A clinician’s view of data protection

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The clinician’s view

The patient

The care record

The care professionals
The clinician’s view

The patient

Care Record Data

The care record

The care professionals
Information in health care

Knowledge in guideline etc.

Apply knowledge to improve care

Assemble results into actionable knowledge

Cycle 3: secondary research; implementation science

Apply insights to improve local service

Cycle 2: primary research; quality improvement

Retrieve data to inform each decision

Cycle 1: patient care

Capture data

Data in records

Analyse records to generate insights

Patient care, self care
The care record

• Doctors learn to write medical notes by apprenticeship

• They all do it slightly differently

• Standards for structure and content are essential for electronic records

• There have been no standards
Current electronic records

- Patient management
- Screening programmes
- Central returns
- Audit
- Disease registers
- Research
Current electronic records

- Patient management
- Screening programmes
- Central returns
- Audit
- Disease registers
- Research
Standards Development Process

1. Need for a standard
2. Search for existing standards
3. Search for relevant evidence
4. Discussion workshop 1
5. Invite online comments
6. Discussion workshop 2
7. To PRSB for approval
8. Implementation and Dissemination strategy

Drafts:
- Draft 0.1
- Draft 0.2
- Draft 0.3
- Draft 0.4

Clinical Record Standard 1.0
### Reason for referral

A clear statement of the purpose of the person making the referral, eg, diagnosis, treatment, transfer of care due to relocation, investigation, second opinion, management of the patient (eg, palliative care), provide referrer with advice/guidance. This may include referral because of carers’ concerns.

### Patient’s reason for referral

Patient-stated reason for referral. This may include any discussions that took place, the level of shared decision-making involved, information about patient’s source of advice. This may be expressed on behalf of the patient, eg, by parent or carer.

### Presenting complaints or issues

The list and description of the health problems and issues experienced by the patient resulting in their attendance. These may include disease state, medical condition, response and reactions to therapies. Eg blackout, dizziness, chest pain, follow up from admission, falls, a specific procedure, investigation or treatment.
Ambulance care records
Enabling patient control
PRSB
Professional Record Standards Body
for health and social care

www.theprsb.org
A Community Interest Company
Limited by guarantee

• Members (shareholders)
• All care professional bodies and associations
• Patient representative organisations
• Industry partners
The function of the PRSB

• To ensure that the requirements of those who deliver and those that receive health care can be fully expressed in electronic care records
The Vendor Forum

• A forum for dialogue on real world EPR interoperability and implementation issues
• Vendors, professions, patients, HSCIC, providers
• Shape the standards products
• Ensure that the nationally required technical products are on the HSCIC work programme
• Commercial Membership of PRSB
• Certification
A Vendor Forum

- The Human Genome
- Pharma
- Telemedicine
- Decision support
- Clinical guidelines
- Mobile technologies
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The PRSB vision