Improved information for the NHS

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The Secretary of State's acceptance of the recommendations of the Steering Group on Health Services Information rounds off a stage of an enterprise that seeks to align the collection, processing, and dissemination of information in the National Health Service to the clinical and economic realities of the present and foreseeable future. The steering group has produced six reports,¹⁻⁶ and on the threshold of implementation—for which targets have now been set⁷—doctors may like to know the rationale and motives that brought the group into being, and learn the extent to which the original aims may be said to have been achieved.

The group's remit—to review information systems and to agree to keep under review the principles and procedures to guide their future development—was formulated after consultation with a wide range of interests in the NHS and the Department of Health and Social Security. This followed years of criticism about the content, availability, and quality of current data systems. A consensus of opinion identified lack of relevance, accuracy, and timeliness as the salient flaws that impeded and often defeated attempts to use the data, as they are intended to be used, for the management of the health service.

Though costly in money and effort, the systems—some of them introduced as early as 1948—had failed to keep pace with the transition from mere stewardship, held appropriate in the 'fifties and 'sixties, to the disciplined allocation and strict accountability for performance that is now sought and will be required in the future. The pressures for stricter management of resources, formalised in the NHS by annual reviews, searching inquiries by the Public Accounts Committee, and the appointment of general managers, exist not only in the United Kingdom but in all developed countries and are the ineluctable result of the tension between limited means and virtually unlimited ends. These pressures mean that the struggle and competition for funds, formerly confined in the main to the Cabinet and the DHSS, are now being experienced most strongly at the level where services are being delivered: in wards, clinics, and operating theatres. Out of date statistics and data, which do not genuinely reflect activity, cut as little ice in this competition as do guesses, unsupported opinions, and anecdotal evidence.

Clinicians' first hand experience

Most members of the steering group and its subgroups came from NHS regions and districts and so were well aware of the urgency of the task and the nature of improvements needed. Not least of these were the clinicians among them, whose first hand experience of the daily push and pull for facilities and staff had sharpened their perception of the managerial import for their profession of the reforms needed.

The greatest danger that threatens an enterprise of this kind is losing touch with the reality that gave it life. The quiet and relaxed atmosphere of committee rooms, the reasonableness and knowledge of members, the scrupulous attention to detail, and the measured pace of progress, all combine to obscure a world in which money, time, skills, and commitment are in short supply.

Pragmatism had to be the watchword, and the group had to

resist the siren voices of enthusiasts inviting it to run before those who will have to implement the recommendations are able or willing to walk. To determine whether those whom the group intended to lead would actually follow was a task of considerable complexity, as they ranged widely from clinicians concerned with information about diagnosis and treatment to nurses recording data about ward occupancy and record clerks structuring and coding the information. In the discussions and in the course of pilot trials several data items that the group or its respondents considered to be desirable proved not to be amenable to consistent and objective collection—or only at prohibitive cost. Concern for the privacy of patients and staff and the exclusion from the group's remit of epidemiological concerns precluded the consideration of other data items. The group's apparent parsimony in proposing very spare minimum data sets has been criticised: but proposals to collect the uncollectable and recommendations that were stillborn because of their cost would not have advanced the cause of better information.

Statistics collected in a strictly comparable national format cannot and are not meant to cater for all events and all interests. They merely represent a common spine, which often needs fleshing out by ad hoc studies and by data collected for local use in response to local problems and demands. The proposed minimum sets are sufficiently flexible to allow for this, and in many instances optional extensions are proposed. The data sets about patients and their treatment in particular are capable of enhancement by clinicians, as is exemplified by proposals about perinatal information and by successful trials in accident and emergency departments; the decision whether such enhancements are to be a local option or a national requirement, and the items that are to be included, is for individual colleges and faculties to determine.

Meeting the identified need

Do the recommendations of the steering group satisfy the identified need for greater accuracy, timeliness, and relevance? The accuracy of data depends on those who collect and record information having a clear and unambiguous understanding of the connotation of each item. They must also be committed to interpreting instructions correctly. Accuracy is engendered and maintained if information is used in decision making and if staff realise that inaccuracies damage the interests of patients and staff.

The steering group's reports specify exhaustive and exclusive definitions and classifications for all data items, and much effort has been spent on preparing training material, holding meetings and seminars, and generally improving the environment in which data are being collected.

The extent to which information is used depends on its being available when needed. In most instances at district and hospital level this does not occur when the processing of data is carried out at regional level or in the DHSS. The recommendations are therefore based on local computing facilities being available, an assumption that in the present state of technology is both desirable and feasible. By capturing and manipulating current data on activity, manpower, supplies, etc, the system will be able to provide managers at all levels with, among other information, up to date budgets for immediate action if required. Subsets and aggregations of the detailed local data will satisfy the legitimate needs of regions and the DHSS. But not even the most sophisticated computer facilities can make up for delays and omissions in the recording of, for example, diagnoses, and operational procedures for all patients using hospital beds. This is an

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important point for those who record data and have a stake in their use.

