

Online services: an overview of online access

The aim of this document is to provide an overview of the important features of online access for patients to practice services and records.

There is detailed guidance on specific aspects of the topic in the rest of the [Patient Online Practice Toolkit](#), in [Patient Online: The Road Map](#) and in recently published [systematic reviews on online access for patients](#). However this overview aims to provide a summary of themes provided in the guidance for General Practices offering online access.

The RCGP Online toolkit has been produced to provide a General Practice (GP) centric view to help practices offer online access in line with the GP contractual requirements for 2014/15 and 2015/16. The [GMS contract 2014/15](#) included an expectation that all practices would enable and promote access to online booking of appointments, repeat medication requests and access to records online by 31 March 2015 (PMS Agreement details can be found [here](#)). This was extended in [2015/16](#) to include all coded data.

Benefits

Offering online services brings immediate benefits to patients including convenience, patient autonomy, involvement in their own healthcare particularly in the management of long-term conditions, and improved patient safety (such as identifying errors in medication lists).

For practices, there is the opportunity to offer a wider choice of patient services as well as supporting patients in the management of their own conditions. When patients use online services they reduce the pressure on practice telephone lines and reception desks.

Risks

Benefits need to be balanced against potential risks for both practices and patients. For practices there may well be additional workload involved in team training, in ensuring that the system processes such as verifying the identity of patients registering for online access work efficiently and safely, and that patients unable to use online services are not disadvantaged (for example, through a lack of digital literacy).

There are issues that may challenge practices, such as: the risk of coercion of patients to unwillingly allow someone else to have access to their records; access by the patient to third-party data about other people in the patient's record; or the complexities of proxy access for someone acting on behalf of the patient such as parents wanting access to their child's record. Patients will also need to be informed about the risks to their privacy and how to safeguard their sensitive medical information.

Guidance on all these themes is provided in the [Patient Online Practice Toolkit](#).

Offering online services: the practice perspective

One of the key considerations for practices when deciding what to offer through online services, will be the functionality that system suppliers offer. System suppliers are contracted through the General Practice Systems of Choice framework contract (GPSoC) to provide online access for patients, but currently there are significant differences in what each supplier offers, with some offering more than the current GMS contract requires.

Providing patient information leaflets about online access when patients register, and about items in their record when they are viewing their data, may ultimately save time for practices. There needs to be clear, well planned identity verification and consent processes, including the management of proxy access.

Practices will of course be well versed in information governance, but offering online access brings with it considerations that are both relevant to data access to paper records - such as managing third-party data - and specific to online access, such as access to confidential medical information by others through proxy access or coercion. It will be important that practice management responsibilities are well defined to ensure that the online service is monitored effectively and continues to run smoothly.

Practices will need to be mindful of the data quality of records, in the knowledge that patients are going to be viewing their data. The principles of good data quality for online access are no different to usual. Patients have long been able to see paper copies of their records, but online access has increased the numbers of patients who do access their records. Patients expect the data to be correct and up-to-date. They may be confused or worried by abbreviations, euphemisms, technical language or administrative housekeeping data. It is important that everyone responsible for recording clinical records in the practice is aware that patients may read what they record.

Getting started: the patient perspective

Online access will be promoted and facilitated by the practice. Patients will expect and should receive clear information about how to register for online services, what the practice requires to verify their identity, what the patient is consenting to and importantly, what their responsibilities are:

- Practices will need to deal with requests for proxy access from parents or from relatives looking after individuals who don't have mental capacity
- It will be important for patients and their proxies to understand what proxy access means, and that clear consent is expressed by the patients whenever possible (and recorded by the practice)
- Those seeking proxy access need to understand their responsibilities in safeguarding sensitive information. This is a complex and potentially time-consuming process, particularly when access to the full record is being considered; the RCGP toolkit offers guidance for practices faced by these requests.

When they register for online access, patients should be told that the practice may withdraw their access to online services in specific circumstances. These are likely to include:

- The discovery of coercion of the patient
- The discovery of third-party data in the record after access has been granted
- When a simple administrative error has put information that refers to another individual on to the patient's record. An example might be a scanned document attached to the wrong patient's record. Patients should also be warned that they may come across information from secondary care, in a scanned letter perhaps, which was not intended for them to read without a verbal explanation from their doctor.

The [Patient Online Practice Toolkit](#) provides guidance on the consent process and account management (such as keeping passwords secure, identity verification, patient responsibilities, information governance and guidance on proxy access).

Impact on the consultation and the recording of data

If patients, especially those with long-term conditions (the expert patient), have access to data such as test results, they may be better prepared for consultations and better able to self-manage their condition(s). Although there are many good resources for patients to learn about the technical content of their records (e.g. NHS Choices and patient.co.uk) the practice may have to invest in time to explain the meaning of data that patients see online.

