Dr Ralph Sullivan, FRCGP, FFCI
RCGP Clinical Champion for Patient Online

Dr Imran Khan, MRCGP
RCGP Clinical Support Fellow
“Two years ago I was at a stage in my understanding … that was so limited it placed the entire weight of responsibility for my care on the doctors treating my condition. I was a passenger, along for the ride.

Access to my medical data … in short I am no longer a passenger, I am now very much part of the management team for the effective treatment of my condition.”

O.C. Manchester Oct 2017
Mental Health Learning Objectives

1. Use Patient Online safely and effectively
2. Health literacy and digital inclusion
3. Coded records for mental health conditions
4. Managing test results for online access
5. Patient Online in care and support planning
Webinar Programme

1. Introduction to Patient Online and the new toolkit
2. Supports mental health conditions.
3. Role in comorbid long term conditions
4. Special precautions for patient with serious mental illness
5. Scenario
6. Questions
GP Contractual Requirement in England

Book and cancel appointments
Order repeat medication
Detailed care record

Contractual requirement for GPs in England

To offer and provide …

… unless it could cause harm to the patient
GP Contractual Requirement in England

Book and cancel appointments
Order repeat medication
Detailed care record
Extended record access (all or part)

Contractual requirement for GPs in England
To offer and provide …
… unless it could cause harm to the patient
RCGP Survey, August-Sept 2016 (n=211)

75% offering online access to the detailed coded record

- GP (30%)
- Practice Manager (54%)
- IT
- Reception
- Secretary
- Other (9%)
Reasons to recommended record access

- Test results
- Record content
- Self-manage LTCs
- Understand LTC care
- Proxy access
- Clinical documents
- Prepare for consultations

% respondents giving each reason
Patients Registered for Patient Online

NHS Digital
GP Data Hub
POMI

Patients Registered for Patient Online

NHS Digital
GP Data Hub
POMI
Health Literacy

• 59% women, 50% men use internet for health information (ONS 2018)
• 43% of working-age adults in England have low health literacy
  - ability to read and write
  - computer and numerical literacy
  - ability to interpret graphs and visual information
• Teach back - chunk and check
Digital Exclusion

People Who Have Never Used Internet (%)

Office for National Statistics
15 August 2018

Age Groups

% Never Used Internet

0 5 10 15 20 25 30 35 40 45 50 55 60 65

18-24 25-34 35-44 45-54 55-64 65-74

NHS Widening Digital Participation

Future Digital Inclusion

Online Centres Network
Practice barriers to record access

• Training
• Workload
  - clinical assurance of the record
  - patients’ response
• Record quality
• Safeguarding
• Motivation

Patient Online Toolkit
**RCGP Patient Online Programme**

**Aim** - to increase awareness and confidence in using Patient Online in patient care

Intended for the whole practice team

**Toolkit** of guidance documents and templates

- Webinars
- Podcasts

**Input** from other Royal Colleges, academia and the voluntary sector, and individual health professionals and patients
Patient Online Toolkit

Book and cancel appointments
Order repeat medication
Detailed care record
Extended record access (all or part)

Managing new applications
Safeguarding
Information Governance
Patient Information
Clinical benefit
Patient Online Toolkit

A toolkit to support the provision of GP online services

The Patient Online toolkit has been written by the RCGP, in collaboration with MHE England, for GPs, nurses and practice staff to offer Patient Online to patients effectively, efficiently, safely and securely. The toolkit also includes clinical exemplars which demonstrate how Patient Online can empower patients to take greater control of the management of their health conditions as part of a person-centred approach to care.

- Introduction
- Setting up Patient Online services
- Registering new applicants for Patient Online
- Record access
- Clinical care
- Clinical exemplar 1: diabetes mellitus
- Clinical exemplar 2: end of life care
- Clinical exemplar 3: dementia
- Clinical exemplar 4: inflammatory arthritis
- Acknowledgements

www.rcgp.org.uk/patientonline
Record Access Clinical Exemplars

Webinars
Podcasts
Guidance documents
Resources
GETTING STARTED WITH ONLINE RECORD ACCESS

Online record access is held by many patients and GPs and can be an important tool for maintaining and managing their healthcare needs. Accessing the patient's online record can provide important information and support during consultations and can be a valuable resource for both patients and healthcare professionals. However, it is important to ensure that patients are aware of the benefits and limitations of online record access and that they understand how to use it effectively.

