

FICM Response to NHS England consultation on NHS Hospital Data and Data sets

Aim:

The stated aim of this consultation is to seek opinion and advice for a wide variety of stakeholders concerning:

- The advantages and disadvantages and feasibility of extracting items of information listed in an illustrative data set.
- Any items that stakeholders consider should be added or deleted from the data set.
- Ways to minimise any additional burden placed on hospital staff by assembling such data.
- How to maximise the quality completeness and timeliness of data extracted.

Commentary:

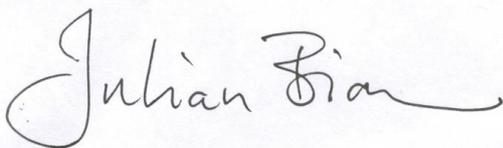
The Faculty of Intensive Care Medicine recognises the value and importance of accurate health system data for administrative, clinical, research and quality improvement purposes. As a speciality at the forefront of information technology and patient safety, we welcome initiatives designed to improve the range, utility, accuracy, security, and availability of data about patient care and resource utilisation, and proposals to improve integration of disparate datasets. In general terms therefore, we strongly support efforts to improve data quality, and to use data intelligently for quality improvement and organisational reflective learning.

However, we have concerns about several of the proposals in this consultation.

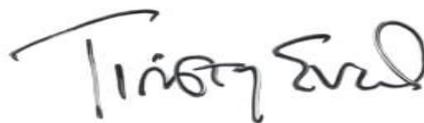
1. The justification for the exercise is not well made, given the scale and work required.. In the executive summary the authors state that it will be 'extremely challenging or impossible' for some hospitals to provide a complete data extract within the timeframe required (beginning of April 2014). Nevertheless the justification provided is that "the Francis Report into the failings of mid Staffordshire Hospital stressed the urgent need to improve hospital data". It is not evident that this general statement provides an adequate foundation for a massive change to NHS data acquisition and the extremely demanding timetable proposed.
2. The proposed granularity of data collection is surprising and its utility uncertain. While the appendix contains selected examples from other health systems of how data has been used for administrative and research purposes, Table 2 does not explain how patient level data such as vital signs charting, or interaction with 'associated AHPS' could be useful at national level, even though this data may well be valuable at a local level in terms of early warning systems or staff rostering. If patient-level data is to be used for performance management or to empower patient choice (patients rarely have genuine choice outside major conurbations) it will require aggregation in some manner. Moreover, how will verification of this level of data be assured?
3. The authors indicate that "many hospitals already have electronic processes in place to meet our likely new demands". The Health and Social Care information centre presumably has (or certainly should hold) precise details of exactly how many hospitals have the capability to provide the data that they seek. If not, an early and important exercise would be to carry out a pilot study to establish precisely these facts. Indeed, rather than expanding or seeking advice concerning an expanded data set (shown in

Appendix B), ascertaining what capacity Trusts in the UK have in order to undertake this exercise would seem to be indicated.

4. Whilst in the Introduction the authors indicate that eventually this process will extend to general practice, mental health, community health, and health and social care; the *consultation* seems to be entirely aimed at the hospital data set, thereby (presumably) excluding a very large proportion of the data that will be needed to achieve the stated aims (increased patient safety, improved outcomes, reduced waste, minimised healthcare inequalities, removal of variation, empowering citizens and staff and delivering high quality healthcare for all).
5. Most clinicians would consider that HES data is used currently entirely for “secondary uses” (page 16). Indeed, data analysis, presentation and the public release of data (eg. Via Dr Foster inc) relies partly or wholly on such data; yet we are told it is “inappropriate” for monitoring and for quality improvement. It would seem important for this extremely sensitive issue and apparent contradiction to be addressed within the document in some detail. In this respect it should be noted that the evidence that HSMRs and SHMIs actually predict care quality is extremely weak, as was acknowledged in the Keogh report.
6. In the section entitled “Future Hospital extracts” (page 18) the authors should state precisely how they believe the modifications that they propose to make to the data set will achieve their desired aims (see 3 above).
7. Pages 22 and 23 indicate that patients, commissioners, providers and researchers could have access to data. It is extremely important for these groups to see how this access will be regulated, and how clinicians (page 24) will be involved in this exercise.
8. Above all, the document has a “top down” feel about it that does not in anyway attempt to address, help or support the institutions that will be tasked with carrying out this exercise. Whilst under the Health and Social Care Act 2012 NHS England has the power to direct the HSCIC to establish information systems and to take account of the standards published, no guidance is provided anywhere within this document as to how this will be financed, regulated or implemented.
9. Finally, the document contains several typographical errors (eg: Page 12: duplication of final paragraph) which suggests that it was produced in haste. Combined with the ambitious timescales proposed, and the very poor track record of government in managing information technology projects, NHS England should focus on assuring quality project management and ensuring adequate buy-in from front-line staff and the public.



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