Lloyd George Digitisation – FAQs

Project initiation

Q.1 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 as was. 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.

Q.2 My practice is about to go 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 an ICB, 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.

Q.3 Can records which have not been summarised be considered for digitisation?

The summarisation of records was mandated in 2004 as part of the then GMS Contract. Practices and ICBs 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.

Q.4 Should practices scan their LG records into separate sections or as one continuous section?

At a local level, practices must decide how their LG records are to be scanned and digitised in regard to either having the contents of records scanned into multiple sections or as one single or continuous section. This decision can be based on a number of factors:

- 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 (available at www.england.nhs.uk – see section on *Digitisation of Lloyd George 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.

Preparation of Records

Q.5 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 regard to sealed LG records, it is is currently advised that sealed records should not be digitised and therefore not included in a practice's batch of records to be digitised. If a scanning supplier identifies sealed records then they should be returned to the practice.

In any other scenarios regarding confidential or sensitive information, 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. See here: Records Management Code of Practice - NHS Transformation Directorate (england.nhs.uk).

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.

Transportation of Records

Q.6 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 third-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.

Records Validation

Q.7 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

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.

Upload / Storage of Records

Q.8 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.

Destruction of Records

Q.9 Can the paper LG record be destroyed once the digitised version has been validated and approved?

The envelope and 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 or stored securely in an electronic repository.

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 ICB when destruction of records is to take place.

Q.10 Do I need to transfer the empty LG envelope, following scanning of the records, if the patient leaves the practice list and I receive a transit label from PCSE?

As of 19 June 2023, LG envelopes can be destroyed provided they have been digitised as part of the patient record and electronically stored in line with national standards. Paper envelopes that have not yet been digitised should be sent from the practice using the existing Primary Care Support England processes.

Q.11 We have destruction certificates for records that have already been destroyed. Do we need a second cert for the LG envelope?

The envelope is considered part of the Lloyd George record and therefore if it is destroyed separately to the content of the envelope, there should be a separate certificate as evidence of the destruction of the envelope provided by the scanning and destruction

supplier.

Q.12 Some envelopes have already been returned to practices due to storage issues after the paper record has been digitised and destroyed (and certifications provided). Can I destroy these envelopes using secure disposal or do they need a certification?

If destructions are carried out locally, a local disposal certificate should still be completed. A practice's normal confidential waste disposal arrangements might not be suitable for the destruction of envelopes, if certificates specifically relating to their destruction cannot be provided.

Q.13 Some envelopes have been returned to the practice, but the paper records have not yet been destroyed by the scanning provider. Does this mean two destruction certs will be necessary or will just the paper record one suffice?

This depends on the exact circumstances. If the paper envelopes are returned to the practice after the paper records have already been destroyed, and then the envelopes are sent for destruction separately, a second certificate will be required. One certificate could cover a series of envelopes and should provide sufficient summary information about the series of records destroyed to provide evidence of destruction of a particular record. If the envelopes are returned to the scanning supplier and then destroyed at the same time as the rest of the paper record, then only one destruction certificate will be needed.

Q.14 We have stored scanned records in a cloud platform due to restrictions on clinical system uploads. What should we do if the patient leaves the practice?

Any scanned records must be printed out and sent using the current transit label process. We recommend retaining the digital file until the new practice is able to confirm that they have received the printed record.

Miscellaneous

Q.15 Will the digitised Lloyd George attachment transfer with the electronic patient record via GP2GP?

All clinical systems are now capable of GP2GP electronic transfer which allows for the secure electronic transfer of a patients record (including attachments) from one practice to another at the point of registration.

In some circumstances the GP2GP transfer may not be possible and in this scenario, practices will need to continue printing out the full electronic record including LG 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.

Q.16 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 a practice may receive a digitised Lloyd George patient record from another practice in an alternative format other than what has been agreed locally. In this scenario it is advised that the digitised file(s) received are not edited or changed and are kept in the same format that they are received in allowing for digitised Lloyd George records to remain in a true and accurate version of the paper original. 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.

Q.17 What should you do if you have already digitised your Lloyd George records?

If a practice's Lloyd George records have been digitised prior to the release of national guidance relating to the digitisation of Lloyd George records, practices should check that their digitised records comply with the new guidance. If a practice discovers a non-compliance issue, practices should discuss this internally or with their ICB in order to plan corrective action.

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.

Q.18 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 supplier's 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 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.

Q.19 If a practice removes a patient from their list on an immediate/eight-day removal, and this patient does not get the chance to register at another practice, what will happen to their record?

If a patient has previously had their LG record scanned, digitised and attached to their electronic record but then has their electronic record (including the digitised LG) immediately deducted from the practice list, the electronic record will remain in the practice host clinical system as 'inactive'. The patient record remains in the practice clinical system and becomes digitally orphaned/stranded as it does not have a home to go to i.e. under the control of a new practice or PCSE.

As part of the wider NHSEI Continuity and Digitisation of GP records programme, NHS Digital is developing a technical solution to manage digitally orphaned/stranded records. More updates will follow.

Q.20 How do I manage patient LG records which have been deducted during the scanning and digitisation process?

If patient record becomes deducted during the scanning and digitisation process, then it is the responsibility of the scanning supplier to return the paper version of the LG record back to the practice so this can then be forwarded on to the PCSE.

If it is not possible for the supplier to send the practice the original paper copy, then the supplier will need to print out a copy of the patients LG using the patient's digital version of their LG record before sending this onto the practice. However, before this can be done the practice must first validate the quality of patients digital version.

Any patient records that become deducted after the records have been returned to the practice for quality assurance will be the responsibility of the practice to print the records.

Q.21 Do we need to scan ECGs?

Yes. ECGs should be scanned by using a manual scanner to manage the length of the document.