Lloyd George FAQs

Digitisation of Lloyd George Records – FAQs

PREPARATION OF RECORDS

Can un-summarised records be sent over for digitisation?

The summarisation of records was mandated in 2004 as part of the then GMS Contract. Practices and CCGs should ensure that records have and continue to be summarised. However, if records are identified as not being summarised then this should not be a barrier for the digitisation of LG records taking place.

Is there any scope to ask for the records to be summarised at the same time, or is there any software that can do this (even at additional cost to practice)?

No – this is a scanning process – the supplier will scan records as they are received – where summary records are desired this needs to happen before they are sent for scanning.

What is the process for scanning, uploading and managing confidential / sensitive sections of the Lloyd George patient record?

There may be paper LG records that practices come across during the preparation stage of the digitisation project that contain adoption information, child protection information, safeguarding and other sensitive and confidential information as well as LG records possibly being sealed. In these scenarios practices should follow current guidance, both local and national, with regards to record management, confidentiality, information security and adhere to the NHS records management code of practice when scanning and uploading sensitive information into the electronic patient record. https://digital.nhs.uk/data-and-information/looking-after-information/data-security-and-information-governance/codes-of-practice-for-handling-information-in-health-and-care/records-management-code-of-practice-for-health-and-social-care-2016 When LG information is scanned and uploaded, the attachment is deemed part of the medical record and any third party information that is included must be easily identified and removed prior to sharing the record with the patient. This can be actioned via the use of redaction software with a number of free solutions available on the market. Depending on the functionality of current redaction software there may still be manual processes required to redact handwritten text, unfamiliar terminology or abbreviations contained within the record.

Is there a naming convention for the imported attached Lloyd George file?

There are a wide range of file naming conventions in use when naming Lloyd George patient records that have been digitised. The naming convention used is heavily dependent on the supplier chosen to digitise the records. According to section 10.5 of "The Good Practice Guidelines for GP electronic patient records v4 (2011)" when attaching a clinical document, it is important to name or categorise the document with the local GP system so that its source and clinical significance is readily apparent when the record is viewed without needing to open the document itself. The attachment should also be correctly attributed and coded to facilitate querying. What this means is that whatever naming convention is used to name a Lloyd George digitised file then it

should be named with clear indicators as to what the file is without needing to open it and also include attributes which allow the file to be easily queried or searchable within the clinical system. E.g. [PDFnumber]_Lloyd_George_Record _[Patient Name]_[NHS Number]_[D.O.B].PDF

Should practices scan the Lloyd George record into separate sections or as one section?

It is advised that practices scan the Lloyd George records as a single section over scanning the record into multiple sections. With the use of Optical Character Recognition (OCR) technology and the contents of digital files easily searchable, there are real benefits scanning the record as one section against scanning into multiple sections. One of those benefits is it would take away the burden on practices not having to sort the contents of records into multiple sections which would incur time and resource to a practice in doing so. The documents are individually scanned but only one PDF file created and uploaded for each LG wallet. They will not be added to the record as individual items. The upload will be visible as an attachment in the Care History section and coded. The record is scanned as a single document rather than in multiple sections and it is searchable using OCR tech as discussed previously. However, the above is guidance and not is not mandated so before practices decide on a format to scan their Lloyd George patient records, there are a number of factors that must be taken into consideration which include: Cost and resource implications of choosing either option Pros and Cons of choosing either option. Current guidance being followed i.e. The Good Practice Guidelines for GP electronic patient records However a practice decides to scan their records, it is imperative that the files are named correctly using the national naming convention which is as follows: [PDFnumber]_Lloyd_George_Record_[Patient Name]_[NHS Number]_[D.O.B].PDF An example is provided below:
1of2_Lloyd_George_Record_[Joe Bloggs]_[123456789]_[25-12-2019].PDF
2of2_Lloyd_George_Record_[Joe Bloggs]_[123456789]_[25-12-2019].PDF.

Will the scanning be in sections or a single scan (PDF)?

The records will be scanned in the manner that they are received by the scanning company – IE if they are in sections they will be scanned in sections and if they are a single record they will be scanned as a single record. The scanned record will be searchable

If duplicate records are present (where they are scanned already but the paper record has been kept), will this be identified or will everything just be re-scanned?

Where practices wish to cleanse / fillet their records this needs to happen before they are sent to the supplier for scanning. Once received by the supplier the records will be scanned in as received including duplicates, blank pages etc. and will be considered the “original record.”

