TALKING POINT

The role of the regional specialist in community medicine for information and research

R D TURNER

In the management arrangements for the reorganised NHS¹ several posts designated "specialist in community medicine" (SCM) were established in the 14 regions in England. There were to be four categories—health care planning and monitoring; capital development; information and research; and medical manpower and postgraduate education. So far as information and research specialists were concerned no formal job description was given, the functions and working relationships being left to each authority. Experience has shown that there are wide variations in practice from region to region.

Collection of data

Health authorities have to determine priorities for investment, and to ensure that the best possible use is made of available resources. At a time of no growth new facilities can be provided only if it can be shown that a saving in financial terms will result sooner or later. A new x-ray machine, for example, should actually replace existing equipment, enable patients to be discharged earlier from a ward, reduce the need for other types of investigation, or have some other effect which will save money, as well as improve patient care.

The first requirement of an information service is hence to monitor the use made of existing facilities from day to day. And in the hospital service, which accounts for about half of all revenue expenditure in the NHS, several information systems, based on the routine collection of data by clerks, have been developed. The most basic is the SH3 return, which is completed once a year in each hospital, and gives the number of beds provided, the number used, the number of patients discharged, the average length of stay, the number of outpatient sessions and patients for each specialty. The returns can be used to show which beds lie empty and whether the number of beds is above or below what is considered a reasonable level of provision for the population concerned, but not much more.

Hospital Activity Analysis (HAA) provides more detailed information. A form is completed for every patient admitted to hospital and sent to the regional health authority computer unit for processing. This is the only routinely collected return which provides information on diagnosis and the nature of any operations performed. It should be possible to use this system to evaluate whether existing resources could be improved upon with benefit rather than merely examining the use made of beds and service departments in terms of patient flow. An analysis of the time spent on the inpatient waiting list by patients with particular diagnoses may show that more investment is required in a given specialty. A long duration of stay for given categories of patients, in comparison with regional or national averages, may reflect a higher standard of care, which should in turn result in improved health and a lower readmission rate for these patients; or it may be that patients in the district concerned are not reaching hospital early enough and consequently have to be kept in for longer.

Factual basis

The real challenge for the SCM (IR) is to work with clinicians to relate factors such as duration of stay and time spent on waiting lists to the outcome of medical care in functional as well as clinical terms, so as to provide a factual basis for planning services. The problem is to decide what kind of information to think about, how to get it, how to organise it, and what to do with it, in terms of analysis and presentation, so that it accurately reflects the use being made of existing resources.

In theory medical services should meet the needs of the community, but people judge their own needs as infinite, yet the resources available to meet these will always be finite. If a particular community has a greater death rate from, or greater prevalence or incidence of, a given disease then there may be a case for investigating the reasons why, and we need more versatile morbidity and mortality statistics both from hospitals and from community services than we have at present.

In some instances a clear case can be made for treating a condition urgently on the grounds that to do so will be cheaper for the taxpayer than keeping the patient off work on a waiting list. More often, medical care is directed towards improving the quality or duration of a patient's life, and financial gains are not relevant, but more information is required on the overall costs of managing patients in different ways and in different situations.

Organisation of information services

An advantage of organising information services from the regional headquarters is that many forms of expertise and data processing facilities are available in one place. Different features of areas and districts can be compared and an overall view of morbidity and mortality in relation to the provision of services obtained, provided that medical, statistical, operational research, and computer specialists co-operate closely in collecting accurate data, analysing it in a meaningful way, and presenting it as and when required. In 1972 Knox, Morris, and Holland² recommended that an overall director of information services should be appointed, hierarchically superior to the heads of the computer and operational research sections, and that this should be a medical post. But the responsibility for data handling systems fell to the management services officers, who were placed at the same administrative level as the SCMs, and made accountable to the RHA through a different member of the regional team of officers. In one or two regions this had led to demarcation difficulties, as feared by Knox and his colleagues. In most, however, an acceptable mode of working has been found, and a typical information planning group consists of the SCM(IR), the management services officer, the regional statistician, and the computer services officer.

So far as liaison with area and district is concerned, most regions have relied on personal contact between medical and management services staff and their counterparts at each level. In one region it is intended that liaison should be on a nodal system based on information rooms in each district general hospital, with a full-time information officer in each. In two others a management information group has been set up which includes an area medical officer, a district community physician, and area nursing officer, and representation from the financial and administration staff at region, area, and district. If the present financial restraint does not improve then most regions will have difficulty in coping with the increasing demands for information.

Confidentiality

As data systems become more comprehensive the SCM(IR) will have an important part to play in confidentiality. Many regions would like some form of record linkage as pioneered by the Oxford Record Linkage Study, but it would have to be made clear to clinicians and to patients that information divulged in confidence will not be disclosed to anyone who may make use of it in a way in which those who provided it would not approve. Arguments suggesting, for example, that the disclosure of those suffering from epilepsy to those responsible for issuing driving licences might be of benefit to the community as a whole will have to be resisted if clinicians are to have any confidence in information systems. If, on the other hand, one or two systems were linked the benefits would be considerable. In many hospitals, for instance, there is no way of learning how long patients survive after discharge from, say, the coronary care unit, unless a regular check is kept on the obituary notices in the local paper. It should be possible to solve the problem by linking the death registration and HAA system.

