merger to explore the benefits. In East Sussex both authorities have been exploring this for the past two years.

The idea of providing general practitioners with census results for combination with information derived from their own systems proved impractical because their data were extremely difficult to interpret. As a result, an innovative approach was developed. The reasoning was that if data could be collected from a consultation in a standard and simple manner and indexed in relation to the person to whom they referred then it should be possible to compare values before and after an intervention and assess benefit. Furthermore, standardisation of the collection of data across many practices should allow the creation of a database about a larger population with a known denominator.

For the pilot project, asthma was chosen because of the recent publication of local guidelines. These formed the basis of a standard set of questions, developed in cooperation with staff from the pilot general practices. Their computer systems' software was used to construct a program that prompted for and encoded "yes/no" or multiple choice answers. This could be used during or after a consultation by anyone in the practice with appropriate access.

Unfortunately this process of standard data collection has been hindered by the current design of computer software for general practice (something that may change with the release of upgraded systems in the near future). As a result, the programs seemed to be slow and prone to error, which made them too cumbersome for the time pressured environment of the consultation. Also, use of questionnaires adds a large number of codes to a patient's record.

The software copes better with adding one or two codes per consultation, so difficulties were encountered with analysis and database management. Despite these difficulties it has proved possible to collect data, in particular from clinics operated by practice nurses.

This project has identified the need to start working with general practice computer software companies to encourage them to take account of the wider uses of general practice data, in particular for needs assessment. It may also be necessary for the rules for accrediting these computer systems to be tightened.

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1 Shanks J, Kheraj S, Fish S. Better ways of assessing health needs in primary care. *BMJ* 1995;310:480-1. (25 February.)

Chronic diseases need to have standard definitions

EDITOR,—John Shanks and colleagues mention the value of morbidity data collected in general practice.¹ Remarkably little is known about the completeness and validity of data on health promotion and chronic diseases. The definition of asthma for the purposes of management of chronic disease has been reported to differ considerably among practices.² I found a similar imprecision in the definition of hypertension when collecting morbidity data in 20 Oxfordshire practices that subscribe to VAMP computer systems. Large amounts of time, effort, and money (£901 000 in Oxfordshire last year) are spent on recording and extracting morbidity data for the purposes of managing chronic disease and health promotion. Many general practitioners are dubious about the value of this information, primarily because the data are not yet used for needs assessment. Until there is a uniform definition of conditions such as hypertension, coronary heart disease, and asthma it will not be possible to aggregate practice

based data. Consequently, this valuable source of morbidity data will remain unexploited.

Allyson Pollock and colleagues seem to support the current orthodoxy that public health practice and general practice are mutually exclusive.³ A clinical commitment would surely enhance the credibility of public health doctors among their practising colleagues,⁴ while basing medical practice on applied epidemiological principles is now well accepted.⁵ The boundary between the practice of public health medicine and work as a general practitioner is narrowing all the time. Such developments can only benefit both specialities.

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Interventions must be effective to be needed

EDITOR,—John Shanks and colleagues suggest that conventional methods for assessing needs require adaptation for use in primary care.¹ They are right that several methods should be used, although this applies in all areas of needs assessment. An important element of needs assessment that they do not mention is whether interventions are effective: if "health need" is the ability to benefit from care then interventions have to be effective to be needed. This is a difficult field, but useful evidence does exist.

In Camden and Islington, as part of an initiative in needs assessment in primary care, we have established a series of newsletters entitled *Health Needs Assessment and Your General Practice*. They use routinely collected information, analysed by practice.

The most recent issue, on asthma, compared information collected by the family health services authority under the health promotion scheme, prescribing analysis and cost (PACT) data on the ratio of prophylactic to bronchodilator treatment prescribed, and hospital data on rates of admission for asthma. Each practice receives a customised newsletter in which its position is indicated relative to that of other practices. Although simply feeding back information may not be sufficient to change practice, the initiative has been welcomed by general practitioners locally. General practitioners and practice staff are involved in the newsletters, and feedback about the newsletters indicates that they are promoting reviews of treatment.

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Tailor data collection to needs

EDITOR,—Our experience in a fundholding practice involved in needs assessment confirms John Shanks and colleagues' views that, to inform purchasing at practice level, needs assessment should combine epidemiological data with an analysis of the views of the primary health care team, other service providers, and users.¹ We have also found that routine epidemiological data need modification to make them appropriate to the purchasing process.

With the extension of fundholding to include community nursing services, practices were allocated a budget for whole time equivalent staff based on existing provision. Team meetings at Paxton Green group practice developed a vision of nursing services that realised the wish of patients to be cared for whenever possible in their own homes and formed the basis of the contract service specification. Changing hospital and medical practice had left the district nursing team feeling that its workload was unduly heavy. Consequently, to purchase the appropriate level of nursing care it was essential to identify patients' district nursing needs.

South East Thames Regional Health Authority funded a study of district nursing, which aimed to inform the purchasing of district nursing based on patients' need.²

We combined an epidemiological study and in depth interviews with "local voices."³ Interviews were held with local providers of care (both statutory and voluntary), users, and carers. Activity and caseload data were drawn from West Lambeth Community Care (NHS) Trust's Comcare records (a computer software package for recording nursing activity data) and district nursing manual records.

We described the teams' workload, case mix, primary activities, and amount of time spent with patients. Comparisons with national and local data showed Paxton Green to have a smaller district nursing team than that expected for the practice's population. The interviews identified gaps and deficiencies in service, and many overlapped with social care. Recommendations for purchasing included the need for an extra whole time equivalent D grade nurse.

We found it possible to conduct a needs assessment study principally drawn from routinely collected and locally derived information, but additional details of patients' dependency were needed to inform purchasing decisions about skill mix. Use of a local dependency model confirmed our initial conclusions. The practice has transferred money from its planned underspend to pay for extra nursing services in 1995-6.

Our study supports the opinions of Shanks and colleagues that routinely available information collected locally can be used to inform purchasing decisions, but, to be completely effective, routine data collection must be tailored to the decisions to be made.

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