Royal College of General Practitioners

Department of Health

BMA

The Good Practice Guidelines for GP electronic records – Quick Reference Guide

Version 4 (2011)

DH INFORMATION READER BOX

Policy	Estates
HR / Workforce	Commissioning
Management	**IM & T**
Planning /	Finance
Clinical	Social Care / Partnership Working

Document Purpose	Best Practice Guidance
Gateway Reference	15787
Title	The Good Practice Guidelines for GP electronic patient records v4 (2011) - Quick Reference Guide
Author	Department of Health (DH)/Royal College of General Practitioners (RCGP)/British Medical Association (BMA)
Publication Date	21 Mar 2011
Target Audience	GPs
Circulation List	
Description	The Quick Reference Guide to The Good Practice Guidelines for GP electronic patient records v4 will act as a reference source of information for all those involved in developing, deploying and using general practice IT systems.
Cross Ref	
Superseded Docs	
Action Required	N/A
Timing	**N/A**
Contact Details	Lesley Cooke DH Informatics 1N24 Quarry House Leeds LS2 7UE 0113 397 4468
For Recipient's Use	

Contents

Contents 3
Chapter 1 – Strategic context for the Good Practice Guidelines for GP electronic patient records v4 (2011) 5
Chapter Summary 5
Chapter Sections 5
GPGv4 Content 5
Chapter 2 – The Purposes of Health Records 6
Chapter Summary 6
Chapter Sections 6
Internal References 6
Chapter 3 – Clinical Safety Assurance 7
Chapter Summary 7
Chapter Sections 7
Internal References 7
Chapter 4 – Records Governance 8
Chapter Summary 8
Chapter Sections 8
Figures and Tables 8
Internal References 8
Chapter 5 – Shared Electronic Patient Records 9
Chapter Summary 9
Chapter Sections 9
Internal References 9
Chapter 6 – High Quality Patient Records 10
Chapter Summary 10
Chapter Sections 10
Internal References 10
Chapter 7 – Clinical Coding Schemes 12
Chapter Summary 12
Chapter Sections 12
Tables and Figures 12
Internal References 12
Chapter 8 – Data Transfer and Interoperability 13
Chapter Summary 13
Chapter 8a – The Personal Demographics Service 14
Chapter Summary 14
Chapter Sections 14
Tables and Figures 14
Internal References 14
Chapter 8b - GP2GP Electronic Record Transfer 15
Chapter Summary 15
Chapter Sections 15
Internal References 15
Chapter 8c – Data Migration 16
Chapter Summary 16
Chapter Sections 16

Internal References 16
Chapter 8d – Clinical Messaging 17
Chapter Summary 17
Chapter Sections 17
Internal References 17
Chapter 8e - The Summary Care Record and the Emergency Care Summary 18
Chapter Summary 18
Chapter Sections 18
Internal References 18
Chapter 8f - High Quality Medication Records and The Electronic Prescription Service 19
Chapter Summary 19
Chapter Sections 19
Figures and Tables 19
Internal References 19
Chapter 9 - A pathway to good paperless practice 20
Chapter Summary 20
Chapter Sections 20
Figures and Tables 20
Internal References 20
Chapter 10 - Electronic Document Attachments 22
Chapter Summary 22
Chapter Sections 22
Tables and Figures 22
Internal References 22
Chapter 11 – Working in an e-business environment 23
Chapter Summary 23
Chapter Sections 23
Internal References 23
Chapter 12 - Education and training 24
Chapter Summary 24
Chapter Sections 24
Internal References 24

Chapter 1 – Strategic context for the Good Practice Guidelines for GP electronic patient records v4 (2011)

Chapter Summary

- Outlines the economic and political context in which general practice operates
- Notes that good records are a requirement for the high quality care expected by government, the public and the profession
- Describes the background to the Good Practice Guidelines stating the need for professionally owned, authoritative guidance for implementers and users of GP systems
- Reviews the analysis of the intended scope for these guidelines, describing how inter-operability and quality are central themes.

