as our clinical staff member has determined that there is a risk of serious harm to you in reading this information without being able to discuss the information immediately.
* At this time, we uphold our initial assessment and therefore are unable to provide you with full online access to your future date.

This does not affect your statutory right to make a subject access request to the practice and to have your information provided in electronic or paper format.

Detailed coded access is also still available to you and allows the viewing of medication, request appointments and order prescriptions.

Should you have any further questions or concerns please let us know, alternatively our DPO can be contacted at Hannah.calway@nhs.net

Appendix 3: SNOMED Code and its application

The following code will ensure an individual is not given access when the go live date is activated. However, this code does not mean that the individual should not have access, only that their record needs review to determine whether access is appropriate.

Enhanced review indicated before granting access to own health record : SNOMED code: 1364731000000104

It is acceptable to be slightly over cautious with the initial coding as long as long as you then ***do*** have a process to review the list and take the code off those who are actually okay to see their records.

Currently, it is our understanding that inputting the below code reverses the first code, however, this is currently being confirmed.

1364751000000106 : Enhanced review not indicated before granting access to own health record

Below are some helpful suggestions on how to consider which patients to apply the code to as a starting point to begin a review.

* Sort patient list in order of those most frequently attended then some names might just pop out at them.
* Ask other staff as well as GP’s if there are patients that they would be worried about having automatic access without reviewing the record. It doesn’t need to be a GP who highlights the patients.

Possible searches to narrow down patients who might be included in this might be

* + Children on child protection plan (& parents linked to these)
  + Any safeguarding codes – adult and children
  + Children in Care / Adoptions
  + Adolescents (13-17yr olds)
  + Domestic abuse / violence
  + Suicidal / recent attempt / self-harm
  + Mental Health (codes and referrals)
  + Learning disabilities
  + Dementia / memory problems
  + Those with a power of attorney recorded
  + Any coded as lacking capacity or having a capacity review.
  + Referred to memory clinic and awaiting assessment.