Why offer online record access?

Online record access provides patients with enhanced control over their healthcare information and can help patients manage their health more effectively. Patients with access to their online records are more likely to be involved in their care and can take a more active role in managing their health. This can lead to improved health outcomes and reduced healthcare costs.

What do patients need to know about online record access?

Patients need to be aware of the benefits and limitations of online record access. They should be informed about what information is available in their online record and how to access it. Patients should also be informed about the security of their online record and how to protect it.

Getting started with online record access

Here are some steps to help patients get started with online record access:

1. Understand the benefits of online record access
2. Familiarize yourself with your online record
3. Use your online record to manage your health
4. Protect your online record

These steps will help patients get started with online record access and make the most of this valuable resource.

By promoting online record access, we can empower patients to take control of their healthcare and improve their health outcomes.
Application form for online access to the practice online services

Surname
First name
Date of birth
Address
Email
Postal code
Mobile number
Telephone number

I wish to have access to the following online services (please tick all that apply):

[ ] Booking appointments
[ ] Preparing repeat prescriptions
[ ] Accessing my medical record

I wish to access my medical record online and understand and agree with the statement (here):

1. I have read and understood the information about each service provided by the practice.
2. I am responsible for the accuracy of the information that I input in electronic records.
3. If I choose to share my information with anyone else, this is at my own risk.
4. I declare that my personal data has been accessed by someone within my household.
5. My personal information is held in a manner that is not accessible to any unauthorized individual.
6. I have made certain that by providing access to someone who is unwilling to use electronic records, I can contact the practice as soon as possible.

Signature
Date

For patients over 16 only
Patient number
Date

Data protection

ICD code

DATA QUALITY

Since 31 March 2016 English practices have been contractually required to provide and offer online access to “all information from the patient’s medical record which is held in coded form”, as well as the usual transactional services. The requirement has not changed since then. By June 2018 almost 90% of patients in England had online record access.

There is also a non-contractual requirement for practices “to provide patients with online access to clinical correspondence such as discharge summaries, outpatient appointment letters, and referral letters [from a chosen perspective date] unless it may cause harm to the patient or contain information to third parties”. There is no requirement to offer access to consultation text file and weekends out-of-hours care but all GP systems are capable of this.

A good quality patient record must be fit for these new purposes. It is not always clear which patients have online record access and it is impossible to know who might have access next month. It makes sense for everyone in the practice who is recording information in the patient record to bear this in mind at all times. This guidance is intended to offer guidance to clinicians about how they should respond to this challenge.

Box 1: Good data quality in data fit for purpose

- The electronic patient record is required for many purposes, which include:
  - reused what happens in consultations, the system of the clinician and the plans agreed with the patient
  - communication between elements of the patient’s health
  - care and management of patients
  - audit and research
  - provide evidence for legal purposes
  - support practice administration
  - assessment of performance for payment purposes
  - communications with other clinicians, through shared record (new)
  - enable clinical audit and research
  - act as a source for all necessary uses of the patient record.

Characteristics of good records for online access

Clinical records that are accurate, unambiguous and well-organised work for patients and clinicians alike. It seems that inaccurate, ambiguous and badly stored data can be misleading and may mislead both patients and clinicians with a negative impact on the patient’s health and safety.

GP systems differ in how they organise patient records, especially the coded data, and particularly problem codes. This guidance does not offer advice on how to use specific systems. Training materials provided by your primary care supplier or the National User Group are the best source of advice for that, but these are principles of what constitutes a good quality record that apply to all systems.

Data quality in the electronic patient record has long been described by the acronym CAREx, standing for Complete, Accurate, Relevant, Accessible and Timely.