Chapter Sections

1.1 Introduction
1.2 Background
1.3 GPGv4 scope and definition
1.4 GPGv4 Content

GPGv4 Content

1. Strategic Context for the Good Practice Guidelines for GP electronic patient records v4 (2011)
2. The Purposes of Health Records
3. Clinical Safety Assurance
4. Records Governance
5. Shared Electronic Patient Records
6. High Quality Patient Records
7. Clinical Coding Schemes
8. Data Transfer & Interoperability
   a. The Personal Demographic Service
   b. GP2GP Electronic Record Transfer
   c. Data Migration
   d. Clinical Messaging
   e. The Summary Care Record and Emergency Care Summary
   f. High Quality Medication Records & The Electronic Prescription Service
9. A Pathway to Good Paperless Practice
10. Electronic Document Attachments
11. Working in an e-business Environment
12. Education and Training

Chapter 2 – The Purposes of Health Records

Chapter Summary

- Summarises the broad ranging purposes of Health Records including:
    - Their use for individual patient care and care of practice population
    - Uses for administrative and contractual obligations
    - Additional purposes such as governance and education
    - Uses in other health care environments

Chapter Sections

2.1 Clinical purposes
2.2 Non-clinical purposes
2.3 Additional purposes
2.4 Emerging purposes

Internal References

None

Chapter 3 – Clinical Safety Assurance

Chapter Summary

- Outlines the clinical safety approach that applies across the NHS in England
- Describes the way that detailed clinical safety testing may be carried out
- Provides information about emerging safety standards that are relevant to clinical safety
- Important in terms of health records inter-operability

Chapter Sections

3.1 Introduction
3.2 Clinical safety approach
3.3 Clinical safety assurance and inter-operability
3.4 Current NHS safety standards for IT systems (DSCN 14/3009 & 18/2009)
3.5 Future Safety Standards including changes to the Medical Device Directive
3.6 Key clinical safety summary points

Internal References

Chapter 6 ……High Quality Patient Records
Chapters 8a-f …….Data transfer and inter-operability
Chapter 12 …….Education and Training

Chapter 4 – Records Governance

Chapter Summary

- Provides discussion and advice on the NHS IT governance framework
- Lists and references all legal aspects, acts, regulations and standards that affect records governance in primary care
- Discusses the issues around consent and disclosure; models, effects and implementations
- Provides detailed advice on the issues arising from records retention after a patient de-registers from a practice
- Outlines the origins and purposes of the NHS Information Governance Toolkit

Chapter Sections

4.1 Information governance framework
4.2 Legal aspects
4.3 Standards
4.4 Other relevant publications
4.5 Governance issues particular to shared electronic patient records
4.6 Records and record keeping – guidance from health professional bodies
4.7 Consent
4.8 Information governance and data disclosure
4.9 Retention of GP electronic patient records and associated audit trails when a patient is no longer registered with a practice
4.10 The Information Governance Toolkit, & Information Governance Statement of Compliance (IGSoC)

Figures and Tables

Figure 4.8 .....The decision to disclose
Figure 4.8.2 .....The nature and uses of data extracts
Table 4.9 .....Access Controls

Internal References

Chapter 5 .....Shared electronic patient records
Chapter 5.2.5 .....At what level does responsibility for shared electronic patient record/detailed care record governance lie?
Chapter 5.3 .....Sharing records with patients (Record Access)
Chapter 6 .....High Quality Patient Records
Chapter 8b.2 .....GP2GP Electronic Record Transfer – The nature of electronic GP2GP record transfer
Chapter 8c.....Data Migration
Chapter 8e.2 .....The Summary Care Record and the Emergency Care Summary - Consent

Chapter 5 – Shared Electronic Patient Records

Chapter Summary

- Describes relevant guidelines for shared electronic clinical records in primary care
- Discusses and outlines the 16 principles developed in the RCGP Shared Records Professional Guidance report
- Discusses governance, medico-legal and patient safety aspects
- Considers the implications of sharing health data and records with patients with respect to benefits and governance

Chapter Sections

5.1 Introduction
5.2 Shared electronic patient records – background
5.3 Sharing records with patients (Record Access)

Internal References

Chapter 4.2.4 .....Records Governance
Chapter 12 .....Education and Training

Chapter 6 – High Quality Patient Records

Chapter Summary

- Provides guidance on high quality patient records
- Discusses the importance of data quality with respect to the multiple different uses of GP data and the effects of different contexts
- Discusses methods and issues that affect the quality of data recording including:
    - Coding and record structures
    - Patient review of records
    - Common sources of errors
    - Processing of received external information
- Explains and elaborates upon the CARAT acronym for assessing data quality
- The effects of data quality in shared detailed electronic records and the Summary Care Record

Chapter Sections

6.1 Introduction
6.2 Information quality and modern general practice
6.3 Capturing information in the consultation
6.4 Capturing information from outside the practice
6.5 Recognising high quality patient records
6.6 System-specific Issues
6.7 Data quality and shared records
6.8 Conclusion