The Lloyd George record may contain historic information on disk, or even floppy in some cases. We no longer have the technology to open these formats and therefore wouldn’t be able to scan the information on. What do we do in these circumstances?

We will be discussing this with the supplier and will be able to respond further in a few weeks.

I don't know about other practices, but we can't store all our records in neat little boxes in alphabetical order. We have over 100 'outsize' records, which we cannot fit into the usual cabinets. These could be in FP111 folders, bankers' boxes or in some cases A4 photocopier paper boxes. Not sure how we'd get these into order with the 'normal' records, or would the outsize ones just be classed as a separate batch?

This is no problem at all, we understand that folders are different sizes and cannot fit in standard boxes as long they contain NHS number, surname, forename and DOB. The supplier will provide boxes and where required will assist with packing them.

How should practices manage digitised Lloyd George patient records that have been scanned into a different format other than what has been agreed locally?

It is possible that practices may receive a digitised Lloyd George patient record from another practice in a format other than the format which has been agreed as part of a local approach. An example of this is when a practice has agreed to scan their Lloyd George records as one single file but receives a digitised file from another practice that has been scanned into multiple sections. In this scenario it is important that practice staff are aware that Lloyd George digitised files may present in the clinical system in different format other to what has been agreed locally and that the file(s) that have been received are to be kept in the format that they arrive in. This aligns with the 'BS10008 Evidential weight and legal admissibility of electronic information' standard which must be adhered to as part of the full digitisation process. As long as digitised Lloyd George patient records have been scanned as a searchable PDF using Optical Character Recognition (OCR) technology then there should not be an issue as to whether records are scanned into multiple sections or as one single section as the content of either format is readily searchable. It is advised that practices should agree locally on a format to scan their records into i.e. as multiple sections or as one single section, and sign an SLA agreeing that all local practices should adhere to the format. Included in the SLA should be the agreement to keep digitised records received from practices outside of the local area in the format that they are received in.

Can patients opt out of having their records digitised?

No. Digitisation is mandatory. It is good practice for surgeries to notify patients 30 days in advance through websites and notices displayed in practices

Some records are huge. How will they be scanned and will they be able to be transferred through GP2GP?

There are no restrictions on note sizes. Each page will be individually prepared and the scanners can scan all sizes of paper and bring them back together in the completed record. We understand that GP2GP has been upgraded and there are no restrictions to file size. A PDF is produced for each LG pouch and attached to the record. The uploaded digital record will be visible In EMIS in the Care history section as an event attachment and will be read/Snomed coded so it is searchable. There is an OCR facility within the PDF, but please note that this only works effectively where the scan is of high resolution, so may not work well with old documents

Some practices store records off-site. Will this impact on the process?

No. Records can be collected from off-site storage. There are several options regarding how these will be checked and logged for scanning. This will be discussed with the practice as part of the process. Please note that records will be scanned as received by the scanning company, so any summarisation needed should be done prior to scanning.

How much work is expected from Practices in digitising their records?

We will lighten the load as much as possible, but there will be some things only the practice can do. Notes need to be summarised prior to scanning. Restore Digital can send a team to pack the records but the surgery needs to be able to accommodate up to 4 people for up to 4 days while they do this. The practice will also need to carry out their own quality checks post scanning, of between 40 and 80 records depending on practice size.

TRANSPORTATION OF RECORDS

If practice members have concerns over security can the collection and transportation of LG records from the practice be refused i.e. records being collected by a 3rd party supplier?

Prior to LG records being collected and transported from a practice, it is the responsibility of both the practice and the supplier to arrange an appropriate date and time for the supplier to attend the practice and collect the Lloyd George records and transport them off site. On attending the practice the supplier must present the adequate forms of identification which clearly state who they are and if practice staff are not happy to authorise the collection for whatever reason then staff have the right to refuse the collection and transportation of records taking place.

QUALITY CHECKING RECORDS

How do I know if records will be digitised correctly?

