

# Hospital episode statistics: time for radical change

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The paper by Dr Andrew Spencer in this issue of *Clinical Medicine* (pp xxx–xxx) describes the latest in a long list of initiatives which have attempted to improve the quality of hospital episode statistics (HES)<sup>1</sup> and make them more suitable for the widening clinical and professional purposes for which they are increasingly being used. These purposes now include more information to patients to enable them to make choices regarding their hospital consultant and treatment,<sup>2</sup> monitoring outcomes and quality of care, analysis of outpatient clinics and services, supporting individual consultant appraisal,<sup>3</sup> national audits and research.<sup>5</sup>

Historically, HES were developed to monitor activity and performance, identify costs and allocate resources in the NHS.<sup>6</sup> They have also been used for epidemiological studies, particularly at the large area level.<sup>7–10</sup> As the uses of HES data have grown from supporting the corporate business of the NHS to these more clinical and professional purposes, the quality of the data held in HES has been increasingly questioned.<sup>11,12</sup> There have been many attempts at improvement, including a major project at the Royal College of Physicians which promoted greater consultant engagement,<sup>13,14</sup> but the data still remain suspect, particularly at the level of the individual patient or practitioner.<sup>15</sup>

The weaknesses in HES data have led to poor engagement and use by clinicians, which in turn has caused an explosion of data collection for specific purposes led by clinicians. This has resulted in an increasing number of disparate datasets, data collection processes and systems, that have focused on individual diseases, interventions or clinical contexts rather than the individual patient. This is inefficient, requiring duplicate data entry and generating a myriad of systems containing data that are not standardised, interoperable or comparable between sites.

While further attempts to improve the quality of HES are commendable, we believe that the future lies in radical change. The vision set out by the Academy of Medical Royal Colleges (AoMRC)<sup>16</sup> argues for a strategic move towards patient-centred electronic records that contain standardised, structured data and are the single source of information not only for individual patient management but for as many secondary purposes as possible. This vision has been echoed in the Department of Health's consultation on an information revolution<sup>17</sup> and is supported by many statutory bodies. A key component will be a radical change in the process for central returns from hospitals that contain clinical data, to widen the data content to be more clinically relevant, and to recommend that central returns will only be accepted if the data have been collected in records that

use the standards endorsed by the AoMRC. The current process for collecting patient outcomes after surgery, which is at present a standalone initiative,<sup>18</sup> could be integrated into the patient-focused record, thereby harnessing a powerful, funded driver to collect data at the point of care, involving both patients and professionals. The Medical Research Council's Research Methodology Programme<sup>19</sup> could encourage studies that harness structured, standardised records to support prospective research. The same principle could apply to national audits.

This change is necessary because the current process for the collection of data for central returns that feed HES, and the content of the dataset itself, are both no longer appropriate for the widening purposes for which HES are used. While attempts to improve the data, as set out by Dr Spencer, are applauded, we believe that they are only a short-term solution. Furthermore, struggling to widen the use of HES data by reforming only the process of data collection has very real and inherent dangers. The belief that this will improve the quality of the data collected has not been borne out in practice, and unmoderated efforts to improve the quality of datasets, such as HES, divert attention and scarce resources from developing appropriate alternatives.

Radical change is needed. This change will be achieved through a standardised, structured record that conforms to national standards<sup>20</sup> and will generate outputs that support individual patient care and wider secondary purposes. It is no longer tenable for trusts to be asked to generate central returns to inform HES, feed as many as 50 national audits and 200 other central returns, when the process could be made much more efficient if the data were captured at the point of care.

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