Internal References

Chapter 2 .....Purposes of Health Records
Chapter 3 .....Clinical Safety Assurance
Chapter 4.5 .....Records Governance
Chapter 5 .....Shared Electronic Patient Records
Chapter 5.3 .....Sharing Records with Patients (Records Access)
Chapter 7 .....Clinical Coding Schemes
Chapter 8a .....The Personal Demographics Service
Chapter 8a.3 .....The Summary Care Record and Emergency Care Summary
Chapter 8a.4 .....The Personal Demographics Service
Chapter 8b.3.2 .....Allergy Information
Chapter 8b.3.4 .....General Record View

Chapter 8c.....Data Migration
Chapter 8d .....Messaging
Chapter 8e .....The Summary Care Record & Emergency Care Summary
Chapter 8f .....EPS
Chapter 9 .....A Pathway to Good Paperless Practice
Chapter 9.6.2 .....Processes for Data Capture
Chapter 9.6.3 .....Coding Systems
Chapter 9.7.6 .....Diagnosis refinement and amendment and deletion
Chapter 9.7.7 .....Consulting with computers
Chapter 9.7.9 .....Document Management
Chapter 12 .....Education and Training

Chapter 7 – Clinical Coding Schemes

Chapter Summary

- Provides an outline of the coding schemes in use in UK primary care including
    - 4 Byte Read
    - Read Version 2 (5 Byte)
    - Clinical Terms Version 3 (CTV3)
    - SNOMED CT
- Describes the structures and organisation of these terminologies
- Reviews their origins, purposes, benefits and actual and potential issues of their use in practice
- Discusses the pros and cons of using coded data or free text
- Reviews the use of codes in data sharing systems including messaging and system migration
- Provides guidance on preparing to move to using SNOMED CT

Chapter Sections

7.1 Coding schemes in current use
7.2 Future standardisation of coding schemes across health care - SNOMED-CT
7.3 Features of Read Codes
7.4 General issues relating to terminology use
7.5 Sharing coded information
7.6 Preparing to move to SNOMED-CT, what to expect

Tables and Figures

Table 7.3.2.4 .....Abbreviations used in some Read terms
Figure 7.4.4 .....Issues to remember with coded terminologies
Figure 7.7 .....Glossary of words and phrases relevant to this chapter

Internal References

Chapter 6.7.2 .....High Quality Patient Records – Data Quality in the Summary Care Record
Chapter 8b .....GP2GP Electronic Record Transfer
Chapter 8c.....Data Migration

Chapter 8 – Data Transfer and Interoperability

Chapter Summary

- Lists six sub-chapters focusing on the issues arising from data transfer and inter-operability:
    - 8a The Personal Demographics Service
    - 8b GP2GP Electronic Record Transfer
    - 8c Data Migration
    - 8d Clinical Messaging
    - 8e The Summary Care Record and Emergency Care Summary
    - 8f High Quality Medication Records and The Electronic Prescription Service

Chapter 8a – The Personal Demographics Service

Chapter Summary

- Describes PDS main purposes
- Discusses the access & security controls and arrangements in place to ensure only authorised use for intended purposes
- Recommends methods for finding patients using PDS tracing functions
- Recommends the use of unique NHS IDs in all patient identifiable communications
- Discusses how to ensure PDS data is of high quality at input and maintenance

Chapter Sections

8a.1 Introduction
8a.2 Access & security
8a.3 PDS tracing
8a.4 The NHS Number (England and Wales)
8a.5 Data quality

Tables and Figures

Table 8a.5 .....Completing the GMS1 form (demographics data)

Internal References

Chapter 8b .....GP2GP Electronic Record Transfer
Chapter 8e .....The Summary Care Record and the Emergency Care Summary
Chapter 8f .....High Quality Medication Records and The Electronic Prescription Service

Chapter 8b - GP2GP Electronic Record Transfer

Chapter Summary

- Provides advice and guidance on the 'GP2GP' service that allows electronic transfer of patient records between practices
- Describes the intended benefits of GP2GP and the reasons for its implementation
- Outlines the methods by which GP2GP operates
- Recognises and describes the areas where GP2GP is limited and how to mitigate these limitations
- Provides specific advice on managing drug allergy records when sending and receiving these by GP2GP
- Explains the handling of record attachments by GP2GP and how these can be managed
- Provides explanations of the procedures for workflow practices should adopt when using GP2GP
- Includes a discussion of training issues, record validation and the continued impact of non-computerised practices