All suppliers who undertake the scanning and digitisation of LG records will be required to develop standard operating processes that comply with the standard 'BS10008 Evidential weight and legal admissibility of electronic information'. By suppliers adhering to these standards it assures practices that paper LG records being digitised will retain the evidential weight and legal admissibility of the record throughout all stages of the process. Quality assurance is one of a number of important stages of the digitisation process and practices will be asked to validate the quality of their LG records once they have been digitised by a supplier. The quantity of how many records to be validated will depend on the total amount of LG records that were digitised. To check the records for quality, practices need to consider accuracy over the burden to the practice; therefore the table below outlines the number of paper records to check in full to ensure the quality of the records. Practice patient base Number of records to check <2000 40 2000 – 3000 50 3000 – 4000 55 4000 – 5000 60 5000 – 6000 65 6000 – 7000 70 >7000 80 80 It is the responsibility of the practice to choose a packing box or boxes at random that contain the required amount of LG paper records based on the table above. This can be done by selecting a packing box number(s) from the patient inventory list and informing the scanning supplier.

AFTER SCANNING

Is the scanned record available in PDF format that can be used with iGPR (a software that checks for accuracy and redacts where required)

Yes, the exact system and software for records sharing, redacting etc. will be clarified during and post tender. Different suppliers are linked with different systems.

What format does the records come back in ie PDF and will it be searchable?

Yes the record will be searchable – more details will be advised post the confirmation of the supplier.

Can records be redacted after they have been scanned?

No. The original record will be as scanned. It can be redacted for sending out to patients on request, but this will not change the scanned record

When a patient needs notes that are redacted, how will this work with a PDF document

There is software that can do this.

Is there a cut off point to destroy electronic records?

The national team are discussing future changes to policy with PCSE. This will be added to the process and associated guidance when it is determined.

Are there any plans to dispose of the old filing cabinets/drawer units used to house the records as part of this programme?

Initial enquiries indicate that the scrap value of cabinets and metal shelves roughly equates to the cost of collection. This will vary on a practice by practice basis. The responsibility for arranging this will be with the practice – support will be provided to identify suitable contractors.

Do the physical records come back to the practice? Does the empty LG envelope come back? How long do the records need to be stored for?

The LG records which have been picked up and digitised will not be sent back only the samples for validation and quality assurance then the records will be destroyed following all standards. The LG envelope does get sent back to the practices and need to be kept for the time being. NHSE National Team are currently seeking legal advice about this.

Can the paper LG record be destroyed once the digitised version has been validated and approved?

The contents of the paper LG record can be destroyed once the digitised version has been validated and quality assured by the practice and is integrated into the full electronic patient record. It is the responsibility of the practice as the data controller to approve the destruction of the contents of the physical records; additionally it is best practice to inform the local CCG when destruction of records is to take place. At the time of writing it is important to note that the Lloyd George envelope must be kept until further notice

After digitisation we are told that the Lloyd George envelopes will come back to us. Does this mean empty envelopes? Surely we will not be getting back all the digitised documents! Are practices legally obliged to keep the empty Lloyd George envelopes? If not, then do practices still need to issue new envelopes moving forward?

Yes this is correct, only the empty envelopes will be sent back to practices until they can be destroyed. Practices are legally obliged to keep them. This is being challenged nationally and we are waiting for guidance from the national team regarding this. Until national guidance is released new envelopes still need to be issued.

What do I do with paper records received after my records have been scanned?

EMIS offer an ongoing digitisation service for new patients registering at your practice and additional paperwork being received for current patients. The service is based on an annual subscription model. Further information from your EMIS Health Account Director

ACCESS TO RECORDS

Does the practice have immediate access to the records that have been scanned and entered onto the cloud, or do they have to wait until their entire records have been scanned before access is granted? If there was a time dependent urgent access required to records once they have been taken to be scanned, would there be the facility for an ad hoc request for that record to be scanned quickly or sent back to the practice? (Safeguarding/Court type issues)

Access to records that are going through the scanning process will be discussed with the successful supplier. It is anticipated that individual records will be available at short notice pre and post scan – exact timescales and out-of-hours arrangements to be agreed with successful supplier.

Should on-line access be given to patients once LG records have been digitised?

Once a LG record has been digitised and uploaded to the patient record it is treated as a 'document' by the clinical system. The default position is that the digitised file would be visible to patients in the same manner as any other document via patient facing services (online-access). With information contained within the LG record most likely written with a view to them not being readily accessible by patients, it is possible information may include language and comments that practices may not wish to share with patients out of context. It is therefore advised that access to the digitised version of the LG record should only be provided via a Subject Access Request (SAR) which has been submitted to the practice by the patient or a patient representative. Digitised LG records can be made 'private' and not visible to the patient by applying a filter within the clinical system. Practices who are unsure on how to apply this filter should contact their clinical system

provider for advice. The requirement to make digitised LG records private is not necessary for practices that have chosen to upload their records to a cloud-based solution due to LG records being stored outside of the clinical system

TRANSFERS IN AND OUT

What if we register a patient from an area that has yet to digitise their Lloyd George patient records?