Research

The emphasis of the post is on information rather than research. The locally organised research scheme takes up about 25% of the time

in at least three regions, and about 10% in another four, but much of this is spent on administration rather than on determining the nature of the proposals themselves. Six out of 11 SCMs(IR) at regional level have had a formal association with a university department of community medicine and this has given the opportunity for personal research projects. These have included analysing the effects of GP deputising services, assessing trends in total hip joint replacement, and projects in communicable diseases control. Joint projects linking management services and the SCM(IR) have been set up, for instance, in the North-western region where a computerised hospital management information system is on trial. In some regions the SCM(IR) is on the steering committee of a project of the Department of Health's experimental computer programme, and in most there is a continuous stream of requests for information from areas, districts, and individual consultants, many of which require considerable development before they can be met. Although personal research may develop in future the development of information services is likely to be on an experimental and piecemeal basis for some time to come.

Medical education

Both undergraduates and postgraduates are taught little about the use of information in health care planning and the ways in which administrators and clinicians can co-operate to provide better patient care. The result is that doctors do not know what administrators do with their time and tend to be cynical about their value in running the Service.

The ideal time to introduce the subject would seem to be to undergraduates. At present their teaching is heavily biased towards the scientific rather than the community aspects of medicine and even epidemiology tends to be taught without much regard to the sources of data in the NHS and the ways in which these can be used to illuminate problems of everyday medical practice. At the middle and senior management levels the impact of clinical medicine in relation to other disciplines within the NHS and to other community services needs to be more widely understood.

Progress to date

The Health Service was reorganised during a financial crisis, and at the same time the reorganisation has given more people—both professional and lay—a voice in its administration. This increase and the need to redeploy existing resources is leading

to an increased demand for information. Health care planning teams have been set up to look at particular aspects of the service. Community health councils require evidence from health authorities rather than opinions as justification for closing down facilities or making changes in the services available. Each level of authority has been obliged to look carefully at the services under its charge and to make economies where they will do least harm.

The post of SCM(IR) has been filled or is being advertised in 12 out of the 14 RHAs. In most regions those appointed have been concerned in a considerable amount of day-to-day Health Service administration as well as developing information services. Most have found that personal research is a luxury and in many regions library facilities within their own headquarters are inadequate or non-existent. Nevertheless, it is generally recognised that relationships in the reorganised NHS have not settled down yet and that the roles of individuals may change considerably in the near future. Meetings are held about four times a year with the DHSS, and, hopefully, national policy on information services will be developed so as to take local needs into account, and vice versa.

Of the specialists in post, four came from regional hospital boards, three from local authorities, and four from university or research positions, so that the group has had a fairly wide experience of the institutions which have formed the new NHS. It is essential that doctors ensure that information is provided which reflects the needs of the population on the one hand and is of practical value to the clinician and administrator on the other.

References

- ¹ *Management Arrangements for the Reorganised Health Service*, DHSS. London, HMSO, 1972.
- ² Knox, E G, Morris, J N, and Holland, W W, *Lancet*, 1972, 2, 696.

Yorkshire Regional Health Authority

R D TURNER, specialist in community medicine (information and research)

Consultants and reduction in work load

Secretary of State replies to Mr Grabham

On 11 September we published a letter to consultants from the chairman of the Central Committee for Hospital Medical Services, Mr A H Grabham (p 657). The Conference of Representatives of Senior Hospital Medical Staffs had passed a resolution advising consultants, who because of the incomes policy were not receiving salary increments to which they were entitled, "to reduce the number of hours which they are currently working in the NHS by an appropriate amount until such time as they are restored to their correct position on the incremental scale." The BMA Council endorsed this resolution. Mr David Ennals's reply (13 September), addressed to the Secretary of the BMA, and the BMA's subsequent press statement appear here.

My attention has been drawn to the text of Mr Grabham's letter to consultants reproduced in the *BMJ* for 11 September (p 657). In this letter Mr Grabham draws the attention of consultants to the resolution of the Hospital Staffs Conference endorsed by the Annual Representative Meeting, advising all consultants who were not receiving salary increments under phase I to reduce their hours of work pending restoration of their position.

I write to say how strongly I deplore and deprecate this action. Mr Grabham's letter shows no recognition that his letter is an invitation to consultants to reduce their hours of work in order to produce a decision from the Government which would be contrary to incomes policy, under which consultants are being treated in precisely the same way in phase II as other occupational groups with incremental salary scales in excess of £8500 a

year. Under phase I, people in such groups received neither salary increase nor increments, but under phase II they will be able to receive pay increases of up to £4 a week and also one increment on their next annual incremental date, without backdating. Where the person in question is on a scale with unequal increments, he may receive either the increment withheld last year or the one which he would have received but for the pay policy, whichever is more favourable. Since your Annual Representative Meeting the Government has agreed to resume within the present phase of incomes policy the payment of new distinction awards.

It is of course true that the year of standstill has created anomalies, but this is inherent in the principle of the £8500 cut-off, and consultants are not being treated worse in this