- Complete - In a high-quality record, all the key data about a patient’s health will be coded (see the Good practice guidelines for general practice electronic patient records: guidance for GPs, 2011). Patients with record access may view diagnoses, allergies, vaccinations, operations or events that they are missing.
- Accurate - A patient’s record changes with time as problems event and become inactive and as working, symptoms-based problems acquire a formal diagnosis. GP records must represent clinical uncertainty, ending unjustified diagnoses may be misleading. It is possible that recent uncertainty may not be visible to the patient, or other clinicians using shared records. When different codes are used for one condition it may appear as though there have been several episodes of, for example, stroke or deep vein thrombosis. Some diagnoses codes are ambiguous and are best avoided. Patients should be warned when they apply that they may not understand all the medical terms in their record (see Health Literacy below).
- Relevant - There may be data that you would normally not use, that would be of particular interest to the patient if they could see it in the
Introducing iGPR™ Patient Online Toolkit

The iGPR Patient Online Toolkit screens patient records for third party and sensitive entries across codes, free-text and attachments.

11-May-2016
Problem
Child on protection register
MR NICHE NICHE
[1200.]

08-Feb-2016
Read Code
Oral Contraception
She has asked that we never mention her contraceptive to her husband and that this would never happen as this is confidential information between patient and doctor.

08-Dec-2015
Read Code
Violent spouse
MR NICHE NICHE
[611.]

26-Jul-2015
Read Code
Anxiety States
She is feeling very nervous about a job interview next week.

Niche Haustiti and NHS England’s Patient Online team have worked together to develop and successfully pilot a medical record screening tool - iGPR Patient Online toolkit.

iGPR Patient Online Toolkit enables practices to screen patient records ready for online access to dramatically reduce this workload.
Summary so far

Online record access

• Benefits and barriers
• GP uptake of Patient Online in England

RCGP Patient Online Toolkit
Book and cancel appointments
Order repeat medication
Detailed care record
Extended record access (all or part)
Patient Online and Mental Health

Book and cancel appointments
Order repeat medication
Detailed care record
Extended record access (all or part)

- Booking appointments potentially less intimidating

- Avoid confusion with complex prescription regimes.
- Reminds patients when they last ordered.
- Alerts them to medication review dates.
Patient Online and Mental Health

Book and cancel appointments
Order repeat medication
Detailed care record
Extended record access (all or part)

Problem list
Lifestyle and work
Examination results
Test results
Questionnaire scores
Care plan codes
Past medication
Allergies and ADRs
Preventive healthcare
Patient Online and Mental Health

Book and cancel appointments
Order repeat medication
Detailed care record

Office of National Statistics survey 2013
- 43% of the British population used the internet for health related information, 35% of which were mental health related

Royal College of Psychiatrists
- Patients use internet to improve health literacy
Book and cancel appointments
Order repeat medication
Detailed care record

**General information**
https://www.rcpsych.ac.uk/healthadvice/atozindex.aspx
https://www.mentalhealth.org.uk/a-to-z
https://www.mind.org.uk/information-support/a-z-mental-health/
https://www.rethink.org/diagnosis-treatment

**Lab Tests**
https://labtestsonline.org.uk/tests-index
Patient Online and Mental Health

Book and cancel appointments
Order repeat medication
Detailed care record
Extended record access (all or part)
Book and cancel appointments
Order repeat medication
Detailed care record
Extended record access (all or part)

Patient Online and Mental Health

Attached documents
Consultation notes
Free text
Hospital OPD letters
Discharge reports
Radiology reports
Referral letters
…
Patients Using the Detailed Coded Record

- Identify any inaccuracies that might be present

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Using the Detailed Coded Record

- Identify any inaccuracies that might be present
- Generally improve their health literacy though access to their detailed coded record

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Royal College of General Practitioners
Using the Detailed Coded Record

- Identify any inaccuracies that might be present
- Generally improve their health literacy though access to their detailed coded record
- Check blood test results

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<td>Test results</td>
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<td>Arthritis-relevant codes</td>
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<td>Care plan codes</td>
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Mental health and comorbid disease

• Patients with long term conditions 2-3 times more likely to experience mental health problems.
• Patient Online can help integrate mental health and physical health more closely
• Can be used for care planning and priority setting and multiple aspects of patient care.

Further detailed guidance on the use of POL in chronic long term conditions such as diabetes, inflammatory arthritis, and dementia are available in the RCGP toolkit.
Mrs EB’s condition slowly deteriorates and Mrs EB’s daughter continues to book repeat medication and look at the Online GP record (as shown in as proxy access in Figure 3 POL + EPaCCS). Mrs EB’s daughter looks at some of the recent correspondence and latest care plans. She is pleased to see that the DNACPR is coded but has noted that her mother is still for full escalation of care which is no longer wanted.