To endow the new systems with the relevance that alone would justify their cost and lead to their extended use the group concentrated its attention on the information needs of the district and its managers. These managers and their health authority are responsible for the provision of facilities and services to the district's population and are accountable for the way that facilities are used and money distributed between specialties, skill groups, and programmes.

For operational and for strategic purposes the district therefore needs to be informed about the profile of the patient population using or waiting to use facilities and services at any one time. It also wants information on the facilities and the way that these are distributed between services.

The first report contains recommendations about the minimum information needed on patients using hospital beds and outpatient facilities, and about other hospital facilities, including operating theatres and diagnostic departments, with utilisation the focus of interest.¹

The second report proposes standard information required on the activity and capital assets of patient transport services.² It also develops certain basic indicators of their efficiency and quality. The systems will replace a diversity of existing ones, inherited from the pre-1974 arrangements.

Rough and ready manpower cuts

Many managers in the NHS have felt aggrieved at what they regarded as some excessively rough and ready manpower cuts imposed by ministers. Yet the fault lay partly with the NHS and the inadequacies and paucity of its manpower information. The third report is an attempt to remedy this and to enable authorities to use and present up to date information about the composition, distribution, performance, and cost of their labour force.³

The subjects of the fourth report include the resolution of certain outstanding questions posed in the first report, such as information about radiotherapy departments, and information about activity and services delivered to patients either in hospital or in the community, including paramedical and maternity services.⁴

District authorities manage community health services which are delivered in the main by health visitors, district nurses, other community nurses, and community medical officers. The contribution of these staff groups does not appear in current statistics, which are based mainly on staff numbers rather than on patients treated. The recommendations of the fifth report aim to remedy this.⁵ Services are structured in accordance with their principal purpose along the main division between preventive and allied services and those concerned with care and treatment.

This programmatic approach is designed to reflect the cost and the performance of services and will make it easier to compare options, not least at the hospital and community interface, where important issues of complementarity and substitution are at stake. The report also contains proposals about the information needed from general practitioners if the extent and nature of population coverage of certain preventive services is to be established.

The sixth report draws together the activity, facilities, and staff data of the previous reports and proposes systems to cost services, by combining inputs and, often necessarily intermediate, outputs.⁶ The main departure from present systems of costing is the recommendation that, for hospital services, costs should be collected on the basis of individual specialties. The accompanying letter from the DHSS emphasises the government's aim to proceed from specialty costing to clinical budgeting; it enjoins authorities to adopt systems of specialty costing that would allow disaggregation of costs to the level of the individual clinician.⁸ This is in line with the Griffiths recommendations about better management in the NHS.

In the past few weeks the steering group has published a report on the administrative arrangements needed to maintain the privacy of the patient and the confidentiality of information about patients and staff.⁹ This report was prepared in response to a widespread demand for guidance and will complement the DHSS consultation process about the wider issues of privacy and confidentiality now being publicly debated.

In addition to the formal reports briefly outlined the steering group has also published, under the aegis of the King's Fund, a series of discussion papers designed to help districts to introduce modern technology and the arrangements necessary to support information services.¹⁰⁻¹⁶ The success of these publications has shown the need for and the usefulness of workshops and seminars from which the contents of the paper derive.

The collection and use of statistics for purposes of government go back to the seventeenth century, when they were aptly called "political arithmetic." Properly structured patient information was first proposed by Dr Francis Clifton in 1731, and Florence Nightingale was an early proponent of good utilisation statistics. Modern technology has made possible the exploitation of data for a wide range of management purposes. Thus tradition and progress reinforce each other in a trend that cannot and should not be resisted. The steering group has led the NHS to the water and cleansed it of sediment and impurities. Given the country's economic and political conditions the service will refuse to drink at its peril.

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THIRTY YEARS AGO

The DUKE OF EDINBURGH, who was heartily acclaimed, said: "I thank you very much indeed for the invitation to come and dine with you [the BMA] this evening, and also for your kindness in making me an Honorary Member. . . .

"There are two points I would like to make. The first is with regard to the individual. Much of the progress in medicine has inevitably been made at the price of deeper and narrower specialization, but the individual is still one unit, and as far as his personal health is concerned a unique unit at that. I am all for studying bits and pieces, but I hope that treatment will remain directed to the whole. Secondly, with regard to all mankind, the maintenance of health and the prevention and cure of disease is a laudable object but it can be followed blindly. Medical science has to face the fact that remedies for one problem may give rise to others. Of one thing I am quite sure, and that is that the Common Health is more than figures showing improved birth rates, death rates, and the incidence of disease. In any event the common health of this country is in your hands, both in the short term and the long term, and I for one am wholly satisfied that it is in good hands." (*British Medical Journal* 1954;ii:164).