

Reviews

Supplement to Annex 2 of Classification Systems for Outpatients: Report of the Project 34 Working Group: Framework for information systems
Department of Health, March 1990. Pp. 87.

This document, published by the Department of Health as part of the project work on information systems needed for implementation of the changes described in *Working for Patients*, is a report by CSL Ltd who were commissioned by the DoH to devise a classification system for out-patient activity. The report itself is prefaced by comments from the Project 34 Working Group on the CSL recommendations.

The present systems of data organisation which were introduced to the NHS following the Korner reports concern in-patients and day patients; the information available centrally on ambulatory patients is minimal, out-patients are counted as aggregated numbers of attendances and non-attendances for each speciality with the source of referral identified. Ward attenders are simply counted by speciality regardless of reason for attendance.

The demands of audit, resource management, and contracting cannot be met within the current information systems. This report by CSL proposes a new classification system for ambulatory patients which will include out-patient attendances, ward attendances, accident and emergency attendances and day cases.

CSL state that the classification is designed to support both the development and monitoring and contracts for health-care services between district health authorities and provider hospitals, and to facilitate the extension of the resource management initiative to cover ambulatory care.

The Korner model of care concerns itself with classification of events according to where they occurred and their duration, together with the consultant responsible for the care.

The CSL report suggests a model called the 'Continuous Care Spell Model' which collects information according to the patient's condition, stage of care and work undertaken on the patient irrespective of location.

The classification structure would therefore be that within each speciality, out-patient or other ambulatory events would be classified by:

- (1) *Care stage*
 - (i) Assessment
 - (ii) Treatment

- (iii) Follow-up
- (iv) Monitoring
- (2) *Procedures*
 - (i) Therapeutic procedures
 - (ii) Diagnostic procedures

The report suggests that for each speciality a list of defined and coded procedures would be available – these proposed lists were obtained by consultation with clinicians although only one psychiatrist appears in the list of clinicians involved in consultation.

The proposed list for psychiatry suggests the following procedures as being suitable for a preliminary list of coded events:

Therapeutic

- ECT
- Psychotherapy: behavioural-cognitive-dynamic
- Occupational therapy
- Industrial therapy

Diagnostic

- EEG
- ECG
- Radiological procedures
- Behavioural studies

The report acknowledges the difficulty in coding by diagnostic groups at present and suggests that as a short term measure the speciality of the carer is used as a broad diagnostic category, this can be replaced by DRGs (diagnostic related groups) or AVGs (ambulatory visit groups) once further work on the validity and usefulness of such systems has been completed.

The Working Group commented that they supported the main thrust of the report but felt that major diagnostic groups would be difficult to collect, and that the sub-categories in the care stages were too detailed, they advised a modified classification of:

- (1) *Care stage*
 - (i) Assessment or assessment and treatment
 - (ii) Follow-up/monitoring or follow up and treatment
- (2) *Procedure*

The Working Group felt that the standard lists of procedures were not essential for the introduction of such a system but would be needed for costings reasons.

This report then proposes a major change in the way information is collected for out-patients, it touches on audit, resource management and diagnostic coding. If our resources are to be managed using such information systems then perhaps psychiatry should become a little more vocal in

responding to proposed changes; supplements to annexes are ignored at your peril.

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Working for Patients: Framework for information systems: The Next Steps
London: HMSO. 1990.

This publication from the Information Management Group of the NHS Executive provides a summary of the detailed conclusions reached from a consultative exercise started in January 1990. The consultation was through the medium of three main documents under the general title 'Framework for Information Systems' supported by 13 stand alone Annexes dealing with specific information areas.

These documents were sent to all regions, districts, FPCs, SHAs; a large number of professional associations and colleges; information suppliers and branches within the Department of Health.

Specialised working groups studied both the documents and the replies from the consultative exercise and identified significant issues for presentation to the joint DoH/NHS Steering Committee.

It is from this series of papers and comments that this document is formed; the objectives and recommendations contained in it have one basic common intention, to identify the minimum changes necessary to nationally uniform information requirements to ensure that NHS reforms can successfully commence from 1 April 1991.

This document consists of a series of sections. Part 1 deals with decisions relating to action by April 1991 for organisational units, specific information areas and general issues which cross information and organisational boundaries.

Part 2 concerns wider and longer term areas and details a series of proposed actions needed to refresh and update information systems in the NHS.

Part 3 discusses particular points raised by the consultation exercise whilst Part 4 is a summary of central action which are proposed.

Appendix 1 provides a list of those involved in the consultative exercise and Appendix 2 is a series of tables of the minimum data sets required for various treatment settings.

From such a long and detailed document covering a wide range of issues it is difficult to produce any overall picture of its content. There are some areas which do, however, merit more detailed consideration by those involved in psychiatry.

All health care providers whether acute, long-stay or community based now have a fixed timetable to meet. By 1 April 1991 they must be able to set prices,

assess potential health demands from their catchment populations, have contractual arrangements with buyers, be able to negotiate contracts, account for services rendered and provide data for nationally defined purposes. The key to all this is the existence of appropriate and functioning information systems.

It is proposed that in-patient systems will be based on modifications to existing Korner based systems and Patient Administration Systems; the report acknowledges, however, that out-patient systems will need substantial modifications and that those providers without a viable existing information system for out-patients will need urgently to consider their requirements.

The situation within the community areas is that where information systems exist they have only recently been introduced and that the only immediate solution is modify the Korner based counts to use as basis for contract data set.

Modification and use of existing systems will, however, carry over the problems inherent in the old systems. The report gives a very bleak picture of the ability of hospitals to code accurately medical diagnoses and operative procedures. Some users appeared unable to code even 50% of episodes within five months of discharge. From 1 April 1991 there will be a requirement to code all cases within one month of the episode; the methods with which this transformation is to be caused are not given in any great detail apart from a statement that urgent and determined action is needed!

The contracts system will hinge on the exchange of information between GP and hospital; the time scale of one month for coding is to ensure that the GP has the details of treatment and the 'bill' at the same time. The GP will in making a referral have to conform to provision of a minimum dataset in the referral letter, the Royal College of General Practitioners and the BMA have endorsed the use of the Read clinical classification system for coding in general practice and referrals will use this coding system.

The data set to be collected on patients will conform with the continuous care model which uses diagnostic categories and coding of procedures as a framework for data collection; the original proposals have been modified because of problems with distinctions between out-patients and day cases, and further work is proposed to define ambulatory patients and the data set for this group. Out-patients, however, will be classified using categories of 'what happened to the patient' subject to the completion of work on clarifying definitions of procedures for various specialities.

With whatever area the patient is in contact, there is a need for a standard set of patient and carer identifier codes which will carry over district boundaries. It is proposed that the NHS number will be the prime patient identifier, the DoH code will identify the GP,