Patient access to record data relevant to mental illness

Coded information enables person-centred care
Safe Online Record Access

Identity verification
Safeguarding – coercion, proxy access
Clinical assurance of the record
Redaction of potentially harmful data
Good data quality – unambiguous
Continuity of care
Safe Record Access in Mental Illness

Increased vulnerability to coercion
Increased sensitivity to record content
Record intrinsically more unsettling
Refusal and withdrawal of access
Proxy access
Mrs EB's condition slowly deteriorates and Mrs EB's daughter continues to book repeat medication and look at the Online GP record (as shown in as proxy access in Figure 3 POL + EPaCCS). Mrs EB's daughter looks at some of the recent correspondence and latest care plan. She is pleased to see that the DNACPR is coded but has noted that her mother is still for full escalation of care which is no longer wanted.
Clinical Scenario

- Andrew Mason is a 32-year-old who over the last few months has problems with his mood.
- He has multiple symptoms of depression.
- He reports that he drinks 22 units per week and smokes 20 cigarettes day.
- His GP carries out a PHQ-9 and a GAD-7, scores 19 and 11 respectively.
- GP diagnoses depression, refers to local IAPT services, and starts Sertraline 50mg once a day, with a review in 2 weeks.
Clinical Scenario coding

• Andrew Mason is a 32-year-old who over the last few months has problems with his mood.
• He has multiple symptoms of depression
• He reports that he drinks **22 units per week** and smokes **20 cigarettes day**.
• GP carries out a **PHQ-9** and a **GAD-7**, scores **19** and **11** respectively.
• GP diagnoses **Depression**, refers to local IAPT services, and starts **Sertraline 50mg once a day**
• Review in 2 weeks.

Coded information in **Red**
Mrs EB’s condition slowly deteriorates and Mrs EB’s daughter continues to book repeat medication and look at the Online GP record (as shown in as proxy access in Figure 3 POL + EPaCCS). Mrs EB’s daughter looks at some of the recent correspondence and latest care plan. She is pleased to see that the DNACPR is coded but has noted that her mother is still for full escalation of care which is no longer wanted.

Clinical Scenario use of POL

Andrew can use Patient Online to access his detailed coded record and use transactional services.

He sees his recent diagnosis of depression, his PHQ-9 and GAD-7 scores, his alcohol and cigarette use.

His medication list includes an acute prescription for sertraline 50mg daily, but he cannot order a repeat.

His review date is noted as a diary entry and reminds him to make an appointment for review with his GP, which he does online.
Clinical Scenario review

1. Several weeks later his GP repeats the PHQ-9 and GAD-7, now 9 and 6 respectively and records the results. Andrew agrees to continue the sertraline and return to the GP places it on repeat.

2. Andrew can continue to access POL transactional services and view his detailed coded record.
Mrs EB's condition slowly deteriorates and Mrs EB's daughter continues to book repeat medication and look at the Online GP record (as shown in proxy access in Figure 3 POL + EPaCCS). Mrs EB’s daughter looks at some of the recent correspondence and latest care plan. She is pleased to see that DNACPR is coded but has noted that her mother is still for full escalation of care which is no longer wanted.

Clinical Scenario overview

1. Highlights how clinical coding can be used in a more straightforward case of depression to enable POL.
2. Coding encourages best practice and provides information that is accessible to the patient via POL
3. Can be used to encourage patient engagement, safe prescribing and medication review.
Mrs EB's condition slowly deteriorates and Mrs EB's daughter continues to book repeat medication and look at the Online GP record (as shown in as proxy access in Figure 3 POL + EPaCCS). Mrs EB's daughter looks at some of the recent correspondence and latest care plan. She is pleased to see that the DNACPR is coded but has noted that her mother is still for full escalation of care which is no longer wanted.

Patient can be useful in mental health conditions … for patients and the practice

Access to coded information supports person-centred care

Patient Online

empowers patients, improves record accuracy and health literacy, and supports `care of co-morbid disease
What’s Next

Guidance document that contains all of the relevant information, resources and links to related guidance

Podcast

Further collaborative work
Questions?