There are a number of options to resolve this issue. Once the patient has been transferred via GP2GP and the receiving practice has received the Lloyd George Envelope from the sending practice, the Lloyd George record will need to be scanned and attached to the patient's clinical record. How the practice does this will depend on any business as usual processes or solution currently in place. This could be that the practice scan the Lloyd George file then manually upload to the patient record in clinical system, or they use a 3rd party supplier to conduct this transaction. If the practice is using a portal solution for their digitised Lloyd George records, they may wish to include new patients Lloyd George records to this solution. In this case the practice will need to arrange with the portal supplier to ensure the new patients Lloyd George record is managed accordingly.

What is the expectation around new patients after the pilot, both within the ICS and external?

The LG scanning programme is for the financial years 20/21 and 21/22. This programme will cover all records within the programme and associated budget. New records that need scanning that are received prior to April 2022 will be collected by the scanning company from practices in batches at regular intervals. After this programme has concluded, responsibility for scanning LG records that arrive at a practice from a patient moving to the area will be with the practice in discussion with the CCG to resource

Will the digitised Lloyd George attachment transfer with the electronic patient record via GP2GP?

All clinical systems are now capable of GP2GP transfers which allow for the secure transfer of a patient's electronic record (including attachments) from an old practice to a new practice at the point of registration. The original version of GP2GP (version 1.1) was only able to transfer files of less than 5mb in size and include less than 99 attachments which was due to the technical limitations of the spine. With the limitations of version 1.1 this prevented the service being able to effectively include Lloyd George attachments as part the GP2GP transfer. The GP2GP service has seen a number of improvements from the original version and is now currently at version 2.2. GP2GP v2.2 includes the functionality to transfer larger messages and an increased number of attachments allowing for Lloyd George patient records to be included within the attachments of the GP2GP transfer. **Note:** There are some clinical suppliers that have not updated their system to utilise the current version of GP2GP service. In this scenario practices that are not on the current version will be unable to include Lloyd George patient records as part of the GP2GP transfer and will need to continue printing out the full electronic record including Lloyd George information and send it on to a patient's new practice. Additionally, as part of a GP2GP transfer it is possible that coded information may be stripped from the record and must then be coded by the patient's new

practice. Solutions to both scenarios are being investigated and any further guidance will be published in due course.

On a patient's death, all of the record is printed and send by post to PCSE who archive and keep for the record keeping standard. Will there be any move to this being a digital transfer as part of this programme?

The national team are discussing future changes to policy with PCSE. This will be added to the process and associated guidance when it is determined.

What happens when patients de-register. Practices will not have the physical LG to send to the new practice?

The intention is that this is a GP2GP transfer.

What guarantees are there that records will transfer by GP2GP in the future as there are currently a myriad of reasons why they don't?

This is not specifically a digitisation issue but an issue that which is being looked into in dialogue between the National team and PCSE. Once we receive further information we will communicate with practices. There is a national GP2GP team which are looking into why files sometimes don't transmit correctly and they have identified that these failures aren't attributed to the actual file.

FUNDING

Can practices have the funding to do their own digitising?

No, the funding is for the programme across NHS Black Country. Practices aren't required to be part of this programme and where they want to do something else they will need to self-fund. Any programme surplus funding per ICP will be used for other areas of the NHS Black Country that received proportionately less funding.

Will there be any funding for the preparation work that practices will have to do. For example, we are expected to remove information from the Lloyd George records that should not be in there (we find all sorts of stuff – misfiled letters, copy birth certificates, etc, etc) or are we relying on redaction after the event? Sorting the records into batches and getting them ready for collection will also take time, as will sorting out disposal of cabinets etc afterwards.

A lot of the preparation work should have been done already and the prioritisation questionnaires that practices have been asked to complete will show how ready/ how much support they may need. As part of the tender specification we did ask the supplier how they would minimise the burden for practice staff so there will be aspects that they will support with as well.

How is it resourced after the pilot?

