



Primary Health Care SG

CLICSIG 23rd March 2019 GPGv5 scope

This CLICSIG was held on 23rd March 2019 to contribute to consideration of the proposed update of Good Practice Guidelines for General Practice Electronic Records v4 (GPGv4) from the version produced in 2011. This was done to help the RCGP design the questionnaire it is to distribute about what the scope of GPG v5 should be. The RCGP's survey on the scope of the new GPGv5 is at <https://tinyurl.com/y2hcm4m2> until 15th April 2019 : please read it, respond and encourage others to do the same.

Chatham House Rules apply to all CLICSIG outputs. Attendees included individuals from BCS PHCSG and the RCGP.

Changes in available and developing technology and its uses in delivering patient care, and in the management and delivery of health and social care, have introduced new requirements since 2011, hence the plan for GPG to be updated and maintained in this rapidly changing environment.

In addition to the requirements for advice - & standards – on data entry, record keeping, making records “fit for sharing” as well as fit for patient care within a single practice, use of Coding and the migration from Read Code and CTV3 to SNOMED, the need for training and education for clinicians and non-clinicians in both general practice and other primary care settings, and the changing technical, legal and organisational frameworks within which general practice and integrated care operates, other areas influencing the requirements for good records were discussed.

The discussion was wide-ranging and included topics which would not necessarily be included in GPGv5 but could influence how it is presented. These included intended use and users, usability and accessibility, maintenance, and ongoing support and funding, as well as practical problems around the identification and dating of changes, and the implications of shared records – both single shared electronic patient records (SSEPRs) where different organisations use a single record for prime entry, and integrated care records such as the Local Health and Care Records (LHCRs) under development at present. Both need clarification of issues around

- Data Controller(s) scope & accountability,
- Construction and structure (e.g. summarisation, problem orientation,, etc),
- clinical & information governance – who controls which data &/or is responsible for dealing with its implications for the patient's care
- and the importance of communication in addition to data access. Placing information in a record does not se ensure that another care professional

who needs to know about it is made aware of it, or will assume responsibility for dealing with it.

Included in the areas identified as presenting difficulties for practices and/or Data Controllers were:-

1. Patient access to their own records is already available in all current systems and it is reasonable to assume this will be included in the specifications for new entrants: however, there is a requirement to conceal third party information when records are shared with those who are not professionals involved in the patient's care . Although it is possible to conceal or redact information in patient records in some systems, it is not clear who may redact what, when and how while ensuring that that the record remains safe to use in all circumstances. It is also important that the rules governing redaction are consistent across different GP systems. Ideally data correction and record curation processes should also be consistent across all GP systems.
2. These problems are particularly acute when an SSEPR is used by a number of different care organisations, often from different professions and with different record keeping conventions For example what data should a GP provide when a patient makes a subject access request (SAR)? Should the practice allow access to the entire shared record or only to the part "owned" by the practice? If the entire record is provided to the data subject, who has the responsibility for identifying (and redacting) third party data, and would a SAR to, say, social services (if they used the single shared record) also include the medical record?
3. GPs are confused about lack of clarity in their legal and ethical responsibilities with regard to sharing patient information and the amount of information to be shared for direct care: how is this to be decided in Integrated Care Records, and where does responsibility lie if/when there is a data breach originating from a shared record? Should detailed advice be included in GPGv5 or referenced in other sources?
4. maintenance and curation of records, particularly when they are used by many different organisations, each of which have their own legitimate record-keeping requirements and style and may have used a previous version of the record.
5. poor usability and the risk of overlooking relevant or essential information because of the record structure (or lack of it), poor or absent curation (un-pruned summaries, entries in unexpected places, incomplete records) with consequent risks to patients.
6. importation of structured information from external sources: how the information is presented and how the recipient is notified: transfer of responsibility for action and informing patients.
7. increasing use – and plans for use – of third-party software and of Apps will need regulation (when is an App a Medical Device? Are there security implications? Who can give – or refuse – consent for software to access patient records? How

do Privacy Policies – and changes in them – operate in an NHS setting e.g. Facebook and Skype?)

A separate major issue identified was infrastructure and bandwidth: with records now held remotely and increasing in size, it is essential that bandwidth is sufficient to support rapid upload, download, and screen refresh times; that logging on is effectively instantaneous and that changing functions or patients is equally fast. (Probably not directly part of GPG – but should be included as requirement somewhere)

The RCGP has an online resource - <https://www.rcgp.org.uk/patientonline> - which could be a model for GPGv5. The advantage is ease of adding, updating or reviewing individual components as necessary rather than saving them until they warrant a new edition of the GPG, each change would include a title, when it was published, and the rationale for making it.

Changes in both the delivery of patient care and technology have and will necessitate changes in how medical records are created, curated, accessed – and by whom - and shared, for direct care and for secondary uses. Whereas originally GP records – including EPRs - were for the sole purpose of management of individual patients within single practices, they now need to be “fit for sharing” – and comprehensible (& computable) in systems other than the one in which they were created. For many records this is likely to require a significant improvement in the quality and organisation of records, including professional agreement about what this means.