Practices are required to extend the offer of access to records from access to summary information to include all coded data by GMS and PMS contracts in 2015/16 and beyond, there will be implications for consultations and record keeping:

- **Access to summary information** which includes, demographic data, allergy status, and medication lists may lead to patients asking the practice about its accuracy, for example missing adverse reactions, prescriptions on the repeat list that the patient cannot remember taking, or incorrect doses
- **Access to laboratory data.** Patients will have access to laboratory results once they have been filed in their records. It can be hard for patients to understand the meaning of results for their health. They can use a number of good online resources (including <http://www.labtestsonline.org.uk/understanding>) to learn more about them but patients may misunderstand the significance of laboratory data. An abnormal result may have technical laboratory significance, which is different to clinical significance. This means that patients may come across data flagged as abnormal by the laboratory because the biological value is outside the laboratory 'normal' range, but is of no significance to the individual patient. A clear explanation for patients of how the practice manages test results and communicates with patients about abnormal results will help. The use of messages provided by clinical staff next to test results and timely communication with patients about abnormal results will also help to reduce anxiety about individual tests. The presentation of the data in graphical form may also help patients to use data in a more meaningful way for them
- **Access to immunisation history or schedules.** If patients provide evidence of past vaccinations, it may be necessary to verify and correct the vaccination record. Questions about the immunisation schedule from patients, particularly about their children, may be triggered by access to the immunisation history. On the other hand it may inspire parents to complete their children's immunisations
- **Access to all clinical coded data** opens up the tension between maintaining data quality whilst recording information on problem lists that may cause or lead to patient anxiety. The recording of sensitive information such as sexual history and contraception could cause major issues for the patient, especially where someone else has proxy access or if coercion becomes an issue in the setting of domestic abuse. Practices will need to decide whether information should be accessible to patients particularly in areas covering mental health and child protection. Suppliers do provide, and are developing, ways of hiding data items from display online. Using the facility can be time consuming and should be done with care and with the patient. Sometimes the best solution may be to withhold online access to the record
- **Access to scanned documents** is not part of the contractual requirement for 2015/16 but practices may decide to allow patients to see hospital letters. Hospital letters and reports may be written by people who are unaware that patients may have online access to their letters, although all letters should be

written for patients to read. Some letters may refer to more than one patient, particularly letters about siblings or families. Patients may have access to letters, once filed by the practice, but before they have been seen by their usual clinician who will have the best understanding of the implications of the content of a letter. As with laboratory results, there is potential for this to cause patients anxiety about what the letters mean.

Risks and benefits of going beyond contractual requirements

Practices may want to (or may already) offer access to patient records beyond contractual requirements. This may include free text data, scanned letters and reports, and data recorded before access was switched on; referred to as retrospective data. Access limited to data recorded after the date when the access was granted is called prospective access.

Retrospective access may be particularly useful for patients with complex histories and long term conditions who may benefit from having access in managing their condition. Information governance issues and considerations do need to be carefully weighed up by the practices that are considering offering it.

Retrospective access requires practices to screen the historical record for third-party data that the patient should not have access to without the consent to disclose the data from the person providing the third-party information. If consent is not available or possible, it may be necessary to redact the information.

Retrospective access to free text data may expose language previously used in the record that is not patient-appropriate, such as euphemisms or contentious information. There may be data, received from a previous practice via GP2GP, of a poor quality over which the current practice has no control. There is a risk here that the doctor-patient relationship could be jeopardised.

In every practice there will be patients for whom a blood result or risk calculation or something similar has been missed or misinterpreted, or a guideline has not been followed completely. Patients may recognise these things if they have online access to their records.

Suppliers are developing systems to provide patients with the ability to add to their record. An example might include patients adding in data from remote blood pressure monitoring. There are also discussions about patients amending or editing their records. This may be problematical because it is important from a medico-legal perspective to ensure that records are a complete and accurate representation of the practice view of the patient's history.

Unintended consequences of offering online access

[Patient Online: The Road Map](#) highlighted the potential for online access to potentially free up administrative time such as telephone usage for booking of appointments and requesting repeat prescriptions. However the use of IT may further disadvantage socially disadvantaged groups, especially those who lack digital skills or health literacy. People who have sensory deficits such as visual impairment, the homeless and those living in poverty may not be able to access the services as easily as others.

Some of these problems can be overcome. There are programs that can help people with visual impairment use computers. Computers or portals in public places such as libraries and surgeries can be used by patients to access their records with appropriate safeguards, such as special care to log out of access and close down web browsers after use.

Practices will of course know their patient population well and understanding the demographics of the practice population will help to plan how the services they offer are enhanced, but not replaced, by online access.

Additional resources:

- [Patient Online: The Road Map](#)
- [Patient Online Practice Toolkit](#)
- [De Lusignan et al.; BMJOpen – ‘Patients’ online access to their electronic health records and linked online services: a systematic interpretative review’](#)
- [Mold et al, BJGP – “Patients’ online access to their electronic health records and linked online services: a systematic review in primary care](#)
- [EMIS National User Group guidance on using EMIS Web for Patient Online Access](#)
- [National Vision User Group guidance on using INPS Vision for Patient Online Access](#)