Chapter Sections

8b.1 The rationale for electronic GP2GP record transfer
8b.2 The nature of electronic GP2GP record transfer
8b.3 The limitations of electronic GP2GP record transfer
8b.4 General clinical safety
8b.5 Electronic and paper GP2GP record transfer
8b.6 GP electronic record quality
8b.7 GP2GP record transfer - good practice guidelines

Internal References

Chapter 3 .....Clinical Safety Assurance
Chapter 6 .....High Quality Patient Records
Chapter 6.6.1 .....Drug Allergies
Chapter 8a .....The Personal Demographics Service
Chapter 8c.....Data Migration
Chapter 8f .....High Quality Medication Records and the Electronic Prescription Service

Chapter 8c – Data Migration

Chapter Summary

- Describes the Data Migration Improvement Project
- Outlines the data migration processes used when migrating data between GP systems including those from different suppliers
- Describes how to handle exceptions and review target system data
- Advises on the requirements for final sign off in data migration projects

Chapter Sections

8c.1 Formalising the process of data migration
8c.2 Data migration process

Internal References

Chapter 4.2.4 .....Records governance - Data Protection Act 1998 (DPA)

Chapter 8d – Clinical Messaging

Chapter Summary

- Addresses and discusses the background to clinical messaging to and from GP systems
- Provides advice on how clinicians should assess new clinical messaging facilities
- Outlines the processes involved in handling clinical messaging data transfers
- Provides specific advice for practices on pathology messaging
- Discusses possible future implementations of messaging systems

Chapter Sections

8d.1 Introduction
8d.2 Background
8d.3 Processes involved in handling clinical messaging data transfers
8d.4 Pathology Messaging
8d.5 Radiology Messaging
8d.6 Out of Hours (OOH) messaging
8d.7 A/E encounter, outpatients encounter, inpatients discharge

Internal References

Chapter 8b .....GP2GP Electronic Record Transfer
Chapter 8e .....The Summary Care Record and the Emergency Care Summary

Chapter 8e - The Summary Care Record and the Emergency Care Summary

Chapter Summary

- The Summary Care Record (SCR) in England and the Emergency Care Summary (ECS) in Scotland are designed to assist in the care of patients in urgent and emergency care settings
- Discusses and details the two consent models used comparing and contrasting their similarities and differences
- Examines how data quality impacts on these services and advises on how this can be improved and maintained
- Advises on the use of NHS Smartcards and how they apply to access and updating the SCR and the importance of ensuring all clinical users employ them
- Notes that both services are under continued development and advises users to review new guidance as it is issued

Chapter Sections

8e.1 Introduction
8e.2 Consent
8e.3 Data Quality
8e.4 Future Guidance

Internal References

Chapter 4 .....Records Governance
Chapter 6 .....High Quality Patient Records
Chapter 7 .....Clinical Coding Schemes
Chapter 9 .....A Pathway to Good Paperless Practice
Chapter 12 .....Education and Training

Chapter 8f - High Quality Medication Records and The Electronic Prescription Service

Chapter Summary

- Provides advice on the Electronic Prescription Service (EPS); the importance of and methods of achieving high quality medication records
- Outlines the release phases of EPS
- Gives guidance on how practices should prepare for EPS
- Lists the intended benefits for patients and carers, and for prescribers
- Discusses the security and confidentiality measures that support EPS, including smartcards
- Provides guidance on determining readiness for EPS Release 2
- Describes prescription types excluded from EPS at present

Chapter Sections

8f.1 Introduction
8f.2 High Quality Medication Records
8f.3 Why is the EPS Service being introduced?
8f.4 Different Releases in EPS
8f.5 EPS Release 2
8f.6 Getting Ready for EPS
8f.7 EPS Consultation Process
8f.8 Benefits for Patients and Carers
8f.9 Benefits for Prescribers
8f.10 Smartcards
8f.11 Release 2 Readiness
8f.12 Security and Confidentiality
8f.13 Access Control
8f.14 EPS Unsupported Prescriptions

Figures and Tables

Figure 8f.4 .....EPS Release 2 Functionality
Figure 8f.5 .....EPS Release 2 Prescription Token with barcode
Figure 8f.11 .....Release 2 Readiness

