Information on community health services

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Information on community health services

More and better information is needed—not less

The current thrust of government policy in the United Kingdom is to shift acute care to alternative settings. The critical question is whether these arrangements will meet the health and social care needs of the local community, and that question can be answered only if there are data on needs, service use, and outcomes. The fragmented arrangements for providing and funding health and social care present a compelling case for universal standardised data collection. Yet the NHS information strategy, far from strengthening community information, suggests its contraction.

Data sets and data collection for community NHS services have a chequered history in the NHS. In 1981 Dame Edith Körner's steering group on health services information recommended standardised datasets for community health services and acute hospital services. As a result, three types of community data are collected: on staff groups, on facilities including beds, and on patient contacts.[1] Despite limitations, the data have proved essential for health service planning and for monitoring changes in provision and performance. The introduction of the internal market created new problems: loss of expertise; loss of central mechanisms to safeguard data quality and collection; and loss of data due to fragmentation of provision. Körner data was not designed to support an internal market or monitor individuals' needs, and the community contract minimum dataset was being developed to meet these needs.

In 1991 responsibility for procuring computer systems and data management was devolved to individual providers. After the Wessex computer scandal NHS trusts were prohibited from pooling resources and so had to procure stand alone systems at great expense. Eight years on, many community trusts are still struggling to procure their own systems and develop datasets in the absence of a definitive national community minimum dataset and national guidance.

The systematic collection of community data was eroded not just by the loss of regional information departments but also by contracting out to the private sector and general practice fundholding. Private providers did not make returns to the centre, fundholders who employed their own community staff did not have systems capable of capturing data on staff or service contacts, while some trusts simply stopped collecting data. Thus the Audit Commission's recent review of district nursing could not use Körner data to distinguish between registered and unregistered community nurses because of incomplete data and discontinuity in classification and definitions.[2]

Several bodies are responsible for delivering community care. Communication between them is vital, yet health services, local authority social services, and other agencies do not even share compatible information. A study in the South West region of community trusts and social services departments showed that it is possible to identify a core dataset.[3] In Merton, Sutton, and Wandsworth community health services

data have been linked to social services data to show that while health and social services serve roughly the same number of individuals in the community, 11% of care packages are jointly provided.[4] Local authorities are using these linkage methods to revisit eligibility criteria for health and social care and to inform joint commissioning.

The decision to abandon work on a standardised community dataset stands in stark contrast to the government's overall approach to developing the NHS information management and technology infrastructure. There the uncoordinated approach to developing minimum datasets without ensuring a common core is identified as a major difficulty.[5]

The long term aim is to integrate primary and community care information systems and draw on the proposed electronic health record, but the contents of the electronic record have still to be defined and the primary care framework to emerge. The strategy document is vague about 24 hour access to the electronic health record for general practitioners and community nursing staff, and updating and quality assurance.

The government is embarking on a radical overhaul of the NHS with the introduction of primary care groups. These groups will need to know that care provision, on a multisector, multiagency basis, is effective and efficient in meeting individual patients' needs; they will also require population data to monitor variations in provision and funding across and within sectors. For example, the Audit Commission's review of district nursing shows a sharp decrease in the number of qualified district nurses between 1995 and 1997 and enormous variation in provision between areas and trusts.[3] Similarly, national returns show that the number of households receiving home help and individuals receiving meals on wheels fell by 13% and 10% respectively between 1995 and 1998.[6][7]

Without data on services and needs, clinical governance and evidence based practice are mere rhetoric. A strategy for information must include a strategy for comprehensive standardised datasets and mechanisms for data collection.

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