Cloud storage costs will be ascertained after the tender has concluded and this will be discussed with the CCGs as costs are known. as re know

OTHER QUESTIONS

What should you do if you have already digitised your Lloyd George records?

If a practice's Lloyd George records library was digitised prior to the release of national guidance, practices should check that their digitised Lloyd Records comply with the new guidance. If a practice discovers a non-compliance issue, practices will need to discuss this with their CCG in order to plan corrective action. An example would be "all digitised Lloyd George patient records must be searchable by date, word or phrase." A practice's Lloyd George library may have been scanned in a format that is not currently searchable. If that is the scenario then one resolution would be for the CCG or practice to purchase a full version of the Adobe Acrobat software (version 7 or above) and follow instructions to enable an OCR function to be applied to the scanned records making the contents of the digitised records searchable. The Adobe Acrobat software is just one example and there are other OCR conversion tools on the market that CCGs or practices could purchase. The previously explained resolution would prevent the need for practices to re-scan their full Lloyd George records libraries which would incur large costs. Once practices have received and stored their digitised Lloyd George records it will be a requirement that practices code the patient's electronic record accordingly informing that the Lloyd George record has been digitised. The national team are currently in the process of requesting a standardised SNOMED code for this purpose and further information will be added to this document once actioned.

Once Lloyd George records have been digitised and stored within the clinical system who has the responsibility of assigning SNOMED codes to the records to notify that records have been digitised?

Suppliers whose responsibility it is to upload digitised Lloyd George records into the clinical system may have the functionality to assign SNOMED codes automatically to the patient's electronic record as part of their upload service. If however this functionality is not part of a suppliers upload service then practices will be able to bulk assign SNOMED codes to patient's electronic records themselves by using current functionality which exists within a practices clinical system. If you would like to learn of how to bulk assign SNOMED codes to patient records within the clinical system please either access the support files of the clinical system in use or contact your clinical system provider and ask for advice

Is it mandatory to take part in the Digitisation Programme?

No, it is not mandatory; however, this is a fully funded programme that will ensure your practices records are digitised (which the GP Contract requires by 2022/23) so all patients can have online access to their full record, including the ability to add their own information. If practices do not take part in this programme, there will be no further funding available and practices will have to resource digitisation themselves.

My practice is currently going through a merger and a clinical system change, will this affect the digitisation of the LG records in my practice?

Once plans have been put in place for a practice merger and clinical system changeover to take place, discussions will need to then focus on whether it will be best to complete the work to digitise LG records before or after a merger / clinical system change can take place? Discussions between a CCG, practices and clinical system suppliers will determine the best option to take and help to aid in the planning and agreement of timescales of when the digitisation of LG records can commence and be actioned.

What is the process going forward for practices to continue records to be digitised and for patients whose physical records are received after they have been sent for digitisation?

It would be the practice's responsibility after the collection for future digitisation

If after digitisation we receive notes in paper format and we have to scan them on, what will we then do with the original documents?

Same as you do now, the original documents can be destroyed once the records have been scanned in the practice.

During lockdown we performed a full record check, which is something we do from time to time to make sure that we have all the records we should and none that we shouldn't. There are still records that we have never received from PCSE (or even from the days of LaSCA) and we are continually chasing these. What do we do about this? Some practices may find that they discover records they should no longer have (we did the first time we did a records check – mainly ladies who had changed their name and the record hadn't been re-filed to the new surname) and these need to find their way back to the correct practice.

This is not specifically a digitisation issue and is being addressed nationally by PCSE and NHSE.

Has the project work currently being carried out to digitise Lloyd George (LG) records received national consultation?

As part of the project work to digitise LG records across general practice, national engagement has taken place with a wide and representative group of healthcare professionals, suppliers and patients. Additionally, further engagement was supported by the Professional Records Standards Body (PRSB) who was commissioned by North of England Commissioning Support Unit (NECS), NHS England (NHSE) and NHSX. The national engagement which took place was to raise awareness of plans to digitise historical LG records in general practice as part of the wider digital transformation of primary care and to gather views and recommendations for taking this programme forward. The PRSB report detailing the findings, views and recommendations gathered from the national engagement will be added to this document once it has been published

Will practices be able to get a rent reduction on space no longer needed to store records?

This is outside the programme scope. It will need to be approached on an individual practice basis as circumstances are different for each practice depending on the type of premise they occupy and current rent agreements

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