Internal References

None

Chapter 9 - A pathway to good paperless practice

Chapter Summary

- Provides guidance on migrating practices to ‘paperless’
- Defines various levels of ‘paperless’ working
- Discusses business and infrastructure requirements for practices to move to paperless working including continuity planning
- Reviews potential benefits and risks
- Gives guidance on using computers in the consulting room
- Analysis of business processes that can be migrated to paperless working
- Advice on clinical data capture and records summarising
- Advice on records refinement, amendment and deletion
- Contact details for GP clinical system user groups
- Advice on the current requirements for accreditation of paperless practices

Chapter Sections

9.1 Introduction
9.2 About this chapter
9.3 From paper to paper-free
9.4 Pre-requisites
9.5 Benefits and risks
9.6 Data quality recording standards
9.7 Moving practice business to paper-light
9.8 System user groups
9.9 Accreditation of paperless practices

Figures and Tables

Figure 9.4.2a .....Hardware
Figure 9.4.2b .....Software
Figure 9.4.2c .....Network Infrastructure
Figure 9.7.3.1 .....What is required for paper-light prescribing?
Figure 9.7.7.2 .....How to sit

Internal References

Chapter 1 .....Strategic context for the Good Practice Guidelines for GP electronic patient records v4 (2011)
Chapter 4.2.4 .....Records Governance
Chapter 6 .....High Quality Patient Records

Chapter 6.3.1 .....Coding, structuring and free text
Chapter 7 .....Clinical Coding Schemes
Chapter 7.4.3 .....Codes or Text?
Chapter 8a .....The Personal Demographics Service
Chapter 8b .....GP2GP Electronic Record Transfer
Chapter 8f .....High Quality Medication Records and the Electronic Prescription Service
Chapter 10 .....Electronic Document Attachments
Chapter 12 .....Education and Training

Chapter 10 - Electronic Document Attachments

Chapter Summary

- Offers guidance on attached electronic documents
- Discusses legal status of such documents
- Advises on appropriate formats and lists key principles to be applied
- Reviews methods employed by systems for document storage
- Outlines document categorisation to manage attribution, coding and identification
- Provides pragmatic advice on document transfer with a review of methods in use today
- Discusses how attachments are handled by electronic referral systems

Chapter Sections

10.1 Introduction
10.2 Attached electronic documents
10.3 Format of attachments
10.4 Storage of attachments
10.5 Attachment identification and coding
10.6 Transferring attachments
10.7 e-referral attachments

Tables and Figures

Table 10.3.1 .....Format of attachments
Table 10.5.3 .....Attachment Identification

Internal References

Chapter 4 .....Records Governance
Chapter 8 .....Data transfer and inter-operability
Chapter 8b .....GP2GP Electronic Record Transfer
Chapter 9 .....A Pathway to Good Paperless Practice

Chapter 11 – Working in an e-business environment

Chapter Summary

- Discusses how general practice fits in the broader electronic world
- Reviews NHS National Network, infrastructure and services
- Offers guidance on creating and maintaining a practice web site
- Examines how to assess consumer e-Health web sites and on line resources
- Discusses the role of personal health records
- Examines the current guidance for internet consultations
- Discusses areas where internet technologies can support the business of general practice
- Outlines requirements for protecting individual privacy and security on line
- Describes GP system 'data extracts' and requirements for practices participating in such schemes

Chapter Sections

11.1 Introduction
11.2 Working in an e-business environment
11.3 NHS connectivity
11.4 Practice websites and on-line services
11.5 'Consumer' oriented Internet health services
11.6 Using the Internet for consulting
11.7 Supporting general practice
11.8 Privacy and security in the online world
11.9 Data extracts

Internal References

Chapter 4.8 .....Records Governance
Chapter 5 .....Shared Electronic Patient Records
Chapter 8d .....Clinical Messaging

Chapter 12 - Education and training

Chapter Summary

- Discusses the importance of education and training to the success of projects using IT for business change and notes that the social and affective aspects of learning are important
- Reviews learning needs in the context of shared records and interoperability and the need for system users to understand the record structures and views that apply to their clinical recording
- Suggests methods for meeting learning needs with respect to individual and practice variations in competency, knowledge and systems
- Emphasises the importance of inter-personal learning
- Provides references to on-line learning resources

Chapter Sections

12.1 Why education and training are important
12.2 Learning needs
12.3 Meeting these learning needs
12.4 Some learning resources

Internal References

Chapter 5 – Shared Electronic Patient Records
Chapter 8e – The Summary Care Record and Emergency Care Summary
Chapter 9.8 – A Pathway to Good Paperless Practice

© Crown copyright Year 2011
First published March 2011
Published to DH website, in electronic PDF format only.
http://www.dh.gov.uk/publications