

## THE CASE AND VISION FOR PATIENT FOCUSED RECORDS

**The following statement, initially produced by the Royal College of Physicians, was adopted by the Academy in May 2010.**

In recent years many national initiatives have stressed the importance of greater focus on the needs and wishes of patients in the delivery of health services, and more patient empowerment and choice. If such requirements are to be met, electronic records that are focused on the patient, rather than the disease, intervention or location will be essential. Such records must cross organisational boundaries, so that appropriate information can be recorded by both practitioners and patients, and accessed by them, in a wide variety of clinical and care contexts. Currently, in hospital care, electronic patient records that comprehensively support the management of individual patients are few and far between, seriously limiting the opportunities to develop integrated services that cross traditional service boundaries.

The record of the dialogue between the clinician and the patient, the decisions made and the actions taken, is the cornerstone of the patient record. The information that is recorded should be accessible whatever the setting or context. This information can take the form of free text, or of structured data that is completely interoperable, and transferable between clinical applications, contexts and settings without ambiguity. Structured clinical data collected in this way also provides the best source of information for the many purposes that underpin service evaluation and research.

To achieve clinical interoperability, and to ensure the validity of aggregate information when data from many records are integrated and analysed, the structure and content of the record must be standardised. To achieve wide acceptance, such standards must reflect clinical practice, be evidence based, developed through consensus and professionally endorsed.

It is important that this approach is adopted across the NHS. It has to occur throughout, and between, primary, community and secondary care.

Effective implementation of standardised, structured, patient focused records requires strongly led culture change, embraced by all medical and clinical staff. They are essential prerequisites for safe, high quality care and for the safe, efficient and effective migration from paper to electronic patient records. They will also enable innovative development of services that cross traditional boundaries, and when patients themselves are given access to the record, empower them to take more responsibility for their own care.