Editable access for Londoners via the NHS Login Service – Frequently Asked Questions for Health and Social Care Professionals

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Overview

What is patient-editable access to the UCP?

Patients-editable access (PEA) enables patients to start, view, and directly add or update selected parts of their Universal Care Plan (UCP) through the NHS App and Online Service. This supports shared decision-making, more personalised care, and improved information quality.

PEA does not provide unrestricted editing. Clinical information and formal decisions remain view only for patients. All patient entered information is clearly identifiable through the audit history.

Why are we enabling patient editing?

We're enabling this to:

- Promote transparency and partnership between patients and professionals

- Support shared decision making and personalised care planning
- Empower patients to contribute directly to their own care plan
- Improve accuracy of information by enabling patients to keep key information up to date
- Reduce duplication across systems and conversations
- Improve safety, especially in urgent and emergency care
- Align with NHS digital and personalised care strategies

Which parts of the UCP can patients edit?

Patients can start and update selected non-clinical sections relating to:

- Personal information
- Preferences and priorities
- What matters to me
- Care wishes
- Carer Contingency Planning

All clinical sections remain professionally led and cannot be edited by patients.

Clinical Safety & Governance

How is clinical safety maintained?

Clinical safety is maintained through a combination of system controls, professional oversight and established governance processes:

- Patient-entered information is clearly visible and identifiable to professionals via audit history
- Clinical sections remain clinician led and are read-only for patients
- The functionality has been developed in line with DCB0160 and clinical risk management standards
- Local governance, safeguarding and escalation pathways remain in place.

Are clinicians responsible for reviewing patient edits?

Patient edits do not require formal vetting or approval by a health or care professional before being saved.

However, professionals remain responsible for reviewing patient-entered information as part of routine care and review, particularly where it may inform clinical decision-making or care delivery.

How will we know when patients update their plans?

Professionals can view patient edits within the UCP audit history. There are currently no automatic notifications when a patient updates their plan.

What happens if a patient enters inaccurate, unsafe, or concerning information?

If patient-entered information raises concerns, professionals should follow existing clinical processes, including:

- Contacting the patient to discuss the information
- Clarifying and validating content
- Updating the care plan where appropriate
- Escalating safeguarding or safety concerns in line with local policy

In addition, the functionality includes automated safety and moderation checks which flag and report potentially harmful or inappropriate content for further review.

Does patient editing increase clinical risk?

Evidence suggests patient editing does not increase clinical risk and can improves safety by:

- Improving the accuracy and completeness of information
- Increasing patient engagement and ownership
- Making preferences clearer
- Reducing information gaps across settings

Clinical Use & Workflow

How does this change existing workflows?

There will be minimal changes to existing workflows. The main difference is that patients may proactively start their care plan or update non-clinical information directly.

Professionals should review patient-entered updates as part of routine care planning, reviews and clinical interactions.

Does this replace clinician-led care planning?

No. Patient editing does not replace clinician-led care planning. It supports shared care planning by improving understanding of patient priorities and enabling more meaningful conversations.

It can also reduce administrative burden by allowing patients to complete relevant non-clinical sections, giving clinicians more time to focus on direct clinical care.

Should professionals still verify information?

Yes, patient-entered information should be reviewed and verified during routine interactions, particularly where it informs care delivery or clinical decision-making.

How should clinicians introduce patient editing to patients?

Clinicians should frame patient editing as a way to:

- Encourage ownership of their care plan
- Support shared decision-making
- Enable ongoing conversations about what matters to them
- Promote regular review and updates

Supporting guidance and resources will be made available to help professionals introduce and embed this in practice.

Why has the decision been made to remove the ability to submit non-clinical forms as 'in progress'?

The option to save non-clinical forms as 'in progress' will be removed to enable people to co-author these sections of their care plan.

Currently, a significant proportion of forms saved as 'in progress' have not been updated for some time. 35% were last edited over a year ago, and 65% were last edited more than four weeks ago. This change provides an opportunity for users to review and submit this information so it remains accurate and useful.

In addition, forms saved as 'in progress' are not visible to urgent care services. Removing this option for non-clinical forms will improve visibility of important information.

Will I still be able to edit parts that patients can edit?

Yes. Professionals can continue to edit these sections. However, patients will also be able to update and overwrite content in patient-editable sections.

Is all information within the care plan visible to patients?

The following areas are not viewable or editable for patients:

- Prognosis
- Non personal alerts used by professionals to flag specific issues to other care staff
- Medication and allergies (as there is already a place to view medication and allergies elsewhere within the NHS App)

This ensures appropriate clinical governance while maintaining transparency in relevant areas.

Information Governance & Consent

Who can see patient-entered information?

Only the person themselves and authorised professionals involved in the patient's care. At this stage, proxy access is disabled.

How is data security ensured?

The UCP is hosted within NHS-approved secure systems, meeting national data protection and cybersecurity standards.

Patient Support & Engagement

What support should we offer patients?

Professionals should offer patients:

- A basic explanation of the purpose of the UCP and patient editing
- Guidance on what type of information to include
- Reassurance about safety, visibility and how their information is used
- Signposting to NHS App support and guidance

What about patients who are digitally excluded?

The UCP remains fully clinician-editable and care planning conversations continue as normal. Professionals can continue to create and update the UCP on behalf of the patient.

Where appropriate, family members or carers may support individuals to access their care plan. We will also work with NHS App ambassadors and voluntary sector organisations to support access.

What about patients with capacity concerns?

Standard mental capacity and best-interest decision-making processes should be followed. Patient editing should only be encouraged where individuals have the appropriate capacity or where appropriate support is in place.

Operational & System Questions

Does this change the legal status of the UCP?

No. The UCP remains a shared clinical care record.

Is patient-entered information part of the legal clinical record?

Yes, patient-entered information forms part of the shared care plan and should be treated in the same way as other information within the UCP.

How does this align with DCB0129 / DCB0160?

The functionality has been developed in line with national clinical safety standards, supported by clinical safety officers, hazard analysis and appropriate mitigations.

Will this increase workload?

Experience from other systems suggests that there may be a small initial increase in workload as the functionality is embedded. However, this is expected to be offset in the medium to longer term through:

- Reduced duplication
- Fewer clarification calls
- Improved information quality
- Fewer errors

Emergencies & Urgent Care

Will ambulance and urgent care services see patient updates?

Yes, patient-entered updates will be visible to all authorised health and care professionals accessing the UCP, including ambulance and urgent and emergency care systems. This supports more informed, real-time decision-making.

Should emergency decisions rely solely on patient-entered data?

No, patient-entered information should always be clinically assessed and used alongside professional judgement and other available clinical information.

Troubleshooting & Escalation

What if a patient reports incorrect or missing data?

If the information sits within a section the patient cannot edit, professionals can correct this within the clinical system (subject to Role-Based Access Controls permissions).

If the information sits within a section the patient can edit, the patient can update this directly themselves, with professional support if needed.

What if we suspect misuse or inappropriate edits?

Concerns should be managed through existing clinical governance and safeguarding processes. Where necessary, a clinician can lock a patient from editing their care plan but a reason for this must be recorded.